January 31, 2006

# Office of Mental Health and Addiction Services
# Responses to Questions Submitted on November 7, 2005
# Children's System Change Initiative Debrief Meeting

**1. Issue: problem w/access to day treatment in Lincoln County, CMHP not giving clear answers, results.** *The Mental Health Organization (MHO) or their designee for children who are enrolled or the Community Mental Health Program (CMHP) for children on an "open card" facilitate referrals to Psychiatric Day Treatment Services (PDTS) programs. A Level of Need Determination, which includes the administration of the Child and Adolescent Service Intensity Instrument (CASII) and assessment of other risk factors, is completed by the MHO or CMHP to determine the child's clinical needs. A Level of Need Determination must be completed within 3 calendar days from receipt of a complete referral. If the child does not meet criteria for PDTS, alternative planning must be made. Level of Need criteria are described in OMHAS Level of Service Intensity Determination Policy One. County specific issues have been dealt with separately from this broader document.*

**School districts are unclear about what to do in "crisis referrals" for PDTS. In the past they got a quick answer about the child's eligibility for PDTS.** *Referrals for a Level of Need Determination to the MHO or CMHP can be made by anyone in the community, including education. Determination must be made within the timeline described above.*

**Foster parents have been offered respite, but nothing has happened. How do foster parents make referrals?** *Referrals for a Level of Need Determination can be made by anyone in the community, including parents and caregivers. Determination must be made within the timeline described above. The availability of respite and other community-based services is dependent upon the service array available in any given community. As needs are identified, communities are encouraged to develop new services and supports. Service level gaps should be identified in the Community Care Coordination Committees and forwarded to the local system advisory councils.*

**Cash flow problems in day treatment program.** *MHOs are required to spend 50% of their allocated Intensive Treatment Services (ITS) funding with ITS certified providers through 12/06. PDTS programs that have contracts with the*

*Office of Mental Health and Addiction Services (OMHAS) to serve children on an "open card" are allocated a set number of "service days" for those children not enrolled in an MHO. Particular provider cash flow issues should be directed to Bill Bouska at 503-945-9717 for a response.*

**Parents are not being offered a CASII screening or planning team by the local CMHP.** *A Level of Need Determination can be requested at any time. If criteria are met, a care coordinator is assigned and a child and family team is formed. If criteria are not met, alternative planning must be made. It is the responsibility of MHOs to ensure that enrollees are informed about the services available to them. For children who are not enrolled in an MHO it is the responsibility of the CMHP to facilitate the Level of Need Determination process and the appropriate service coordination. OMHAS is working with the MHOs and CMHPs to assure the availability of this information.*

**2. How is workforce development, an administrative cost, factored into rate setting?** *The actual cost of providing a Medicaid service should be determined through a cost allocation plan. Providers should bill or encounter this cost. Fee-for-service payment will be made on the established reimbursement amount. However, the actual cost of service is valuable in future rate setting. The Mental Health Organizations are allocated administrative fees for the work necessary to comply with contract requirements that are not reimbursed through other means. The OHP managed care rate setting process for 07-09 rates will include an analysis of administrative costs.*

**3. ITS providers are requesting a guarantee of payment from CMHPs who refer children who are on an "open card."** *CMHPs do not authorize payment for children on an "open card" who are referred by them to PRTS or PDTS. These services are reimbursed through direct contracts with OMHAS. CMHPs facilitate the Level of Need Determination process that assesses the child's clinical needs. When criteria are met, the CMHP makes a referral to the appropriate program and remains involved over the course of treatment in order to facilitate effective aftercare planning. If the program accepts the referral, the Level of Need Determination documentation must be part of the clinical record. The billing and payment procedures for PRTS and PDTS services provided to children who are not enrolled in a MHO have not changed.*

**4. Open card/MHO enrolled ratio.** *OMHAS established fee-for-service bed days for Psychiatric Residential Treatment Services and service days for Psychiatric Day Treatment Services using the same 2004 data set that was used in*

*rate setting by the actuary. OMHAS has established a fee-for-service utilization tracking report and this data will be analyzed on a monthly basis. If it is apparent that utilization trends have changed dramatically we will work with communities and providers on an individual basis to ensure appropriate utilization of state resources.*

**Insufficient psychiatry.** *A shortage of Psychiatry and especially Child Psychiatry is a state and national phenomenon. These services need to be directed in a manner that is most useful to the children and families and programs that need this service. OMHAS has established a standard that children with intensive psychiatric needs have the highest level of expertise available to them. There are many models of service delivery available to communities, including tele-psychiatry, consultation, and supervision that can be developed. OMHAS is working with the Oregon Health Sciences University to increase the capacity of Child Psychiatry throughout the state.*

**Conflicting regulations.** *OMHAS is currently in the process of reviewing administrative rules. A unified children's rule would help mitigate conflicting rules. OMHAS staff would welcome specific examples of conflicting regulations that inhibit appropriate service delivery.*

**ITS residential providers reluctant to sign county/MHO contracts.** *Business partnerships will take some time to solidify. The ITS pilot project provided significant opportunity for providers and contractors to work out relationships.*

**Unanticipated cost of system change.** *There is start up administrative expense any time business practices change.*

**Workforce development.** *OMHAS recently sponsored a stakeholder forum on behavioral health workforce development for adults and is in the process of planning one for children. The objective of the forum will be to identify and agree upon essential core competencies and the core curricula needed to support them in training programs, continuing education, and employment-based training. OMHAS is actively working on work force development concepts and we are supportive of partnering with communities for training*

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**EBP training partnerships for ICTS providers.** *EBP training is an essential component of workforce development. Identifying the need for EBP workforce development and meeting it is a priority for OMHAS.*

**BRS bed and MHO home.** *Currently children who are placed in PRTS care outside the catchment area of the responsible MHO remain capitated to that MHO for purposes of continuity of care. This is not the case when the child is placed in a Behavioral Rehabilitation Services (BRS) program by child welfare or Oregon Youth Authority; the child's capitation is based on the location of the program. It is important that BRS programs and CMHPs maintain a collaborative working relationship to ensure continuity of care for the children they serve.*

**Impact of MHO capitation reduction of MH system.** *A capitation rate change went into effect on January 1, 2006. This rate change has been planned for nearly a year and well communicated with the MHOs. The rate reductions affect out patient and hospital rates, they do not affect rates for ITS. Rates are set on a biennial basis using encounter data from the previous rate period. It is critical that accurate encounter data based on actual cost of service is submitted for future rate setting.*

**5. Increase in administrative cost for ITS programs – needing to manage multiple contracts w/MHOs. Contract requirements being passed on to providers.** *Changes in business practices and business partners will have an initial administrative cost.*

**6. Cash flow – no payment for services in October.** *There will be a lag in payment from direct state contracts to payment from the MHOs. This will be especially true for providers and MHOs that did not work out contractual relationships prior to October 1, 2005.*

**Fiscal impact of data collection – cost shift to providers.** *OMHAS has been working with the Quality Data Improvement Group (QDIG) since 2004 to develop outcome and system measures that are meaningful. It has been a significant focus of this group to develop measures using existing data sets. Collection of the CASII data has been added as a data element. This data will be extremely valuable to monitor the system and establish additional system needs.*

**What's the process for Level of Need Determination for preschool children (3-5)?** *The ECSI (Early Childhood Service Intensity Instrument) is being field tested for children younger than 6. Until it is available for use, the Level of Need Determination for children younger than six will be based on the other criteria (current mental health assessment, risk factors) as described in OMHAS Level of Service Intensity Determination Policy One.*

**Schools concerned with financial liability if they attend child & family team meetings.** *There are efforts to resolve this issue locally. A school meeting can be*

*requested at anytime by the parent/legal guardian to address education issues. The child and family team meeting is a mental health function and not directly related to a child's education requirements. This is an opportunity to coordinate system efforts.*

**Does the PDTS day rate include medication management?** *No. Programs that provide medication management must establish business arrangements with the responsible MHO. PDTS providers may bill OMAP directly for medication management for children who are not enrolled in an MHO.*

**How will long-term education funding be flexible to the number of children a program serves?** *There has been no change in the allocation of long-term funding for education. The Oregon Department of Education (ODE) will monitor the use of these funds to ensure that the education needs of children are met. ODE has a workgroup that is analyzing Long Term Care and Treatment education system-financing options.*

**7. Are MHOs expected to fund "room and board" for children in foster care who score CASII level V & VI?** *"Room and board" is included in reimbursement for acute hospitalization, psychiatric residential treatment and long-term psychiatric care services. If a child's clinical needs require these services, they should be provided by the appropriately certified provider. Depending on the service and the child's OHP coverage, these services are reimbursed by MHOs or OMHAS. DHS, Children, Adults, and Families fund foster care for children in the custody of DHS and these efforts should be coordinated at the local system level or case-by-case basis.*

**Can school districts initially state a time period that it will always take from date of IEP placement to the start of school?** *ORS 343.961(5) states that "The Department of Human Services shall give the school district providing the education at a treatment program 14 days' notice before a student is dismissed from the treatment program." It is critical that the education system is engaged in the child and family team and service coordination processes. Individualized planning and service coordination are key aspects to the system change, this is especially true when a child transitions to or from intensive treatment services.*

**8. Day treatment contracting with OMHAS & 5 MHOs, but no contract or cash flow for October.** *There will be a lag in payment from direct state contracts to payment from the MHOs. This will be especially true for providers and MHOs that did not work out contractual relationships prior to October 1, 2005.*

**9. Will the state implement a "network of care" website similar to the one operated by San Diego County?** *The state is looking at multiple ways to*

*disseminate mental health system information to family members and the public. OMHAS is investigating the "network of care" website as a model for effective information flow. We try to keep the OMHAS web site up to date with information about the public mental health and addiction services system. The San Diego County website http://sandiego.networkofcare.org/mh/home/ is a great model for information dissemination.*

**10. What about the idea of having a single 800 phone number to call for CSCI issues/system navigation?** *OMHAS has established a hotline number 877-667-7070. Staff will respond to messages received through this line within 24 business hours.*

**11. What are the functions of the Child & Family Team and the ITS treatment team? Who pays for what?** *Detailed descriptions can be found in OAR 309-032-1240 through 309-032-1305 "Standards for Children's Intensive Community-Based Treatment and Support Services" (ICTS) and OAR 309-032-1100 through 309-032-1230 "Standards for Children's Intensive Mental Health Treatment Services" (ITS). In general an interdisciplinary team focuses its efforts on the mental health needs of the child, whereas a child & family team assesses and identifies needs and supports across a broader set of domains. Another important distinction is that treatment planning utilizes the medical model, whereas service coordination planning utilizes a strengths-based, family-driven model. The functions of these teams are not mutually exclusive and in fact are intended to complement each other. Although the team-driven process results in planning or the review of planning across all life domains, funding is specific to the responsible child-serving agency/provider.*

**12. For children on an "open card" in residential prior to 10/1/05, who is responsible for paying or contracting for outpatient or ICTS services prior to discharge from residential?** *Effective 10/01/05, CMHPs are responsible for facilitating Level of Need Determinations and making referrals to PRTS and PDTS programs as well as providing care coordination for children on an "open card." For children placed prior to that date, CMHPs are encouraged to collaborate with programs in transition planning for these children, as they will likely be providing services upon discharge. It is recommended, but not required, that a Level of Need Determination, which includes a CASII, be completed as part of the after care/discharge planning process to identify services and supports that are needed and how they will be provided.*

**13. There is a need for family-driven local crisis & planned respite care that can be encounterable.** *These services are encounterable.*

**0-6 evaluation system leaves something to be desired.** *Note answer to question #6 regarding development of the ECSI. OMHAS is actively working on projects with the early childhood service system including work on an early childhood diagnosis system.*

**Family advocates need training in the use of mental health services terminology.** *OMHAS has developed a mental health acronym list. We will post this on our website and redistribute it to family members. OMHAS will continue to support training efforts and collaboration with family organizations.*

**14. Need description of "family care coordinators." Heard they are "gatekeepers."** *MHOs and CMHPs are responsible for facilitating the level of need determination process for children who may benefit from intensive community-based treatment and support services and the integrated service array (ISA). These criteria are defined in OMHAS Level of Service Intensity Determination Policy One. Children who meet criteria are to be assigned a care coordinator who is responsible for forming a child and family team. The purpose of the level of need determination and assignment of a care coordinator is to assure identification and appropriate services and supports for children, particularly those with significant mental health needs.*

**15. Need update on MOU between OMHAS and CAF.** *The MOU has been signed and will be widely distributed. It can be found on the OMHAS website. http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/letterofagreement.pdf*

**16. Need training about difference between "placement" and mental health services responsibilities of child welfare and mental health.** *This issue predated the CSCI and continues to be an important topic of discussion. Clearly many children in the custody of child welfare have significant mental health treatment needs, thus there is a shared responsibility for coordination and service delivery. DHS, Children, Adults, and Families fund foster care and these efforts should be coordinated with mental health services and supports at a local system and/or case-by-case basis.*

**17. What if the child and family team recommends day treatment, but the CASII score is low.** *The level of need determination which includes*

*administration of the CASII assesses level of service intensity need not how or what services are needed. If Psychiatric Day Treatment is not clinically indicated for a child, alternative planning must be made. Additionally, if there is a disagreement about what services are appropriate and efforts to resolve the issue are unsuccessful, a grievance can be filed.*

18. **MHO capitation should not change when a child is placed in an out of area Behavior Rehabilitation Services (BRS) program.** *Child welfare is discussing enrollment policy options for children receiving services in a BRS program. However, changes will not occur in the short-term. In the meantime, it is important that BRS programs and MHOs and/or CMHPs maintain a collaborative working relationship to ensure continuity of care for the children they serve. Continuity of enrollment decisions can be made on a case-by-case basis.*

**19. Schools are concerned about liability for children with higher needs, reluctant to engage for that reason.** *There are efforts to resolve this issue locally and at the state level. A school meeting can be requested at anytime by the parent/legal guardian to address education issues.*

**Lack of active/strong family support groups in many parts of the state.** *The ICTS OAR requires that certified providers have a formal relationship with a family organization. This requirement in conjunction with continued training and support with the Oregon Family Support Network and National Alliance on Mental Illness will continue to increase family involvement in the system.*

**Increase community awareness of mental health issues, develop informal & natural supports as participants on child & family teams.** *Natural support systems need to be developed or enhanced for children and families. It is critical that child and family teams include anyone who is important to building recovery and resiliency of the child and family. The ICTS rule requires this involvement. The stigmatization of mental health is a national issue. OMHAS continues to develop public messages regarding mental health prevention, identification, services, and outcomes.*

**20. How will changes affect BRS programs? How do programs need to adjust?** *The CSCI does not directly effect financing or operation of the BRS system. BRS programs are vital services for children in the custody of child welfare and the Oregon Youth Authority. The MHOs remain responsible for the*

*mental health needs of the children receiving services in BRS programs. BRS providers should be involved in local system decision-making processes.*

**Where can BRS programs get updated information on the changes?** *DHS website: http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/main.shtml*
*Each MHO has an identified children's system coordinator and an identified system planning and advisory process. BRS programs should contact their local CMHP or MHO for detailed information about local system planning and delivery of mental health services.*

**21. Are all MHOs sending "notice of action" to DHS caseworkers as "OHP member representatives?"** *MHOs are required by contract to send a notice of action to the MHO member or member representative, each time a service or benefit will be terminated, suspended or reduced, or a request for service authorization or request for claim payment is denied. OMHAS will reinforce the importance of notifying the member representative as required by contract.*

**22. State should set an example and hire full-time family member to give TA and help to all family members.** *OMHAS did develop a half time Family Partnership Coordinator over a year ago. We are limited to the position authority given to us by the Legislature.*

The following issues and recommendations were submitted on behalf of the Children's Array of Psychiatric Programs (CHARPP).

**23. Interface/alignment with parallel systems - CHARPP recommendation: That an ongoing cross-system venue be established for identifying opportunities for the state to provide leadership and direction for local communities in cross-system collaboration.** *The MOUs between state agencies to are important components to the promotion of collaboration and OMHAS will continue its efforts in that regard. The system is designed to promote interagency collaboration on the case and program level in local communities (Community Care Coordination Committee), through local and regional oversight of the CSCI (MHO Children's Mental Health System Advisory Council), and statewide through the Children's System Advisory Committee. Additionally, the monthly Children's Mental Health System Coordinator's Meeting was created as a forum for stakeholders to discuss implementation issues specifically.*

**24. Interface between Child and Family Teams and ITS Teams - CHARPP recommendation: That OMHAS staff research the issue (interface between**

**child & family teams and ITS treatment teams) and address it at an appropriate regular meeting in which the various stakeholder groups are participants, with the agenda announced in advance, or alternatively at a special meeting.** *See question #11. Care coordination, service coordination planning, and the functions of child & family teams and how these components of the ICTS rule interface with ITS services is an important issue. The Child and Family Team and Service Coordination Plan as described in the ICTS rules define the roles and responsibilities of each party involved in providing services and supports to a child and family. The Individual Plan of Care and Interdisciplinary Team as required in the ITS rules define and direct the active psychiatric treatment provided while a child is receiving that service. Since the Children's Mental Health System Coordinator's Meeting addresses implementation issues, that group is the most appropriate venue for this issue.*

**25. Use of the CASII – CHARPP recommendation: That OMHAS staff investigate the use of the CASII around the state, and establish a process through which it would be determined as to whether or not the CASII could be used as a tool to determine the need for continued stay. This process would ideally involve stakeholders, either within an existing venue (announced as an agenda item in advance) or in a special meeting. Additionally we recommend that OMHAS collect objective information regarding inter-rater reliability for the CASII.** *OMHAS welcomes the opportunity to work with both stakeholders and the American Academy of Child and Adolescent Psychiatry (AACAP) to determine the viability of using the CASII as a continued stay tool. An initial discussion regarding this issue is scheduled on February 9th at the Children's Mental Health System Coordinator's Meeting. One of the CASII's strengths is the strong inter-rater reliability of the tool. The OMHAS Program Analysis & Evaluation unit is collecting objective CASII data and a plan to monitor inter-rater reliability is being developed in consultation with AACAP.*

**26. Provider Level Administrative Burden - CHARPP recommendation: That OMHAS pursue avenues to relieve the administrative burden on providers, potentially to include rate increases, standardization of contracts, standardization of authorization mechanisms, standardization of reporting requirements, or other opportunities that may become available.** *Changes in business practices and business partners will have an initial administrative cost. As partnerships grow between ITS providers and MHOs there will be a natural standardization of mechanisms and requirements. Providers should complete a cost allocation plan and use this information to bill the actual cost of services provided. This information is important in future rate setting methodology.*

*OMHAS is conscious of the administrative costs to providing care. We have been careful to use existing data requirements for monitoring and oversight. OMHAS is in the process of reviewing administrative rules to minimize duplication and inefficiencies that may currently exist in the rules. CHARPP should establish a mechanism to collaborate with MHOs on administrative mechanisms that would provide more uniformity and consistency throughout the psychiatric residential treatment services system.*

**27. Capacity/Resources - CHARPP recommendation: That OMHAS monitor the capacity/resource issue and pursue opportunities that may arise to encourage and/or incentivize MHOs to incorporate economy of scale considerations into contracting decisions.** *OMHAS has established multiple monitoring mechanisms to ensure that within available resources that children with severe emotional disorders and their families receive medically appropriate array of supports and services. OMHAS does not ordinarily become involved in MHO subcontracting agreements. The children's mental health system is changing including business practices and service system design. We will continue to focus efforts in what is in the best interest children and their families within available resources.*

**28. Cash Flow - CHARPP recommendation: That OMHAS be aware of monetary cash flow problems that arise for providers and take action when indicated for specific agencies to leverage assistance and/or relief.** *OMHAS is aware that contract and business practice changes have had an effect on programs resources. This is a short-term issue as the system changes from reliance on direct contracts with the state to contracts with the MHOs. In the past we have supported providers through billing practice changes. As needed we would have discussions with individual CHARPP agencies.*

**29. Open Card/Fee for Service - CHARPP recommendation: That OMHAS analyze the data for a factual understanding of the dimensions of the problem (number of FFS children in PRTS exceeding projections) and design mechanisms if indicated to ameliorate the situation for specific agencies and/or the system in general.** *OMHAS is closely monitoring the PRTS fee-for-service utilization and comparing this data to individual PRTS fee-for-service*

*contract allocations. In addition, capitation errors are being corrected when indicated and subsequent FFS utilization numbers are adjusted as a result of these corrections. We will analyze three months of clean utilization data to look at service utilization and patterns. Providers are encouraged to manage service delivery within the 18 month contracts that were effective October 1,2005.*

**30. CSCI Evaluation - CHARPP recommendation: That OMHAS establish an inclusive advisory type of group to work with the designated entity in the (independent) evaluation on of the CSCI.** *OMHAS is working with Portland State University to conduct a system evaluation. We will work closely with the Children's System Advisory Committee (CSAC) and provide regular updates and information. CSAC will have the opportunity to have input and monitor the progress of this system evaluation.*

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