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

RESPONSE TO SPECIFIC INFORMATION REQUESTS:
HB5023-A Budget Note
Children's Mental Health System Change Initiative

Evaluation of Children's System Change Initiative conducted by Portland State University

INTRODUCTION

The Department of Human Services (DHS) was directed by a Budget Note within HB 5023-A from the 2005 Legislative Session to report to the June 2006 State Emergency Board with a report on the status of the Children's Mental Health System Change Initiative (CSCI). That report was accepted, with the recommendation that a subsequent report be submitted in November 2006 regarding evaluation of the Children's System Change Initiative, conducted by DHS contractor, Portland State University (PSU).

This report summarizes the changes made to the child and adolescent treatment system, progress on the work that still needs to be completed, and shares the results of the qualitative evaluation conducted by Portland State University.

BACKGROUND

The 2005 Budget Note (HB5023-A) directed DHS to report to the Emergency Board on efforts to improve the coordination of care in the children's mental health system in response to directives from the 2003 Legislative Assembly. The written report was provided May 26, 2006 and discussed at the June 22, 2006 meeting of the Emergency Board.

This report describes changes made to the system, the results of the qualitative evaluation conducted by the Regional Research Institute at Portland State University and progress toward the work that still needs to be completed. This work included adopting a set of principles to guide the changes to the system. On October 1, 2005, the intensive treatment services Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Treatment Services (PRTS) were included in the managed mental health care contracts. Providers contracted

directly with Mental Health Organization (MHOs). Care coordination for children and their families and approval for admission to the intensive treatment services (ITS) is provided by the MHOs, or for children in fee-for-service, the County Mental Health Programs (CMHPs). This represents a major shift in service delivery, support to families and for providers.

STATUS UPDATE ON CHILDREN'S MENTAL HEALTH SYSTEM CHANGE INITIATIVE

As a statewide system reform effort, the goals of CSCI are to increase the availability and quality of individualized, intensive, and culturally competent home and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized. CSCI requires local or regional managed care environments to bring together previously isolated service components into a system for providing coordinated care and supports to parents in a more collaborative manner. The children's mental health system now uses a standardized method of determining a child and family's level of service need. It assures care coordination and flexibility. Interagency collaboration and accountability are increased. Services are more community-based with management, decision-making, and service delivery occurring at the local level.

There have been both successes and challenges in early stages of the Children's System Change Initiative. Everyone involved is learning from the challenges and using the information to build a successful future. The CSCI was not designed to remedy every child serving system deficit; in fact, it has further elevated the importance of the interconnectedness of all aspects of local and state systems. The Addictions and Mental Health Division (AMH) of DHS is confident that as we work through the challenges, the children's mental health system will become better organized to deliver meaningful family driven, community-based services to children and their families. The ultimate goal is to provide intensive community-based services so that children and their families receive services to keep a child at home, in school, with friends, and out of trouble.

Summary of Changes Made to System Design since July 1, 2005

1. The Oregon Health Plan funds for PDTS and PRTS were contracted to Mental Health Organizations (MHOs) in order to create single points of authority and accountability. Additional, though limited, state General Funds were distributed to Community Mental Health Programs (CMHPs) to

enhance system capacity for children and families not eligible for Medicaid. CMHP requirements were revised to implement screening, referral and service coordination planning for children and adolescents.

2. The Division adopted a uniform community-based method to assess level of mental health need in order to make referral to the appropriate level of mental health services. Since October 1, 2005, nearly 900 children have been approved for an intensive array of mental health services and supports through the new uniform level of need determination process.

3. The Division added MHO contract requirements for assessment (level of need determination), continuous care coordination, child and family teams, coordinated service plans, community care coordination committees, local or regional advisory councils, and a state advisory committee. All nine MHOs have fully operational advisory committee structures. Eight of the nine MHOs have operational community care coordination committees. All MHOs have quality improvement committees and use a child and family team structure to develop and implement individualized plans of care.

4. The Division adopted new administrative rules that define standards for Intensive Community-Based Treatment and Support Services. There are currently 51 public and nonprofit programs that have been certified to provide a new array of services that look at the needs and strengths of a child and family and create community-based services and supports for the child and family.

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

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

7. The Division provided a cultural competency consultation to evaluate the children's mental health system and recommend improvements.

8. The Division revised Policy Three- Meaningful Family Involvement, with input from the Children's System Advisory Council (CSAC) to include the

definition of Family-Driven Care as used by the national organization Federation of Families Children's Mental Health.

9. The Division funded workshops facilitated by NAMI and the Oregon Family Support Network, Inc. (OFSN) that trained family members and professionals in collaborating as system partners. A total of 123 family members and professional have been trained. There have been nine family members that completed a train the trainer model to increase this important technical expertise.

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

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

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

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

Problems Identified and Steps Taken since June 30, 2006

1. **Problem:** *MHO enrollment instability. This resulted in greater numbers of children being in fee-for-service (FFS).* In April of 2006, Actuarial Services Unit staff analyzed an increase in fee-for-services (FFS) expenditures for Psychiatric Residential Treatment Services (PRTS) as part of the April 2006 Rebalance. These

services had been delegated to the MHOs as of October 1, 2005 for children enrolled to their plan. Children not enrolled in a plan were paid through direct contracts with PRTS providers on a FFS basis. The analysis identified three main causes of the increase in FFS bed days:

- FFS payments made to providers for individuals who were enrolled in managed care;
- Individuals disenrolled from managed care effective October 1, 2005 and subsequent PRTS services were paid FFS; and,
- Individuals were retroactively disenrolled from managed care at the time of PRTS services and the provider was paid FFS.

Steps Taken: The first issue, capitation payments and FFS payments for the same individual, was immediately addressed by creating an edit in the payment system. Previously, the managed care and FFS payment modules of the MMIS system did not reference the other to verify the correct status. The system edit implemented in April 2006 provided the necessary interface between the modules to prevent duplicate payments. Individuals for whom duplicate payments were made were analyzed for appropriate enrollment status and the payment made in error was recouped.

To address the remaining two issues, an emergency rule (OAR 410-141-0060) was implemented on May 4, 2006 which increased MHO managed care enrollment of children, prevented children receiving services in PRTS from being disenrolled from their MHO, and enrolled FFS children into MHOs at discharge. Reimbursement to providers and/or MHOs on behalf of individuals whose change in enrollment violated this rule was recouped.

Prospectively, MHOs and Providers notify AMH staff when an individual's enrollment comes into question. AMH staff investigate the case and provide enrollment recommendations to the Health-screen Maintenance Unit (HMU). By collaborating at the admission to PRTS services, fewer billing errors are made, lessening the ongoing recoupement totals.

Ongoing analysis indicate a lessening of the budget impact. AMH and Children, Adult & Families Division (CAF) staff follow a process to determine the appropriate enrollment when working through questionable enrollment. The Actuarial Services Unit continues to analyze claims and encounter data, as well as additional data submitted to the Actuarial Services Unit directly by the MHOs, to

determine the appropriateness of assumptions made during the 2005 MHO Rate Setting process.

In addition, AMH is submitting a proposal for a Medicaid Program Demonstration Project: Community-Based Alternatives to Psychiatric Residential Treatment Facilities. This federal opportunity allows the state to use existing Medicaid resources in a more flexible and evidence-based manner as long as it is cost neutral. The emphasis of this five year demonstration project is to serve 120 Medicaid eligible and currently non-Medicaid eligible youth ages 4-18. These youth are being served in psychiatric residential treatment facilities under fee-for-service designation, or meet criteria for admission into psychiatric residential treatment facilities but could be served in home and community-based settings. Among this fee-for-service population, the household-of-one designees are growing rapidly. This designation is used for children who are only eligible for Medicaid when they are institutionalized and for eligibility purposes Medicaid considers the child a "household of one". These children are the most needy and most inadequately served group of children in our state, with a high level of utilization of institutional services, without particularly good outcomes.

The goals of this project are to more adequately serve the FFS population in home and community-based settings when clinically appropriate and empirically feasible. This project will encourage infrastructure development in rural parts of the state for home and community-based services, as well as expanding the breadth and depth of those same services statewide.

2. **Problem:** *Practices not in compliance with Oregon Health Plan (OHP), Mental Health Organization contractual requirements and with the intent of the Oregon Health Plan Demonstration Project.* In June of 2006, the Addictions and Mental Health Division (AMH) of the Department of Human Services (DHS) became aware of practices by Jefferson Behavioral Health (JBH) that were not in compliance with the Oregon Health Plan, Mental Health Organization, contractual requirements and the intent of the Oregon Health Plan Demonstration Project. These practices create problems with access to medically appropriate services in the least restrictive setting for the children with severe emotional disorders in the JBH region, which includes Douglas, Coos, Curry, Klamath, Jackson and Josephine Counties.

Steps Taken: An AMH Management team visited JBH in July 2006 to review JBH practices compared to the contractual requirements. The on-site visit included document review as well as staff and provider interviews.

A Notice of Intended Remedial Action was sent to JBH on August 3, 2006 citing ten areas of non-compliance and requesting a Corrective Action Plan within ten days to bring JBH's practices into compliance. The areas addressed in the Notice are timely notification of authorization decisions to providers, timely reimbursement to providers for services rendered, basis for utilization management decisions, coordination with community partners, timely submission of encounter data, and policy and procedure revisions.

After reviewing the JBH response, AMH notified JBH that it had not fully complied with requirements. JBH's Corrective Action Plan has been accepted but AMH is preparing to apply financial sanctions for non-compliance, with timely submission of encounter data.

AMH will monitor JBH's progress in reviewing routine data submission, quarterly reports, and regular contact with the plan and local stakeholders. In addition, JBH is required to submit self-monitoring reports to AMH on December 1, 2006, for activity from the 3rd Quarter. This process will continue quarterly or more frequently until AMH is satisfied that JBH is monitoring their practices sufficiently and taking appropriate action.

3. **Problem**: *Inadequate communication between the MHO Contractors and the children's system coordinators of the MHOs and CMHPs.*

Steps Taken: Formation in May 2006 of the Integrated Service Array Operational Workgroup, a subcommittee of the MHO Contractors. This workgroup now reports to the MHO contractors monthly meeting and provides information for each group regarding problem-solving.

4. **Problem:** *Overlapping and outdated administrative rules governing administration of Addictions and Mental Health services and policy.*

Steps taken: A steering committee was formed within AMH in July 2006. The Committee is streamlining Oregon Administrative Rules (OARs) for Addictions and Mental Health Division (AMH) services and policies. Providers need relief from the current administrative burden. With budgetary constraints of the past several years, administrative requirements have become a greater burden for providers, as they have had to make their operations more efficient and maximize their resources. The goal of this effort is to balance regulatory standards with decreased administrative burden to providers.

Children's Mental Health System Change Initiative
Implementation Evaluation

Conducted by the Regional Research Institute for Human Services
Graduate School of Social Work
Portland State University

The evaluation examined the implementation of the Children's Mental Health System's Change Initiative (CSCI) for the Addiction and Mental Health Division, Oregon Department of Human Service. The evaluation covered the time period from October 2005 through August 2006. The CSCI was mandated by Legislative Budget Notes. 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 effected children and youth.

The evaluation focused on the first year of CSCI implementation and examined the changes in structures that local MHOs and CMHPs established to assess the determination of needs of children and families, and the authorization and delivery of services to address those needs. The report is organized around eight evaluation questions:

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

2. What approaches and structures have Mental Health Organizations developed to establish and implement the Integrated Service Array (ISA)?

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

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?

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

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

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

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. The following documents pertaining to the CSCI were reviewed:

- Budget Note HS-3
- CSCI Logic Model
- OMHAS (AMH) Policy Statements 1-6
- Oregon Administrative Rule Chapter 309, Division 032 Standards for Children's Intensive Community-Based Treatment and Support Services.
- The OMHAS (AMH) /MHO Contract Agreement effective January 2006
- Meeting minutes and frequently asked questions/materials from the AMH website.
- 2005 Oregon Youth Services Survey for Families

According to evaluation staff, 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 are divided into two distinct domains: one for the review of infrastructure development and one for service delivery development.

Using the information collected from document reviews, interviews with AMH staff, the six policy statements and the research categories outlined above, the evaluation team developed six interview protocols around these infrastructure and service delivery domains. 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 approved by the Portland State University (PSU) Human Subjects Research Review Committee.

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. The overall data collection process was strategically designed to gather information incrementally, with frequent updates provided to AMH and the state-level Children's System Advisory Council (CSAC). The evaluation team began by interviewing either the MHO Director or the Children's System Coordinator in each of the nine MHOs. This overview allowed the team to understand the varying MHO structures and organize the subsequent interviews accordingly. 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 Partnership Specialist). A representative from each of the Family Advocacy Organizations, members of the state-level Children's Mental Health System Advisory Committee (CSAC), and care coordinators from each of the nine MHOs were also interviewed. CSAC family members, providers and agency staff from child welfare, OYA, and the schools also provided input.

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 evaluation team collected interview data and observed meetings between April and September 2006.

Summary and Conclusions:

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 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 the Division of Medical Assistance Programs (DMAP). 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 education about wraparound, processes for level of need determination, 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. 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; and,
- 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.

CONCLUSIONS AND NEXT STEPS

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

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

One of the families receiving services since CSCI shared their story. An extract from this story is included as Attachment A. It illustrates the effect of this degree of system change in offering valuable support to children and families who are struggling with the ravages of childhood mental illness, and to provide hope and encouragement to families in continuing to advocate for their children when it may seem hopeless.

The CSCI has been an ongoing effort among families, advocacy agencies, MHOs, CMHPs, non-profit providers, and state agencies. There have been changes in financial allocations, contracts, family and advocacy involvement, system collaboration, service delivery, administrative procedures, workforce development, and system oversight. The CSCI has affected all aspects of the children's mental health system. The report from PSU details the significant successes of the initiative to date and outlines the challenges that remain.

As PSU researchers noted, change of this magnitude takes time to stabilize. It seems clear that the infrastructure, a critical piece, is established and operative in most if not all MHOs and CMHPs across the state. Family involvement is strong,

and poised to grow stronger with continued efforts. Refinement of the system should be the next goal, with particular attention being paid by AMH to develop neglected areas of the system: workforce development with particular attention to cultural and linguistic competencies, working with providers and MHOs toward more collaborative and creative approaches for promoting community-based, least restrictive service options, and continued enhancements to the service delivery structure.

Next Steps:

- DHS will continue to monitor managed care enrollment and fee-for-service reimbursements for youth in PRTS to assure that systemic changes are resolving the problems previously identified.
- AMH will monitor the progress of JBH by reviewing routine data submission, quarterly reports and regular contact with JBH and local stakeholders. JBH is required to submit several self-monitoring reports to AMH on December 1, 2006 for activity from the 3rd Quarter. This process will continue quarterly until AMH is satisfied that JBH is monitoring their practices sufficiently and taking appropriate action when metrics are found to be out of compliance.
- The steering committee to review and revise OARs will continue to move forward in that process.
- Technical assistance strategies will be focused on promotion of creativity and alternative approaches while adhering to standards, and problem solving systemic issues that arise in the process, while also minimizing administrative burden.
- AMH, stakeholders, and other interested parties should begin to articulate outcomes for the second year of the CSCI, including attention to workforce development around cultural and linguistic competencies, refinement of service delivery structures, and developing more collaborative and creative approaches to service delivery.
- Focused attention must be paid to integration of services across child-serving systems, creating flexibility in funding streams, and truly creating a system of care across state agencies for our children. AMH is furthering this effort by making a proposal to CMS for a Medicaid Program Demonstration Project: Community-Based Alternatives to Psychiatric Residential Treatment Facilities.
- The next period of CSCI implementation should build on progress to date, refining communication mechanisms, providing training, technical

assistance, and other support in areas such as care coordination, family and youth involvement, and in 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.