Children's Systems Change Initiative
Focus Groups

Location: Oregon City - 19 participants
Date: Dec. 9, 2008
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Topics (# priority dots)

Level of youth & family involvement
Parents don't always have access to mental health services, but need them. (12)
Difficulty financially supporting the family support services. (2)
Lack of billing for family or peer provided services. (1)
More family involvement needed at county councils. (1)
Consistent outreach to a variety of youth groups / individuals to gain their input & involvement.
Lack of family and youth involvement consistently
Families within our program do not know about these services.
Solutions and Comments
Family may need higher level of services. Some parents have cognitive limits but not eligible for DD.
Provide more family therapy.
Develop billing code to incorporate more than one person.
Have parents see psychiatrist as well as child.
Increase training for staff in family therapy.
Could ICTS pay for any medically needed services - flex $.
Substance abuse treatment.

Access & Referral

Many staff in schools do not know how to refer students to access services (process continues to evolve). (5)
Pressure from partners & families for higher level of care when not medically necessary or when lower levels had not been tried. (5)
Access to ISA in Clackamas County still low in consideration of eligible OHP. (4)
There are always those problematic cases where the child doesn't warrant a psych res placement but has behaviors that prevent the child from being able to stay in their home. (2)
Family / individual knowledge of how to access services. (1)
Access for professional consultation & referral seems to be great in Clackamas County - we need to maintain this focus. (1)
Minimal access to respite services.
Good access to respite to decrease need for more intensive services.
Pamphlet + phone number provided - but no clear info beyond that.
ESCII is still not available. Standardized assessment & tool is needed, but early childhood professionals should be trusted to make decisions about populations with which they have expertise.
Information on services available is unclear and community is not well informed.
Training made available to family serving programs, like Healthy Start, on recognizing and referring families to support services.

Solutions and Comments

Education to school districts + ESD
Hard to organize people to address the problem
Complicated MH system
Need a flowchart
Focus on school superintendents
Identify entry points (not everyone), key people (2-3)

Training in August
Include Head Start & early childhood programs
Develop a DVD to explain CSCI or interactive link
Family Navigator program
Training on level of care
Pressure for Increased LOC
Educate parents on likely outcomes from PRTS
Clackamas does a good job on child / family assessment up front - slows the process down.
Care coordinator (neutral) explain pros /cons of different services (PRTS, ICTS)
Schools don't have a lot of faith in MH system - so they wait until the end / crisis.
Provide respite care earlier.
Have parents deliver message to other parents.
When a child comes to residential treatment with a plan, it is hard to back up and find out other services that might work in community.

Transitions between levels of care
Increase collaboration & coordination when clients bump up or down levels of care (identifying roles of providers). (5)
Planning & preparation with schools as students transition from programs & into programs. (5)
Clients moving up or down levels of care often have to change agencies, providers and/or psychiatrists. (5)
Shorter stays in PRTS require much faster assessment, tx planning & discharge planning. (2)
Challenges coordinating transitions between ICTS provider & CMHP - kids returning to outpatient services with no change in presenting problem. (1)
Not clear when child / family should move to the next level & who should initiate.
Difficult transitions out of PRTS / sub acute.
Shortened length of stay in residential programs creates a challenge to establish effective education program while in residential & next ed. placement.

Increase opportunity to collaborate with providers.
Clearer definition when clients move up or down the level system (consensus for discharge or step down).
Transitions from higher levels of care to outpatient are a big step for families - could benefit from more training for providers on those transitions.
Challenge outpatient staff participating in CFT meetings when child not in OP services - += helps with continuity of care but takes significant time to attend (some kids in ICTS for extended time).

Administrative Rules and contract issues
Overlapping/duplicative OARs re: ICTS - multiple tx plans depending on # providers. (10)
No real incentive of MHOs to not use PRTS - you get future $ for that utilization. (2)
Consistent OARs - need consistent language i.e. treatment plan, service plan, etc. (2)
Provider agencies can be audited many times by MHOs - independent auditing processes - inefficient, inconsistent, expensive. (2)
Too much documentation required by state, various reports. (1)

Solutions and Comments
Variance to OAR
Encourage ISSR process
Unfunded mandates (supervision) doesn't help
Training staff in EBP fidelity is prohibitive
Emphasize outcomes rather than fidelity.
Need to highlight strengths as well.

Service array availability
As mental health has reported success with change initiative, increased financial burden on schools. (5)

Lack of available planned and crisis respite services. (4)
Need for increase in ability to serve families in their native language. (3)
Limited availability of resources in rural communities with no meaningful incentives for new providers to come to town. (2)
Lack of respite options (1)
2-3 weeks between therapy sessions for young children makes it difficult to build relationships and effect change. (1)
Changes in availability of mental health service has shifted more responsibility to schools. (1)
As a system, we struggle to find shelter care (short term) in our local communities.
County does not know the array available
Increased costs to school district as more students are served in the community.
We believe our MHO has done a nice job trying to secure in-home support.
Care coordination for youth not meeting minimum level of need.
Success in keeping youth in community and school then puts higher level of services (residential) at risk of closing; some youth will still need that higher level of care. No incentive to keep doors open.
I have seen as we problem solve the needs of the most difficult youth, the system is flexible in confronting wha is needed - especially families with private insurance that don't meet those needs.

Ability for systems / agencies to collaborate
Need for multi-disciplinary system approach to working with families. (5)
Cost shift to education for mental health services. (3)
Challenge to collaboration: time involved for outpatient staff attending child & family team meetings (conflicts w/ clinic based services; time to get to meetings, time of meeting (especially when after work schedule); clinical issues not always addressed; child/youth may not be receiving outpatient services at that time). (3)
Collaboration between systems dependent on a few people…need to increase the pool. (2)
Partners wanting ISA for all referrals; wanting to "jump to" higher (ISA) services rather than use outpatient services. (2)

Presently Clackamas County works very hard at maintaining our collaboration between agencies - this is a priority & needs to be maintained. (2)
Collaboration requires highly skilled care coordination. Appreciated David Barkin trainings - staff continue to need consultation & follow up. (1)
Increase knowledge of school personnel re: services and Level of Care & Access x2
Challenges resolving clinical differences/approaches among providers
Collaboration discussed, but after 3 yrs, results not seen.
We believe we have a great system of collaboration & communication. We are always able to talk things through and find solutions.
Knowledge of CSCI to community partners, providers, individual clinicians.
Utilize local Commission on Children & Families to gain input on programs, joint planning & advocacy w/ board of Co. Comm.

Provider stress and financial limitations

Clinical staff retention is an issue due to high stress, crisis oriented clients and evening / weekend work in ICTS contracts. (9)
High turnover rate among providers / therapists impacting stability and continuity of care. (4)
Need a more in-depth cost-basis analysis of ICTS services to determine cost sustainable to providers. (1)
MHOs (also impacts doc. structure & staff training needs). All shifts very labor intensive / expensive require sophisticated knowledge about Medicaid w/ little consultation. (1)

$ for services - care coordination - advocacy - youth advocacy. (1)
Funding for community based activities and programs.
Low payments create high turnover.
Resentment by partners and providers / re: funding changes
Old capitation rates funding an increasing more expensive mental health world.
Having new system being aware to a voluntary referral to DHS when family ability to pay for a placement because difficult if not overly burdensome.
Shift from per diem residential payment to fee for service outpatient requirements - increase knowledge of medicaid code / medicaid necessity - change of billing system structures & staff structures & staff training to provide document & bill under code - manage billing structure to address varied codes by different
AMH - please allow early childhood diagnoses for day tx code.
Funding for care coordinators / family & youth advocacy
Kids youth returned to outpatient services w / team expectations of a service (3 sometimes 4)
Continuing our ability to address private insurance cases where needs are great.

Workforce issues
Staff training - community versus facility - requires higher capacity training skills; higher clinical skill level; more knowledge as they manage challenging child & family situations independently; recruiting, training & supervising staff to appropriately rise to these challenges - costs $ and requires effective consultation. (9)
Need for more Spanish-speaking providers across the service array. (4)
Regional & statewide training: level of need determination screening, child & family team, documentation, principles of Wraparound. (3)
Clinicians receiving more adequate compensation as direct providers. (1)
Limited bilingual ICTS providers - children in need stay in Outpatient services

Other

Lack of meaningful outcome data - although starting in 2009, we have lost 3 years of possible data. (10)
Need for resources for transitional aged youth. (2)
Consistent and proportional state funding to counties based on need. (2)
Heard about CSAC & CSCI, but only received pamphlets about services in this county last spring.

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