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Emergent Issues

in the

Public Mental Health System

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Prepared by James I. Carlson

Office of Mental Health Services
Mental Health and Developmental Disabilities Services Division

Emergent Issues in the Public Mental Health System

Executive Summary

The 1990s are a transition period for the public mental health system in Oregon. Funding constraints challenge the goals of comprehensive and inclusive mental health services for all Oregonians who need them regardless of ability to pay. Inclusion of mental health services in the Oregon Health Plan promises integration of services for consumers, but challenges the current state-county partnership in providing those services.

These challenges are not unusual, but are part of a recurring cycle in which the public mental health system has re-examined its structure and goals about every ten years. In 1959, Governor Mark Hatfield appointed a committee to design an improved mental health system for Oregon, and the 1961 Legislature adopted the committee's recommendation to create the Mental Health Division (later changed to Mental Health and Developmental Disability Services Division - MHDDSD). One initial objective was to build a strong network of locally directed community mental health services beginning with existing components: three psychiatric hospitals, two training centers for the mentally retarded, several child guidance clinics, and a single alcohol outpatient clinic. (1)

About ten years later, the 1973 Oregon Legislature acted upon recommendations of a 1972 task force to revise civil commitment laws and set into statute the Comprehensive Community Mental Health Program Act, which codified the emerging community-based system. The matching fund formula for financing community mental health programs was changed to require 50% state and 50% county funds for most services with up to 100% state funding for defined alternatives to state hospital care. (2)

In 1980, a Governor's Task Force on Mental Health again reviewed the mental health system. State hospitals had successfully reduced their census in favor of less restrictive care in community programs; however, the community programs had to be focused on those most in need of services. The 1981 Legislature passed the Local Mental Health Services Act which established priority populations, mandated a range of community mental health services, and had the state assume 100% funding for most mental health programs. (3)

In 1988, a Governor's Commission on Psychiatric Inpatient Services was appointed to examine an apparent erosion of the quality of care in state hospitals. That report recommended

substantial improvements in the quality of state hospital care and the development of 155 local acute care beds to provide short-term psychiatric hospitalization close to home. (4) Many of the state hospital improvements were not made due to budget restrictions. However, the local acute care initiative is nearly complete. Almost all acute admissions of adults are now to local acute care units rather than to state hospitals, bringing closer the Commission's goal of allowing state hospitals to concentrate on intermediate and extended rehabilitative care.

The challenges facing the mental health system today are no less significant than in the past 30 years. A key issue is redefining the statutory relationship of the state and the counties for mental health services in a managed care environment. Existing mental health statutes direct the state to provide community mental health services in cooperation with the counties. It is unclear how this directive relates to prepaid health plans (PHPs), although under the Oregon Health Plan they will be increasingly important as managers and service providers. Many PHP roles will overlap or replace current county responsibility for service delivery. Further examination of this issue is called for as it cannot be quickly resolved by this report. Another key issue which needs to be addressed is how comprehensive and inclusive the publicly funded mental health system can be in an era of limited resources. There is some concern that funding limitations could lead to weakening of the community support network built up over the last 30 years as an alternative to extended state hospital care.

Ten policies are governing operation of the mental health system through this current transition:

1) maintain a strong working relationship with counties in developing and coordinating the changing mental health system.

2) continue to treat persons with the highest level of disability as the highest priority service population.

3) serve persons with psychiatric needs in local community inpatient units, rather than in state hospitals.

4) continue the development of state hospitals as specialized treatment resources for intermediate and long-range rehabilitative care. For both financial and programmatic reasons, minimize the use of state hospitals as long-term custodial facilities.

5) upgrade the quality of state hospital care by concentrating staffing from downsizing on the remaining smaller number of patients.

6) continue the development of specialized statewide and regional extended care programs in the community as an alternative to prolonged hospitalization.

7) continue an active role as the catalyst in the development and provision of housing for persons with severe and disabling mental illness.

8) support the integration of medical care, chemical dependency, and mental health treatment in the Oregon Health Plan (OHP).

9) encourage a variety of mental health delivery models during the OHP mental health phase-in period to see which works best.

10) assume a more active role in system integration and quality assurance by the Division's central office as the mental health delivery system is decentralized.

The following pages cover the development of these policies in light of the Division's guiding principles, the statutory roles of the state and counties, and the expected impact of the Oregon Health Plan.

Footnotes:

(1) Adult Mental Health in Oregon: A Report from the League of Women Voters in Oregon, Salem OR, August 1986.

(2) 1973 - A Turning Point for Mental Health Programs in Oregon, Mental Health Division, Salem OR, October 1973.

(3) Report of the Governor's Task Force on Mental Health: Recommendations for Services for the Mentally or Emotionally Disturbed, State Capitol, Salem OR, December 1980.

(4) Report to Governor Neil Goldschmidt on Improving the Quality of Oregon's Psychiatric Inpatient Services, Governor's Commission on Psychiatric Inpatient Services, Salem OR, September 1988.

THE EVOLUTION OF OREGON'S MENTAL HEALTH SYSTEM

Introduction

Changes and impending changes in the publicly-funded mental health system have raised questions about where that system is headed and how it will be integrated. Understanding the significance of these changes requires understanding the evolution of the system. Three clear themes emerge from review of the past 30 years of mental health history in Oregon.

One is movement away from state hospitals as settings for long-term care and custody of persons with serious mental illness who have nowhere else to go. The direction is for hospitals to be active treatment centers, well integrated with a broader community-based system of care.

The second theme is meeting the needs of consumers of mental health services to enable them to live the most normal lives possible. This psychiatric rehabilitation philosophy calls for working closely with consumers to identify realistic goals for where they want to live, work, and learn, and with whom they want to socialize -- goals that all of us have. Mental health care then includes not only psychiatric treatment but social supports needed to achieve and maintain these goals. This approach not only normalizes lives but lessens the need for expensive psychiatric services such as hospitalization.

The third theme is providing mental health services through a state-county partnership with strong local control.

Given these three themes, the development of Oregon's publicly supported mental health system has been coherent and consistent over the past 30 years. Mindfulness of these themes is needed to continue that focus and continuity through the next decade.

The Evolution of Oregon's Mental Health System

When the Mental Health Division was founded in 1961, it consisted of three state hospitals, two training centers for the developmentally disabled, 11 child guidance clinics, and a single alcohol outpatient clinic. The initial objectives of the system were to build a strong network of locally directed community mental health services and to upgrade institutional care and treatment. "It was believed that this two-pronged approach would serve more people more effectively by catching problems early, removing barriers to treatment, and shortening

or even eliminating the need for institutional care." (Adult Mental Health in Oregon, League of Women Voters, 1986, p.3) This direction was consistent with the report of President Eisenhower's Joint Commission on Mental Illness and Health which recommended a shift in care of the mentally ill from the hospitals to the community. Following this report national legislation was passed to establish Community Mental Health Centers.

Nationally, state hospital populations peaked in the early 1950s. A long decline then began which has been attributed to the introduction of psychotropic medications (Thorazine was the first in the 1950s) and to a movement away from the concept of the state hospital as a long term care custodial institution. Mental illness was no longer a disease without hope of recovery. Between 1950 and 1990, the total number of beds operated by state mental health authorities nationally declined from 569,455 to 98,304, an 83% reduction. (Witkin M, Center for Mental Health Services, personal communication quoted in Hospital and Community Psychiatry, September 1994, p.11) Oregon has followed these national trends. Oregon's state hospital census peaked in FY 1957-58 at 5,065 patients, dropping to 943 by December 1994, an 81% reduction. (The December, 1994 figure includes 106 patients in state-funded local inpatient units). As of 1992, the most recently available national statistics, Oregon's hospitalization rates for adults and for children were in the mid-range of national rates, showing Oregon neither ahead of nor behind the national trend.

On a purely budgetary basis, this is a fortunate trend. If Oregon's 1994 hospitalization rate remained at the 1958 level, there would be about 8,900 patients in state psychiatric hospitals today. This would cost about $767 million more per year using 1995 cost-of-care rates. From the mental health perspective, the most significant shift has been a change in the role of the state hospital from an institution emphasizing long term care and custody to an active treatment program designed to restore a patient to functioning in the community.

The evolution of community mental health has supported these changes. Federal legislation in the 1960s provided funds for establishing Community Mental Health Centers (CMHCs). Only a few federally funded CMHCs were established in Oregon -- Eastern Oregon, Lane County, and in the 1970s, Clackamas County and several in Multnomah County. Instead, most Oregon Community Mental Health Programs (CMHPs) were developed using a 50:50 mix of state and county funds. By the early 1970s, there were 27 Community Mental Health Programs and 17 contract programs providing services to all 36 Oregon counties. Thus, from the beginning, Oregon's Community Mental Health Programs have been developed through a state-county partnership with strong local control.

In 1973, the Oregon Legislature passed the Community Mental Health Programs Act. This Act:

1) set up three regions statewide combining the programs of communities and state hospitals. Each hospital served a catchment area;

2) established a structure for counties to operate CMHPs in three program categories. The areas were Alcohol and Drug (A&D), Mental and Emotional Disturbances (MED), and Mental Retardation and Developmental Disabilities (MR/DD);

3) established mental health services of two types: (a) basic services including outpatient services, aftercare for persons hospitalized in state institutions, training, consultation and education, and prevention services; and (b) services that were alternatives to state hospitalization including 24-hour emergency care, day and night treatment services, local alternatives in housing, and inpatient care in community hospitals.

The funding formula continued to require 50:50 state:county funds for basic services, but provided up to 100% state funding for alternatives to state hospitalization.

By the late 1970s, it became apparent nationally that the CMHCs were not adequately serving persons with severe mental illness, especially former state hospital patients. The National Institute of Mental Health (NIMH) began a Community Support Program, and the Carter Administration appointed a President's Commission on Mental Health. Both initiatives focused on the plight of the deinstitutionalized patient who was not being adequately served in the community. In 1977, Oregon became one of the first states to begin a community support program pilot project.

In 1980, the Oregon Legislature mandated creation of a task force to study the needs of persons with mental illness; Governor Atiyeh appointed a Task Force on Mental Health which published its report in 1981. This resulted in the passage of the Local Mental Health Services Act which is still the basis for Oregon's community mental health system. This legislation established a clear patient priority system and mandated that community mental health services be focused on the most severely disabled clients. Community support programs were established statewide. The result was a clear and impressive reduction in state hospital admissions between 1979 and 1985. This was the only significant reduction in state hospital admission rates in over 40 years. (Note: State hospital admissions have shown a

more recent major drop due to the local acute care initiative discussed in the following paragraphs--see Graph 1).

By the late 1980s, concerns were growing about the erosion of the quality of care in state hospitals. Dammasch and Oregon State Hospital suffered periods of decertification and were unable to bill Medicare or Medicaid for covered services. In January 1988, Governor Neil Goldschmidt appointed a 14 member Commission on Psychiatric Inpatient Services.

In the Executive Order establishing the Commission, the Governor noted an apparent erosion of the quality of care in state hospitals and called for a thorough reappraisal of Oregon's inpatient care for the mentally ill. The Commission "found alarming deficiencies in the state hospitals" including overcrowding, understaffing, lack of essential staff training, and obsolete and deteriorating facilities. (Report to Governor Neil Goldschmidt on Improving the Quality of Oregon's Psychiatric Inpatient Services, September 1988, p.2)

As a corrective action the Commission recommended the diversion of most acute care patients from adult psychiatric wards by 1995 through the establishment of 155 acute psychiatric beds in general hospitals throughout the state. The report noted that this would permit state hospital services to be rededicated to the provision of intermediate and long-term rehabilitative care in secure settings." (Ibid, p.29)

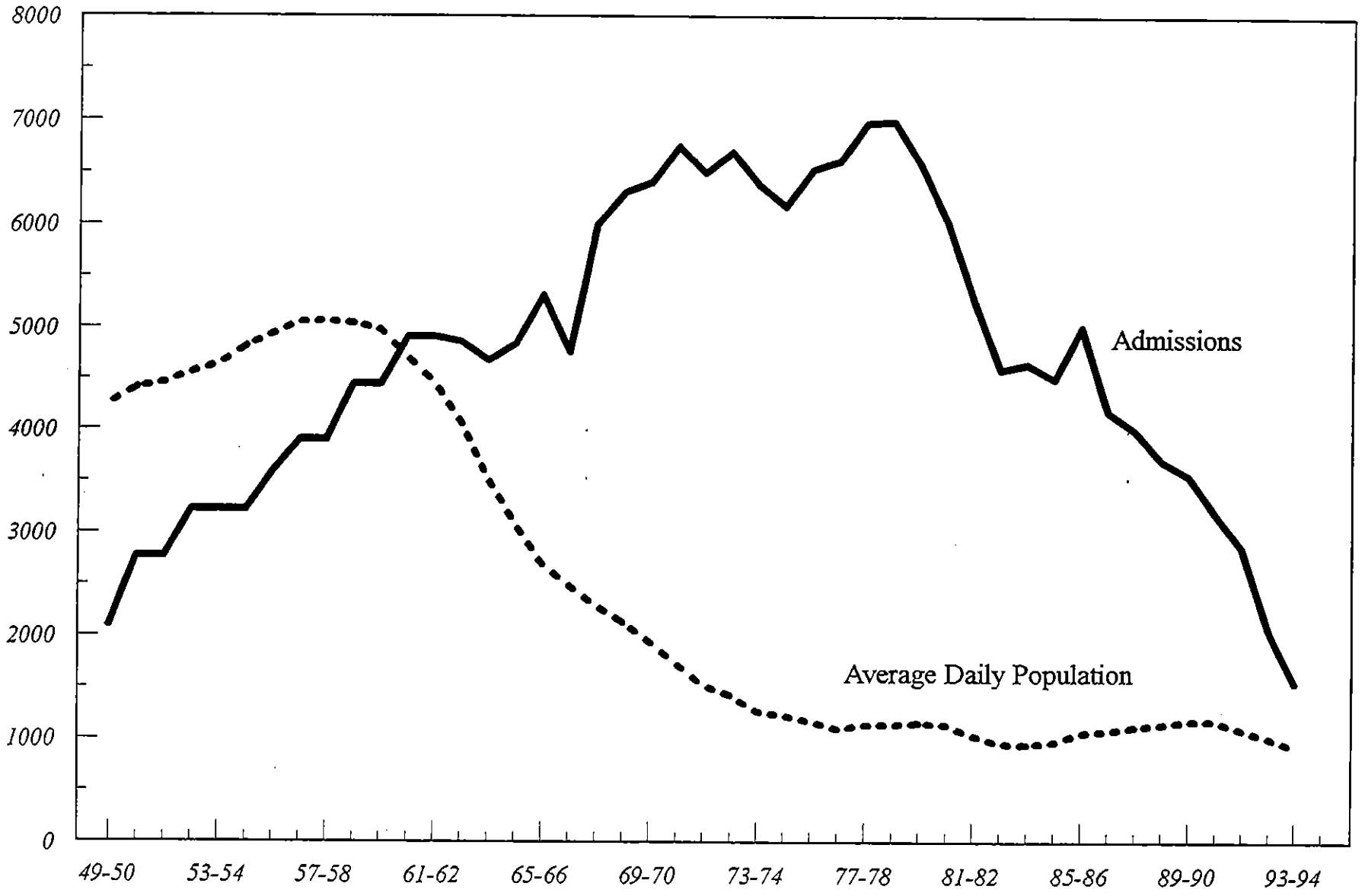
As of 1994, much of the shift of acute care to local general hospitals has occurred (see Graph 2). The Division now contracts with ten hospitals throughout the state to provide a total of 111 local acute care beds. An exception to the diversion of acute treatment from state hospitals is Eastern Oregon Psychiatric Center in Pendleton which continues as both the acute and long-term rehabilitative center for the Eastern Oregon region.

In developing the local acute care unit it was clear that unless a local "envelope of services" was provided, the units would soon fill with patients who had no place to go. Therefore, discretionary funds to assist with discharges were included in each acute care budget. These "envelope" funds are typically administered regionally by councils representing the CMHPs that are served by each local inpatient program. They have been used to pay for crisis/respite beds, regional coordinators, enhanced case management for discharges, transportation, and other services to permit earlier discharge of patients. Regional management of the envelope funds and the local acute units themselves has been successful in promoting optimum use of these resources.

Graph 1

Census and Admissions 1950-1994

All State Hospital Programs Combined



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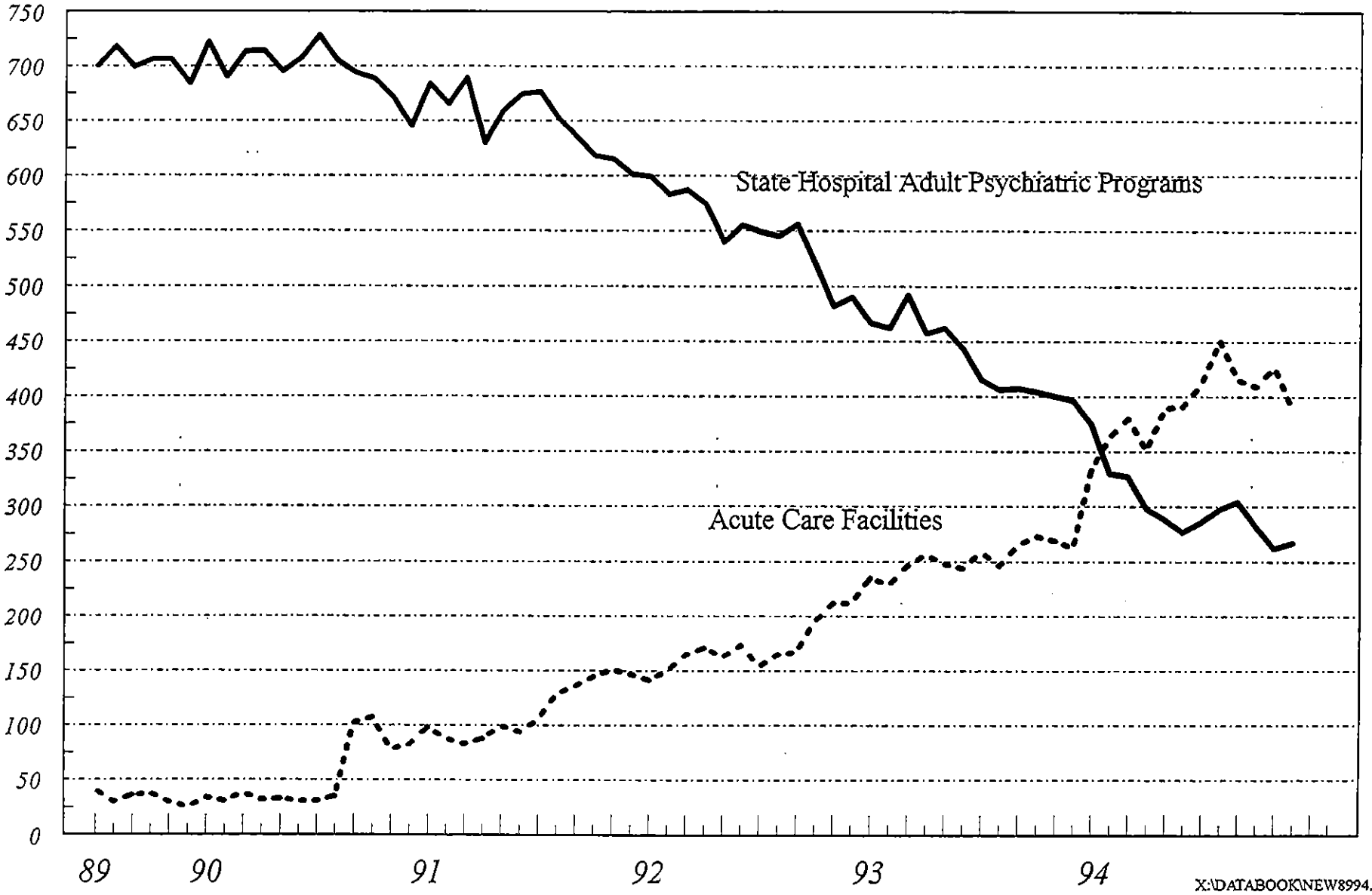
Graph 2

State Hospital Adult Psychiatric and Acute Care Facilities

Unique Clients Served July 1989 through December 1994



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While the local acute care initiative has unfolded, there has also been extensive development by the MHDDSD of other statewide and regional programs to permit discharge of long term patients from state hospitals. During the 1991-93 biennium, three innovative projects were developed: consumer-operated case management services (30 slots - Community Survival Project); two joint ventures between MHDDSD and the Vocational Rehabilitation Division to provide job training for persons with mental illness (40 slots - Psychiatric/Vocational projects); and 65 individualized discharge plans with special supports to meet the needs of long-term patients, the "365" Projects, so named because those served had been in the state hospital longer than a year. During the 1993-95 biennium, 124 additional slots (the PASSAGES projects) were developed; these were an extension of the previous biennium's successful "365" projects.

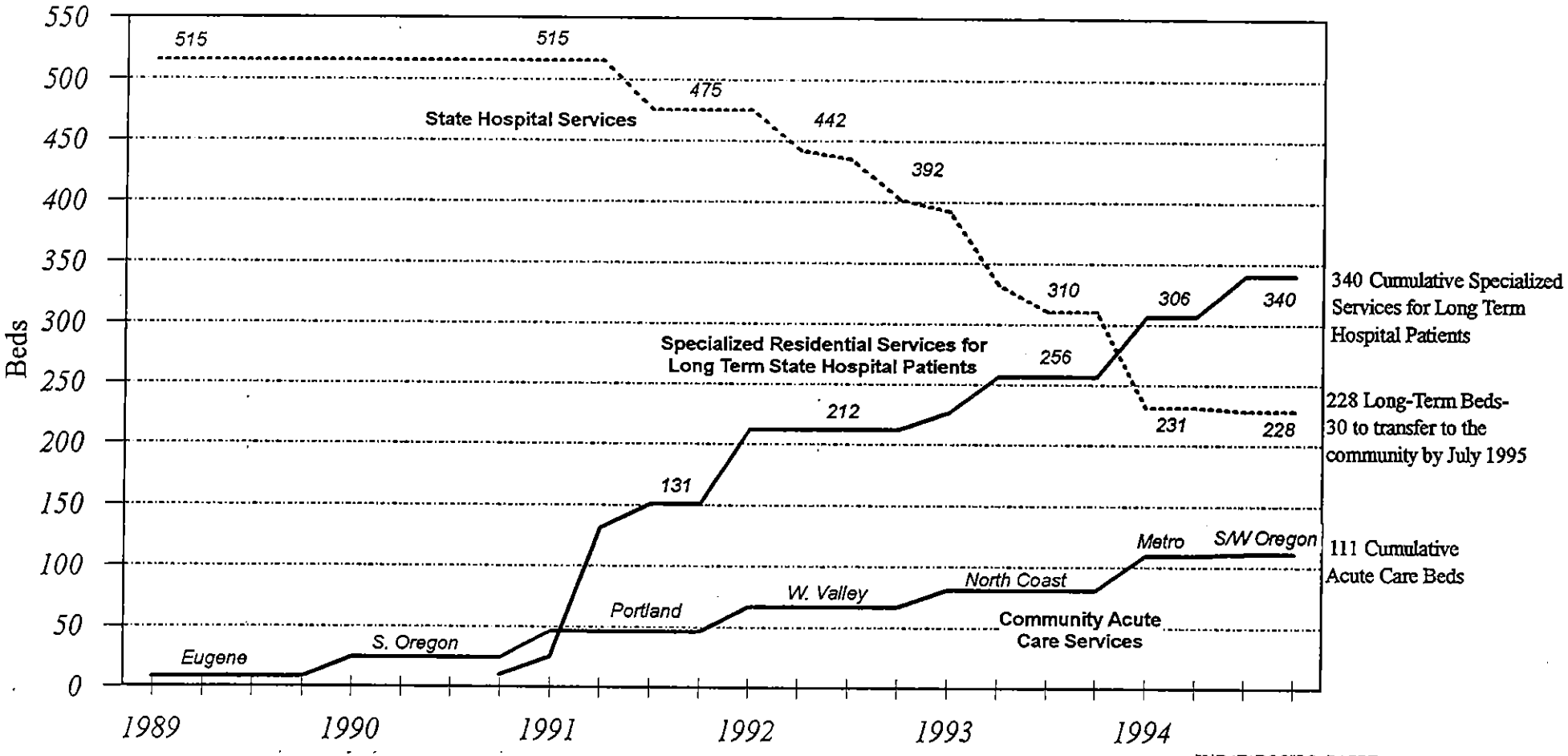
Evaluation of the Passages projects shows that they have been successful in reducing prolonged state hospital stays. As of January 1995 134 persons with an average hospital length of stay of 2.4 years were discharged into Passages projects. As of October 1994, 89% of the people discharged have remained in their new placement successfully, while 11% have returned to a state hospital.

Over the past two biennia, a total of 86 Enhanced Care Facility (ECF) beds have been developed jointly with the Senior and Disabled Services Division. These specialized programs allow community placement into nursing homes of individuals with a psychiatric condition and special medical care needs. An additional 28 ECF beds were developed by MHDDSD using its own funds, which allowed closure of the medical care ward at Dammasch in April, 1994. The cumulative effect of all of these specialized facilities along with the local acute care units is shown on Graph 3.

The recent reduction in the size of state hospitals has occurred in adult psychiatric programs, which had averaged about half of all state hospital beds. The remaining half has been comprised of programs for children and adolescents, the elderly and others who require intensive nursing for medical as well as psychiatric conditions, and forensic patients. Census on these latter programs has remained relatively stable while adult psychiatric programs have grown smaller. Note in Graph 3 that the reduction in the number of adult psychiatric beds has been offset by the development of alternate care sites -- the local acute care units as well as specialized programs for extended care. The final step in this transition is the expected closure of Dammasch State Hospital upon opening a 40-to 70-bed state-operated replacement facility in Portland in April, 1995.

Graph 3

State Hospital Adult Psychiatric Program Bed Capacity
Community Acute Care Capacity
Specialized Residential Services



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February 22, 1995
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The downsizing of adult psychiatric programs has allowed progress toward a second goal of the Commission on Psychiatric Inpatient Services -- that of upgrading the quality of care in state hospitals. As hospital census has declined, remaining staffing has been concentrated on a fewer number of adult psychiatric patients. This should achieve staffing levels which can meet standards of the Health Care Financing Administration (HCFA), the oversight agency for Medicaid. At present only the Geropsychiatric, Child and Adolescent, and Eastern Oregon Psychiatric Hospital programs meet HCFA standards.

Another relatively new programmatic thrust for the MHDDSD is a more active role in rehabilitation or new construction of low cost housing for persons with psychiatric disabilities. MHDDSD has long encouraged local programs to develop such housing using federal Housing and Urban Development or other grant funds. Since 1989, MHDDSD has awarded nearly $1.4 million to 43 housing developers to create or preserve housing for 441 persons. These awards have leveraged, on average, $12 from other sources for each state dollar invested. A renovation program was started in 1993 in which $91,000 has been used to fix health and safety problems in residential programs serving 189 residents with mental illness.

The development of this extended care support network is consistent with the long-term direction of the Division to create specialized community supports for persons with severe mental illness. The more active recent role has been demanded by a shrinking stock of low-cost housing available to the poor generally, and to persons with mental illness specifically; failure of public assistance to keep up with the increasing cost of housing, and the growing recognition of the problem of homelessness. Up to 30% of the homeless have a mental illness. Each year in Oregon about 6,000 to 8,000 people with mental illness are in need of housing support.

It makes sense both fiscally and programmatically to take a direct role in solving these problems. Fiscally, hospitalization is the most expensive treatment resource. There is no fiscal sense in prolonging a hospital stay due to lack of an acceptable discharge site. Programmatically, providing the range of community supports needed to help citizens with mental illness function in the least restrictive community setting is consistent with Division policy.

This programmatic thrust is also consistent with legislative policy. As specified in ORS 430.610, the Local Mental Health Services Act:

"It is declared to be the policy and intent of the Legislative Assembly that:

1) subject to the availability of funds, mental health

services should be available to all mentally or emotionally disturbed . . . persons regardless of age, county of residence or ability to pay;

2) services shall be conducted in the least costly and most efficient manner and shall be effective and coordinated;

3) to the greatest extent possible, mental health services shall be delivered in the community where the person lives in order to achieve maximum coordination of services and minimum disruption of the life of the person; and

4) the State of Oregon shall encourage, aid and financially assist its county governments in the establishment and development of community mental health programs."

These principles, codified in law, have provided a firm foundation for mental health system development. The question facing the system today is how will managed care affect the state's ability to adhere to these principles, particularly in a time where funding falls short of the demand for services.

MENTAL HEALTH RELATED STATUTORY ROLES OF STATE AND COUNTY GOVERNMENT

State Statutory Roles

The MHDDSD is authorized by statute to:

1) administer state mental health programs and mental health laws of the state - ORS 430.021(1);

2) operate the state psychiatric hospitals - ORS 179.301;

3) accept the custody of persons committed to its care by courts of this state - ORS 430.021(7);

4) establish, coordinate, assist and direct a community mental health program with local government units and integrate such a program with the total state mental health program - ORS 430.021(5);

5) contract for specialized statewide and regional services - ORS 430.695(2).

The above is not an exhaustive list but conveys the main topics. Specific duties regarding the administration of mental health can be found throughout multiple ORS chapters, primarily 161, 179, 426, 428, and 430.

County Statutory Roles

The statutory responsibilities of counties for mental health are relatively simple. They involve two functions:

1) the first right of refusal to directly operate or subcontract for a comprehensive community mental health program (CMHP) - ORS 430.640; and

2) paying the cost of emergency psychiatric care and custody - ORS 426.241.

First Right of Refusal

ORS 430.640 gives counties the first right of refusal to directly operate the local program or to subcontract for its provision. There is no mandate that counties participate. Counties may decline to directly operate or subcontract in which case the MHDDSD is authorized to directly contract with another public agency or corporation to run the program, or may operate it directly on an emergency basis. Although counties do not have to operate a CMHP, once they choose to do so they accept all the concomitant statutory responsibilities, which include

investigations and recommendations for civil commitments under ORS 426.070.

Emergency Care and Treatment

Should a county choose not to participate, only one statutory responsibility remains for mental health services. Counties are responsible for the costs of emergency psychiatric care and treatment not provided in a state hospital when any funds allocated by the state for that purpose are exhausted. Emergency mental health care and treatment includes hospitalization and all other care which may be necessary while an allegedly mentally ill person is being investigated for possible civil commitment, and care provided to civilly committed persons who are temporarily in the county's custody after apprehension from unauthorized leave or revocation of a trial visit.

Due to funding limitations the MHDDSD has for some time limited by contract the amount of state funds which can be applied to emergency care and treatment. No such use of state funds was authorized during the 1993-95 biennium and this situation is likely to carry over to 1995-97.

The Broader County Role

In addition to the specific mental health obligations of counties, they have a broader role for the protection of the community's public safety and health and must deal with the many consequences of care of the poor in their communities. Counties are in a unique position to care for entire communities through their ability to:

1) gather data to assess community needs and monitor outcomes;

2) develop county-wide plans and policies to address these needs through partnerships with multiple providers and consumers;

3) use statutory powers to assure that services provided as a result of developed policies are being delivered in a coordinated and cost-effective manner;

4) coordinate with other programs for provision of services and care, i.e., Local Commissions on Children and Families, Juvenile Services, Community Corrections, and Alcohol and Drug Programs.

(Excerpt from policy paper on Local Health and Human Services Under the Oregon Health Plan, adopted by the Association of Oregon Community Mental Health Programs, September 8, 1994.)

The State-County Partnership

The right of counties to decline participation in administering a CMHP has not been exercised. All counties, either individually or as a consortium, directly operate or subcontract for their local mental health programs using state funds allocated for that purpose. The CMHPs also rely on a combination of county general funds, private grants, private payment, private insurance, Medicare and Medicaid funds to supplement the provision of services. Statute prevents the state from using the county's program fees, third party reimbursements, or contributions as offsets to the amount of state funds the county would normally receive - ORS 430.695(1).

The current mental health statutes clearly specify roles of the state and counties as well as the CMHPs but make no specific allowance for the state contracting with prepaid health plans for provision of mental health services to county residents. This authorization is a result of Oregon Health Plan (OHP) legislation and the MHDDSD's authorization to contract for specialized statewide or regional services. It is clear, however, that the mental health statutes which specify the range of services to be offered by a CMHP, and the directive to the MHDDSD to establish local mental health programs with local government units, are not entirely consistent with the Health Plan legislation. Some of the implications of the OHP for the state-county partnership in providing mental health services are examined in the next section.

THE OREGON HEALTH PLAN (OHP)

The OHP has two impacts on Oregon's mental health system. First, many clients now served in state hospitals or in CMHPs are Medicaid eligible, and therefore will be able to get medical services through the OHP. In addition, people enrolled in the OHP, whether or not they currently receive publicly funded mental health services, will be eligible for mental health services. Beginning in January 1995, about 25% of all OHP enrollees will receive their mental health benefit through a managed mental health care organization on a prepaid, capitated basis. The complete integration of mental health services into a capitated, prepaid managed care system will occur by July 1996. This is referred to as the "mental health phase-in" in this paper.

In examining the impact of the OHP on the public mental health system, it is important to remember that not all persons served by MHDDSD are Medicaid eligible. In FY 93-94 nearly 70% of children served by CMHPs were covered by Medicaid; 30% were not. During the same period nearly 42% of adults were eligible for Medicaid; 58% were not. Under the OHP, only persons eligible for Medicaid are covered. Therefore, some of the current public mental health caseload, the non-Medicaid eligibles, will not be included in the mental health phase-in projects. This population will continue to receive CMHP services, subject to availability of funds, through the current state-county partnership, until such time as all Oregonians have mental health coverage as part of their health care insurance.

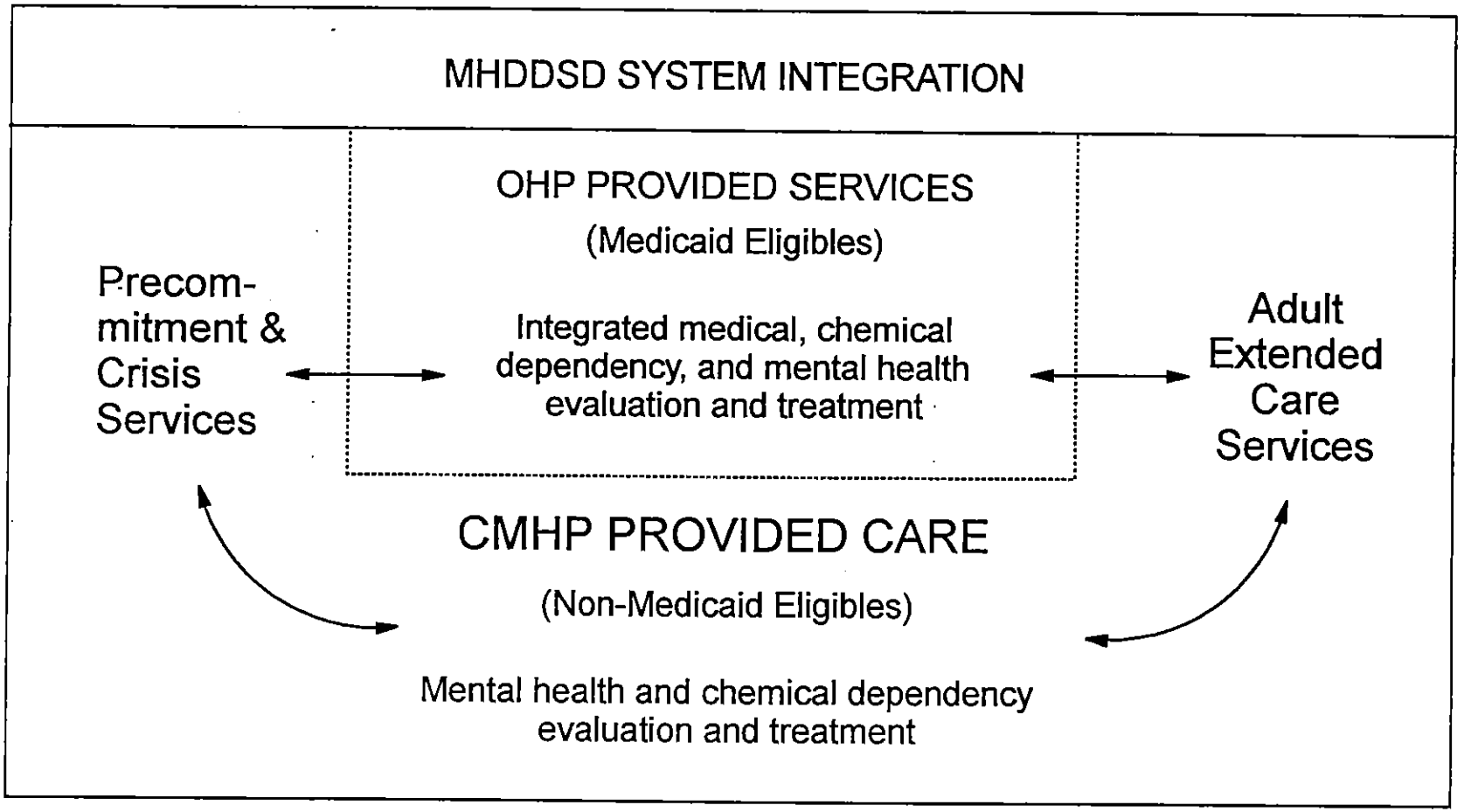
The exact size of the non-Medicaid eligible population which will be served by CMHPs cannot be determined at this time. At least two factors are influencing that number. One is the extension of Medicaid to include all Oregonians below the federal poverty level; this has reduced the number of non-Medicaid eligibles. A countervailing trend is an apparent increase in the number of people served in CMHPs who are above the federal poverty level. It is not clear at this time where these two trends will level off.

A second critical point is that the OHP will cover only some mental health services. Mental health services can be displayed as a continuum ranging from: precommitment and crisis services, to an intermediate range of diagnosis and treatment, to extended care. This is displayed in the following chart.

Note: A more detailed version of the attached chart showing specific services is included in Appendix 1.

Chart 1

THE MENTAL HEALTH SERVICE DELIVERY SYSTEM IN THE HEALTH PLAN PHASE-IN PROJECTS



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Precommitment and crisis services require 24-hour accessibility, quick screening, and rapid intervention for those presenting an immediate danger to themselves or others. Since this intervention may lead to initiation of civil commitment proceedings, precommitment and crisis services are often thought of together.

These are not services which will be covered by the OHP for two reasons. One is that civil commitment involves temporary loss of some civil liberties, so it is best handled by public rather than private agencies. Second, precommitment and crisis services deal with public safety and order like the police, fire, juvenile justice and health departments. Public safety and order functions require close coordination with each other. This has traditionally been achieved at the local level by city and county governments. Therefore, precommitment and crisis services will continue to be provided through the state-county partnership.

State funds for precommitment and crisis services have been distributed to counties using a mental health block grant approach. Consistent with the "public utility" concept, there is movement toward distributing these funds using an equity formula as is shown in Chart 2, The Changing Mental Health Service System During the OHP Mental Health Phase-In Projects. The equity formula approach supports the concept that local precommitment and crisis services need to be offered on a consistent basis in all counties.

Between precommitment and crisis services and extended care, both of which will continue to be provided by the state-county partnership, lies an intermediate area of mental health services. These services include 24-hour urgent care and emergency response, evaluation, consultation, case management, medications and medication management, skills training, and daily structure and support. It is the vision of the OHP that these services be provided along with medical care and chemical dependency treatment. Funding for these services is included in the capitated rates. Funding for non-Medicaid eligibles is through block grants to counties to operate CMHPs. This is illustrated in Chart 2 by diagonal lines bifurcating what can eventually be a seamless middle range of services. The arrows indicate that OHP contractors will be providing an increasing share of the intermediate range of mental health services as the phase-in projects progress.

Chart 2

THE CHANGING MENTAL HEALTH SYSTEM DURING THE OHP MENTAL HEALTH PHASE-IN PROJECTS

SERVICE	SERVICE PROVIDER	FISCAL RESPONSIBILITY	FUNDING FORMULA
Precommitment and Crisis Services	State/county Partnership	State and County General Fund (GF)	County GF for emergency care; State GF moving toward equity formula
Healthcare Services (integrated medical, chemical dependency, and mental health services)	Oregon Health Plan Contractors / State/ County Partnership (mental health and chemical dependency only)	Medicaid / State GF, Medicaid, Medicare, Private pay, Insurance Federal block grant	Actuarial Estimates / State block grants to counties; Fee-for-service
Adult Extended Care Personal Care Housing Supported Employment	State/County Partnership	State general fund, Medicaid, Medicare, Private pay, insurance	State block grants to counties; Fee-for-service
Long-term Hospitalization	State		Capacity
Specialized Statewide Resources, e.g., Passages	State/County Partnership		Request for Proposals

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The third tier of services involves extended care. Successful treatment for adults with severe and persistent mental illness requires bringing together crucial services such as personal care, specialized or supported housing, assistance in preparing for and maintaining employment, and occasionally, extended psychiatric hospitalization. As need for these services is more related to level of disability than to diagnosis, they are excluded from OHP coverage where diagnosis and the treatment which can be provided are closely linked. OHP contractors will refer clients needing these services to the existing CMHP service network.

Extended treatment for children can involve intensive day and residential programs. Under the OHP, children's extended treatment services are handled differently than for adults. Extended treatment services for children, including extended psychiatric hospitalization, are included as OHP covered services but are currently outside the capitated rates. During the phase-in projects, these services will be delivered on a fee-for-service basis through the existing mental health system. (See Appendix 1 for detail.) The long-term goal is to provide extended care services for children fully inside the capitated rates.

Given the above picture, it is clear that two parallel mental health delivery systems will operate for the immediate future. During the mental health phase-in projects, counties will handle the front end (precommitment and crisis services), the back end (extended care), and the intermediate range of mental health diagnostic and treatment services for non-Medicaid eligibles. Managed care contractors are responsible for the intermediate range of mental health services for Medicaid eligibles in the phase-in project counties. However, as will be seen in the following section, most counties in the phase-in projects are also the managed care contractor for mental health services. This means that the potential bifurcation of CMHPs will not be occurring in most counties during the phase-in projects.

Nevertheless, the potential remains for a major alteration in the provision of mental health services. If the county is not the managed care contractor for mental health services, and this is a potential under a fully implemented OHP, traditional county monitoring and service coordination functions may be assumed, at least in part, by prepaid health plans. At least two questions arise from this potential. One is how the state-county partnership could be affected. The second is how a mental health system which may be decentralized among a number of PHPs can be integrated. Each will be discussed in turn.

The State-County Partnership Under the OHP

Much of the existing state-county partnership is being maintained under the OHP mental health phase-in projects. The state and counties will continue to contract for precommitment and crisis services, extended care services for adults, and mental health diagnostic and treatment services for non-Medicaid eligibles. The question facing the counties has been what role they want to play in providing intermediate range diagnostic and treatment services for Medicaid eligibles, which is a rapidly growing share of the mental health delivery system, especially for children and adolescents.

The range of possible roles for the counties during the mental health phase-in projects is shown in Chart 3. Lesser county involvement is shown on the left of Chart 3 with greater involvement on the right. The lowest level of county involvement (other than non-participation in running a CMHP) is to provide only non-OHP covered services. As discussed above, this includes precommitment and crisis services, extended care for adults, and intermediate range diagnosis and treatment for non-Medicaid eligibles. In the mental health demonstration projects Washington County has chosen this option. Given historical circumstance, this is a logical choice. Washington County has chosen to provide mental health services primarily through a subcontracting model, with the county providing coordination and oversight. This resulted in a strong local network of independent subcontractors which has been able to forge a relationship with each of the three competing managed care contractors that will be operating in Washington County. Thus, the existing mental health provider network will remain largely intact during the phase-in projects. Washington County will be testing how local coordination will evolve in a more decentralized mental health system involving multiple managed care contractors and their subcontractors, when the county is no longer the contracting agency.

The big surprise in the demonstration projects was the relatively large number of applications received directly from a county, or from a consortium of counties, to be the managed care contractor for mental health services. This model completely "carves out" mental health services from other OHP covered services. Medical care is contracted to the prepaid health plans. Mental health services are contracted to the counties. The two contractors are independent but must work together to ensure service coordination. This arrangement ensures a continued county role in service monitoring and coordination. Eighteen of the 20 phase-in project counties chose this option.

Another possible county role has been chosen by Benton County. Benton County submitted a joint application with a prepaid health plan in which the county provides mental health services while the PHP provides medical services as well as overall administration of the capitated funds. This "full partnership" of the county and the PHP preserves the expertise and role of the county as well as the existing mental health service provider network. It also grafts onto the system the expertise of the private sector in managed care.

A final alternative was not funded in the demonstration projects but is included in Chart 3 to show another possible county role as the OHP phase-in progresses. In this alternative, a county becomes a subcontractor of a PHP in providing mental health services. Again, the county's expertise and service network is preserved while gaining the expertise of the private sector.

In both the "subcontractor" and "full partner" models, the ability of the county to effectively coordinate the local mental health delivery system is dependent upon how many competing PHPs there are in the county and whether the county has a contractual relationship with each. For instance, Multnomah County is a full partner in Care-Oregon, a prepaid health plan. However, there are 15 other competing PHPs in Multnomah County with which the county is not a partner. Thus, even a full partnership with a PHP does not assure full county control of the mental health service system. Multnomah County was not chosen as a mental health phase-in site. However, the potential for counties to lose their primary role in contracting for, monitoring and coordinating local mental health services for their citizens is a clear possibility as the OHP evolves.

It should also be noted that most PHPs do not currently have the expertise or the provider network to care for persons with severe mental illness. The lack of applications from PHP contractors to completely assume the role of mental health service provider underscores this point. In 19 of 20 phase-in project counties the county or a consortium of counties, not prepaid health plans, were the primary bidders to provide mental health services. It remains to be seen whether this situation will continue as 100% coverage for mental health services is phased-in for all counties.

Chart 3

RANGE OF COUNTY ROLES IN THE OHP MENTAL HEALTH PHASE-IN PROJECTS

LESSER COUNTY INVOLVEMENT ⟷ *GREATER COUNTY INVOLVEMENT*

Only provide non-OHP covered mental health services. Coordinate with P.H.P.* for medical care and OHP covered mental health services	Subcontractor of P.H.P.* for some or all of OHP covered mental health services	Partner with a P.H.P.*	Provide all mental health services (complete carve-out) Coordinate with P.H.P.* for medical care
Washington County - 2 competing P.H.P.s* and 1 non-profit mental health corporation are responsible for all OHP covered mental health services; primarily to be provided by subcontract with the existing network of service providers.	This alternative is not funded in phase-in projects	Benton County	Clackamas County Coos County Josephine County Greater Oregon Behavioral Health (consortium of 15 Eastern Oregon counties)

* P.H.P = Prepaid Health Plan

In facing this uncertain future, the counties must choose among a wider range of options than they have currently. Now the choice is whether or not to operate services directly or to subcontract for services. As has been seen, all counties now choose to participate in monitoring or providing mental health services. This option remains under the Health Plan, albeit on a smaller scale. But, under the OHP, there are the additional options of being in a direct partnership with or acting as a subcontractor of a managed care contractor. There is also the complete carve out model where the county becomes the sole contractor for OHP covered mental health services. Since all counties will not choose the same option, it is likely that the administrative complexity of the system will increase. Under the OHP the system should be simpler for the consumer who will have a single contractor, or two contractors in the "carve-out" model, which are responsible for all medical, chemical dependency, and mental health services.

What will these changes do to the state-county partnership? One difference is that there will be a new power at the table. Integration of the entire system will require the integration of the state, the counties, and multiple managed care contractors. Counties will have a greater or lesser role depending upon the relationship they forge with managed care contractors. It is clear that the statutory roles of the state and counties will have to be revised to adjust for the new triumvirate -- state, counties, and managed care contractors. Specifically, the local CMHP services specified under the Local Mental Health Services Act may need to be changed, as many of these services will become OHP responsibilities. The direction to the state to "establish, coordinate, assist and direct a CMHP program in cooperation with local government units" also needs to be modified to integrate with OHP legislation.

Finally, the whole philosophy of the roles of the state and counties in provision of services to citizens should be re-examined. How far does Oregon want to go in privatizing services to its citizens? Should this privatization include "public utility" functions? Should privatization include services of last resort to vulnerable populations such as the disabled, children, and the elderly? How much local control should be maintained, and how? Answering these questions is clearly beyond the scope of this paper, but the answers are needed to guide the evolving mental health system.

System Integration

The second issue, which is critical during the OHP mental health demonstration projects, is system integration. How will the more decentralized model of the state, counties, and multiple prepaid health plans interact to create the coordinated and effective mental health system which is mandated by law? - ORS 430.610(2). Integration issues can be expected at all of the boundary areas of service provision:

1) the relation of county-operated precommitment and crisis services to OHP urgent/emergent care and to other OHP services;

2) the relation of OHP contractors to county and state operated extended care programs;

3) the relation of the mental health programs operated by OHP contractors for Medicaid eligibles with CMHP provided services for non-Medicaid eligibles.

Pre-OHP Integration Issues

Integration issues are not new to the mental health system. Recurrent problems arise concerning:

1) the relation of state hospital to community responsibility for hospitalized patients;

2) access to and sharing of statewide and regional mental health resources among counties; and

3) access of clients with psychiatric disabilities to medical services.

Item 1 is a problem as there are programmatic and financial incentives for counties to leave some long-term patients in state hospital care. These patients may manifest behaviors which are difficult to manage in the community. Or, once in the community, the client may require intensive support which diverts limited resources from other clients. ORS 430.610(3) (Local Mental Health Services Act) establishes as legislative policy that; "to the greatest extent possible mental health services shall be delivered in the community where the person lives in order to achieve maximum coordination of services and minimum disruption in the life of the person."

Implementation issues arise in the interpretation of "to the greatest extent possible." This is often a function of the availability of specialized community support services which may not be equally available in every county. Recent development of

specialized statewide resources has begun to address this problem.

However, this has created the potential for a new access problem. It is not cost effective for all counties to operate specialized programs, yet residents of all counties need equal access. To provide equal access to the recently developed program, contracts now require access to all Oregon citizens regardless of county of residence. The MHDDSD is studying extension of this provision to other specialized programs developed in prior biennia as alternatives to state hospital extended treatment.

Management of access to these specialized programs is the responsibility of the Division's Extended Care Management Unit, a professional team authorized by the April 1994 Emergency Board. The purposes of this unit are to assure that long-term psychiatric services are delivered:

1) in the most clinically appropriate setting;

2) in an effective and efficient manner; and

3) in a way that assures that consumers return safely to preferred community living environments.

The third level of integration problems is the difficulty which persons with psychiatric disabilities may have in gaining access to medical care. These clients are often indigent and may lack the skills needed to access medical services. Their appearance and behavior may discourage family oriented medical practices from seeing them. This has put an additional burden on mental health case managers to ensure at least minimal access to medical services.

In sum, there are multiple levels of integration problems in the current system. Progress is being made with many of these problems through development of regional specialized programs, contract provisions ensuring equal access for all Oregonians to these programs, and with establishment of the Extended Care Management Unit to provide a mechanism for handling access and utilization. And, the OHP promises to solve a long standing problem of access to health care by persons with severe mental illness.

Integration Issues Under the OHP

The full impact of the OHP upon the above issues is unknown at this time. However, it is clear that managed care contractors, when they are not the counties themselves operating under the "carve-out" model, have programmatic and financial incentives to shift responsibility for mental health services to the state-county extended care system. Following the guiding

principle that these issues are best dealt with at the local level rather than a "one size fits all" state mandate, each potential managed care contractor was required to address the following questions in their response to the RFP for the mental health demonstration projects:

1) describe the nature of the Contractor's treatment coordination at the point of admission and discharge planning to and from state-funded extended care resources.

2) describe how you will assure maximum feasible continuity of care for persons admitted to and discharged from a state hospital and back into your delivery system.

3) describe how you will assure continuity of care for children admitted to extended care services such as residential psychiatric treatment and the Child and Adolescent Treatment Services at Oregon State Hospital.

4) for those enrollees needing services outside the capitated rate, describe how you will link up and coordinate your services with other providers.

(MHDDSD Request for Proposals, July 8, 1994)

A similar set of questions details the OHP contractor's plan to integrate with the county precommitment and crisis services system.

In addition to the above integration mechanisms, clients with mental illness will have case managers to ensure they get all necessary services. There will be several types of case managers available. Any client with a disability or especially complex medical needs has access to a medical case manager who is responsible for assessing need for and ensuring access to medical services. This will include all clients with disabling mental illness. Most clients with disabling mental illness will also have an agency case manager from a Department of Human Resources agency such as Senior and Disabled Services Division, Children's Services Division, or the Mental Health and Developmental Disability Services Division (MHDDSD). Agency case managers are generally responsible for the client's social service needs -- including social, educational, vocational, and mental health service needs. MHDDSD's mental health case managers are located in the Community Mental Health Programs (CMHPs). They are responsible for hospital discharge planning, assistance in applying for financial aid, coordination of service, case planning with other agencies, and assistance in acquiring resources to meet such needs as health care, housing and employment. In CMHPs, case management is not a discrete service but is included along with mental health treatment.

During the OHP mental health phase-in projects, the contractor responsible for providing mental health services, whether it is a PHP or a CMHP, is required to provide mental health case management services. In 19 of the 20 phase-in project counties, the contractor responsible for providing mental health services will be a CMHP. This means current mental health case management will remain the same in these counties. The difference will be that the CMHP case manager will now have a medical case manager in the prepaid health plans with which to coordinate medical care for their clients. In the case of Washington County, the one county out of the 20 where mental health services will be provided by PHPs, the PHP will assume the mental health case management role. As has been noted, this will most likely be a mental health case manager from the existing service provider network.

Concerns about integration of the system, especially the linkage between medical and social service case managers, were expressed by federal officials in reviewing Oregon's request for a Medicaid waiver to implement the mental health demonstrations. Oregon's response provides the best statement to date of actions to be taken to ensure the success of the system and safeguards to back up the system if it doesn't work:

> "Potential areas of confusion or conflict include diagnosis and treatment decisions, access to care, and availability of ancillary services. If disagreements are not able to be resolved through direct interaction between case managers in the social service and medical arenas, there are several steps that can be taken. These include policy clarification from agency staff, PHP benefit package clarification, the RN Hotline to help determine OHP covered benefits, the OMAP Medical Director's office for clinical advice, and grievance procedures both within the PHPs and through DHR. The OHP ombudsman's office will also provide mediation between case managers in the medical and social service arenas.
>
> DHR agency case managers will receive training about the OHP managed care delivery system, clarification of roles, and how to interact with the health care providers. They need to understand what a PHP is, how it works, and what the roles of Exceptional Needs Case Managers and Primary Care Practitioners are. They need to understand what a PCCM is and what their responsibilities are. The PHPs and PCCMs need to know similar information about the DHR agencies and the agency case managers. . . .

> There will inevitably be some conflict and confusion, and in order to minimize this it is important to clarify what the boundaries of the respective case managers' roles are, and address the appropriate interaction that should occur when the roles overlap or intersect. Protocols will be established addressing lines of responsibility and resolution of any differences."
>
> (Letter of May 23, 1994 to Ron Deacon, Project Officer, Health Care Financing Administration, responding to questions regarding Oregon's waiver request, pp. 22-23)

Summary of Integration Issues

There are new integration problems which the OHP will bring to the system while largely solving an old problem of system boundaries between medical, chemical dependency, and mental health care. Mechanisms have been developed to address these new issues. OHP providers have been asked to detail how they will interact with the CMHP and state-operated mental health system. Medical case managers from PHPs and social service case managers from the state-county system are expected to integrate services for their clients. It is too soon to tell how these mechanisms will work.

In the meantime, current integration problems concerning cross-county access to specialized long term care resources are being addressed by the newly formed Extended Care Management Unit. Again, it is too soon to tell how well this will work.

Regardless of which system is devised, it is likely that integration problems will arise. Mechanisms have been devised to deal with expected problems in the upcoming system. The role of quality assurance monitoring and program evaluation in determining what works and what does not is the critical next step.

CONCLUSION

Three principles have guided the publicly funded mental health system for the past 30 years:

1) development of state hospitals as active treatment centers in a broader community-based system of care;

2) assisting consumers of mental health services to live the most normal lives possible; and

3) providing mental health services through a state-county partnership.

Each of these principles must now find expression in a managed care environment. State hospitals are completing the transition from providing acute care, to focusing on intermediate and long-range rehabilitation. These services will be available to Oregon Health Plan enrollees. An array of extended care community supports which help persons with psychiatric disabilities to live more normal lives (personal care, supported housing, employment), is being maintained through the state-county partnership and made available to OHP enrollees. Throughout these changes, counties are exploring new roles. Twenty of Oregon's 36 counties are now involved in OHP mental health phase-in projects. In 19 of these, the counties are the managed care contractors for mental health services showing continued commitment to the state-county partnership in providing mental health services.

This paper has examined these transitions as well as raised unanswered questions concerning the statutory definition of the state-county partnership. Another unanswered question is how the extended care network of community services which supports persons with psychiatric disabilities will fare in a time of fiscal restraint. Will cutbacks in this support network reverse an almost 30-year trend of declining need for long-term hospitalization?

This paper does not answer all of these questions, but it discusses the issues. Quality assurance standards, including specific client outcomes, have been built into the evaluation of the Oregon Health Plan. Conducting this monitoring and acting to keep the mental health system integrated and focused on its core principles will be a primary job of the state mental health authority over the next decade.

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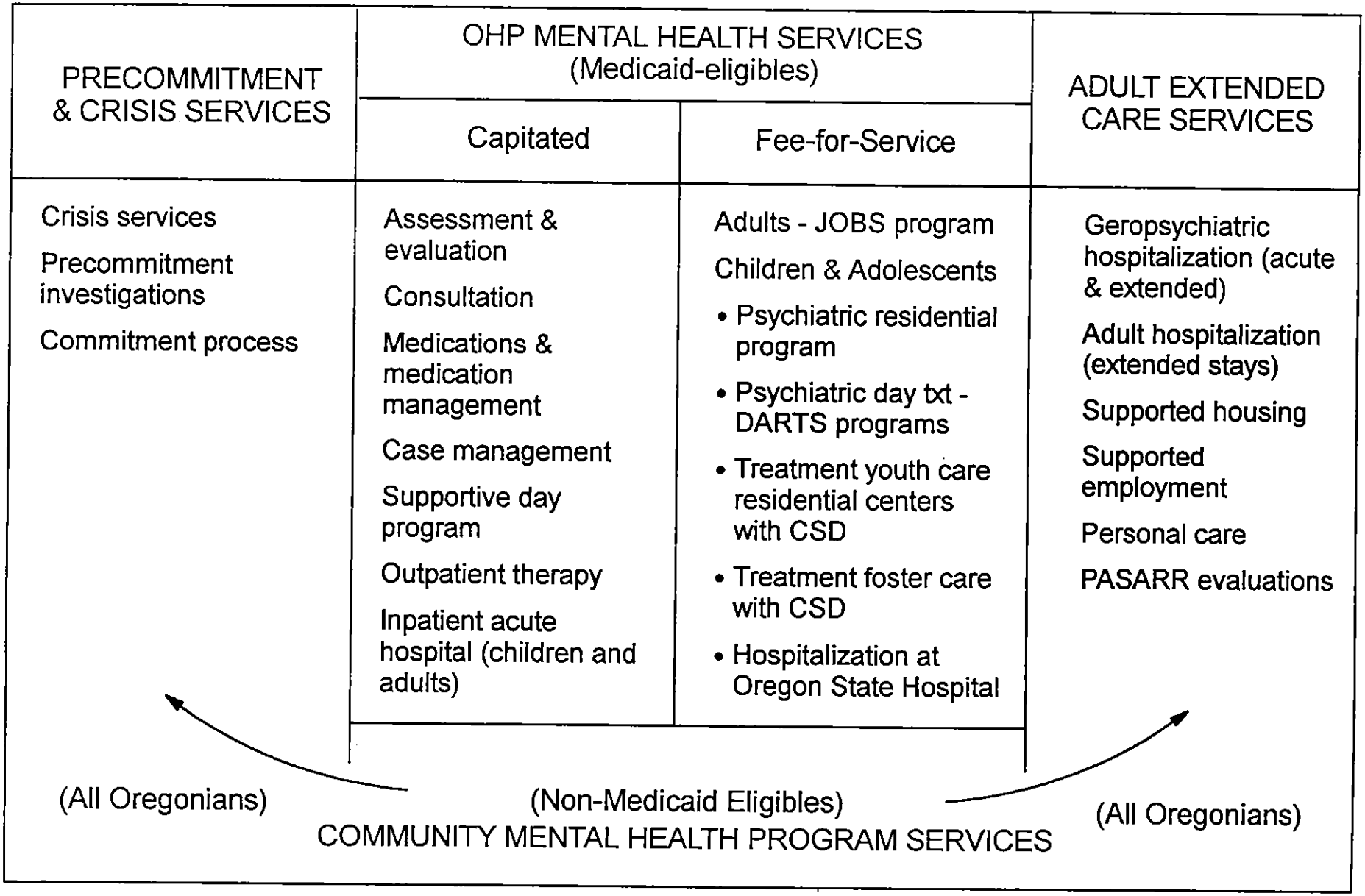
Appendix 1

MENTAL HEALTH SERVICES UNDER THE OHP MENTAL HEALTH PHASE-IN PROJECTS



Office of Mental Health Services

State Hospital, Regional Acute Care, and Extended Care Service Slots by Program

February 22, 1995

State Hospitals	# of Slots	Location
Oregon State Hospital		
Adult Psychiatric Beds	70	
Transition beds from Dammasch	30	
Eastern Oregon Psychiatric Center	60	
Holladay Park	68	
Total State Hospital Beds	**228**	

Regional Acute Care Units	# of Slots	Location
(1) Lane County Psychiatric Hospital	10	*Lane*
(2) Southern Oregon Regional Psychiatric Unit	17	*Jackson*
(3) Ryles Center	22	*Multnomah*
(4) Good Samaritan Hospital	12	*Benton*
(5) Salem Hospital	10	*Marion*
(6) OSHU/North Coast	5	*Multnomah*
(7) Care Mark	24	*Multnomah*
(8) Oregon Health Sciences University	7	*Multnomah*
(9) Bay Area Hospital	2	*Coos*
(10) Merle West	2	*Klamath*
Total Regional Acute Care Beds	**111**	

<u>Specialized Services in the Community</u>

Enhanced Care Facilities	# of Slots	Location
Ashland Manor	15	*Jackson*
Life Care Center of Coos Bay	10	*Coos*
Good Neighbor Care Centers	10	*Lane*
Camelot Care Center	15	*Washington*
Gresham Retirement Center	12	*Multnomah*
Hood River Care Center	15	*Mid-Columbia*
Independence Living Center	10	*Polk*
Mountain Vista Center	15	*Union*
Newberg Care Center	12	*Yamhill*
Total Enhanced Care Facilities	**114**	

Extended Care Services	# of Slots	Location
Psych/Voc Projects		
Supported Housing and Vocational Services	20	*Washington*
Laurel Hill Project	20	*Lane*
Total Psych/Voc Slots	**40**	

365 Projects	# of Slots	Location
Residential Care and Transfer	5	*Clackamas*
Individualized Plans	2	*Coos*
Round 2, Individualized Plans	1	*Coos*
Round 2, Individualized Plans	3	*Jackson*
Intensive Case Management	2	*Klamath*
Enhanced Adult Foster Care, Round 2	5	*Lane*
Enhanced Adult Foster Care, Round 1	4	*Marion*
Capitol House--Shared, cooperative housing	5	*Marion*
Enhanced Adult Foster Care--Round 2	4	*Marion*
Mill St. Enhanced Adult Foster Care	3	*Marion*
Pisgah Home Colony	10	*Multnomah*
Mt. Hood MHC ICM and Supported Housing	8	*Multnomah*
Delaunay Freedom Village	4	*Multnomah*
Mt. Hood Transitional Residential Services	5	*Multnomah*
Enhanced Adult Foster Care	1	*Multnomah*
Total 365 Project Slots	**62**	

PASSAGES	# of Slots	Location
Leland House	12	*Clackamas*
King Road Fairweather Lodge	5	*Clackamas*
Community Alternatives	6	*Columbia*
Ashland View Enhanced Care Expansion	5	*Jackson*
Individual Rehabilitation Plan	2	*Jackson*
Jackson Enhanced Foster Care	5	*Jackson*
Southern Oregon Secure Treatment Facility (Open 7-1-95)		*Josephine*
Bohemia Residential Community	5	*Lane*
Lane Stabilization & Rehabilitation	8	*Lane*
Laurel Hill Transition Program	15	*Lane*
Paul Wilson Home	10	*Lane*
Malheur County Foster Care	1	*Malheur*
Marion County Enhanced Foster Care	9	*Marion*
Garlington Center	10	*Multnomah*
Glisan St. House	10	*Multnomah*
Intensive Case Management	5	*Multnomah*
Individual Plan	1	*Multnomah*
Ryles Regional Treatment Center (Open 7-1-95)		*Multnomah*
Taft Home	10	*Multnomah*
Polk Independence Nursing Facility	5	*Polk*
Total PASSAGES Slots	**124**	
Total Specialized Services Slots	**340**	

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