

Cindy Becker, Director

DATE: October 11, 2011  
TO: Members, Oregon Health Policy Board  
FROM: Cindy Becker, Director   
Health, Housing, & Human Services  
SUBJ: The Value Proposition that Counties bring to Health Transformation

Thank you for the opportunity to testify on behalf of Community Mental Health Programs. Several people worked very hard on the language currently contained in Section 24 (4) of HB 3650:

4) Recognize the responsibility of counties under ORS 430.620 to operate community mental health programs by requiring a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority. The written agreements:

(a) May not limit the ability of coordinated care organizations to contract with other public or private providers for mental health or chemical dependency services;

(b) Must include agreed upon outcomes; and

(c) Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:

(A) Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

(B) Care coordination of residential services and supports for adults and children;

(C) Management of the mental health crisis system;

(D) Management of community-based specialized services including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children; and

(E) Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

We didn't do this to protect counties; rather we felt it was critical that there be a strong partnership between local mental health authorities and CCO's to support a system of health care for people with serious mental illness and co-occurring disorders for the following reasons:

- Without a viable crisis system, individuals who could be treated and stabilized in the community will end up in jail, the emergency room, acute care hospitalization, or the state hospital. OHP funding is critical to maintain this infrastructure for the entire community.
- We did not want an unintended consequence of the legislation to be the establishment of two systems – one for the insured and one for the uninsured. In fact, Individuals routinely move between being insured and uninsured even though their service needs are the same.
- Many of the systems in place today – children’s system of care, AMHI, state hospital transition – rely on the ability to utilize/integrate OHP, State, and County General Funds to support a continuum of care for individuals with severe and persistent mental illness, addictions, and co-occurring disorders.

Over the years, counties –as the local mental health authority – have developed core competencies in:

- Braiding funding – people’s needs don’t fall neatly into funding streams, so we’ve had to be creative in leveraging all available dollars.
- Building partnerships – individuals with serious mental illness and addictions touch many systems which have benefitted from a wide range of local partnerships– formal and informal – to problem solve individual cases and barriers at the local level.
- Care Coordination – the individuals we see typically have multiple, complex needs. In fact, outpatient treatment sessions are less effective without housing, employment, health care, and other social supports. This is our target population and we coordinate services across disciplines in the course of everyday business.
- Community-based care – insuring the provision of needed services in people’s homes, schools, parks, grocery stores, and even work places.

We believe these are valuable skills and experience that we can bring to the table in partnership with CCO’s.

**MENTAL HEALTH AND ADDICTIONS  
LOCAL MENTAL HEALTH AUTHORITY (LMHA)/COMMUNITY MENTAL HEALTH PROGRAM (CMHP) ROLES**

SERVICES		SYSTEMS	
INTEGRATED SERVICES	SPECIALTY SERVICES	SYSTEMS MANAGEMENT	SYSTEMS COORDINATION
<p>Services integrated with physical and dental health to support Patient-Centered Health Home</p> <ul style="list-style-type: none"> <li>Behavioral Health Consultation</li> <li>Individual, group and family counseling</li> <li>Peer-delivered services;</li> <li>Medication management;</li> <li>Care Coordination with other health services and social services</li> </ul> <p>Services can be provided or contracted through CMHP or primary care clinic</p>	<p>Specialty Services are provided for people with more complex Mental Health and Addictions</p> <p>More intense services described on the left plus:</p> <ul style="list-style-type: none"> <li>Case Management</li> <li>Supported housing</li> <li>Supported employment</li> <li>Supported education</li> <li>Peer-delivered services;</li> <li>Early psychosis programs</li> <li>Community skill-training: budgeting, shopping, food prep, use of public transport, accessing social activities, and spiritual life</li> </ul> <p>Services are provided or contracted through CMHP and delivered in the community</p>	<p>LMHA / CMHP as Service Planner, Quality Assurance and Safety Net</p> <ul style="list-style-type: none"> <li>24/7 crisis response</li> <li>Pre-commitment investigation and court testimony for commitment</li> <li>Abuse investigation and reporting</li> <li>Co-management of Oregon State Hospital patients, referral and discharge</li> <li>Jail liaison and release planning</li> <li>Psychiatric Security Review Board (PSRB) discharge planning and supervision of community placements</li> <li>Facility siting and community planning</li> <li>Service development and contracting</li> <li>Licensing /oversight of residential facilities</li> <li>Statutory biennial community needs assessment and state plan for mental health and addictions services</li> <li>Assurance of quality in a system of care</li> <li>Workforce development</li> <li>Primary and secondary prevention activities</li> <li>Disaster planning and training</li> <li>Peer program development</li> </ul>	<p>LMHA/CMHP Coordination and Consultation with Community Partners</p> <ul style="list-style-type: none"> <li>Commissions on Children and Families</li> <li>Local offices of Department of Human Services: Seniors &amp; People with Disabilities; Children, Adults and Families</li> <li>Local Mental Health and Alcohol and Drug Planning Committees</li> <li>Schools, district offices and ESDs</li> <li>Local public safety – sheriff, police and courts</li> <li>Community Corrections</li> <li>Oregon Youth Authority</li> <li>Emergency food and shelter services</li> <li>City and county housing authorities</li> <li>Community emergency preparedness entities</li> <li>NAMI, DDA and other support groups</li> </ul>

## Local Mental Health Authority Responsibilities, Risk and OHP Funding Examples

**Managing the State Hospital Population** *requires access to and authority for contracting and payment utilizing both OHP and State GF funding streams.*

The Local Mental Health Authority (LMHA) has the responsibility to manage both the front and back doors to the State Hospital. This includes a continuum of services:

- Community Supports and Treatment of Seriously Mentally Ill Adults
- Involuntary Commitment Investigation and Court Proceedings
- Diversion from State Hospital from Acute Care
- Transition planning out of the State Hospital back into the Community
- Contracting, Quality Assurance, Utilization Management and Plan of Care approval for the Adult Residential and Foster Homes programs
- Early Psychosis interventions

This responsibility includes financial risk for the LMHA; under the State Hospital co-management plan, counties can be liable for some of the costs of state hospitalization if they are not adequately fulfilling these responsibilities. More than 80% of individuals at risk of, or transitioning from state hospitalization are OHP eligibles.

Community service plans that are successful in diverting or transitioning these consumers rely heavily on OHP funds. LMHA's are obliged to create unique packages of services, find and contract with appropriate providers, and monitor the plans' success. Sometimes these plans, to be successful for a given consumer, involve a range of person-centered services such as:

- Mentors and Peer-delivered services provided with OHP funds
- Consumer drop-in center services paid for with State General Funds
- Personal Care services provided with State GF
- Skills trainers to supplement staffing in Adult Residential Programs, paid for with OHP funds
- Translators in Residential Programs paid by OHP funds
- Transportation to transfer consumers from acute care to the State Hospital paid with State GF
- Rental Subsidies paid for with State GF
- Respite care for care providers paid for with State GF
- Clinical consultation with Centers of Excellence for Evidence-Based Practices for programs working with clients with unique service needs paid with both OHP and State GF
- Funding of therapeutic activities to support treatment goals (for example, gym membership to minimize weight gain and provide a pro-social activity to decrease isolation)
- Support to family members through funding of organizations such as NAMI with OHP and State GF

**24 Hour Crisis Response System** *relies on the ability to braid funding, without which would dismantle crisis systems in many communities as well as the ability of the LMHA's to meet statutory obligations.*

By statute, LMHA are charged with the responsible to provide a 24-hour crisis response system to individuals with mental disorders, developmental disabilities and addiction disorders regardless of insurance coverage. It is typically difficult to collect reliable insurance information from users of a crisis service but estimates of the number of OHP users of this system range from 30 to 60%. 24 hour phone access, mobile crisis teams, triage centers, drop-in centers, and same day appointments are services contracted, coordinated, or provided by LMHA's utilizing braided OHP and State GF funding streams.

**System of Care for Children with Intensive Service Needs** requires access to and authority for contracting and payment utilizing both OHP and State GF funding streams.

In 2005 as a result of the Children's System Change Initiative, MHO's and LMHA/CMHP's were engaged in more assertive management of the highest levels of care for children. The facilitation of multi-system Child and Family Teams by local community mental health programs to identify strengths, needs, supports and services; develop service coordination plans; and provide system and clinical care coordination succeeded in:

- Increasing the number of children served in the community by 33.6%.
- Decreasing the number of children served in Psychiatric Residential Treatment settings by 24.5%.
- Decreasing the number of children served in Psychiatric Day Treatment settings by 32.6 %.
- Increasing the number and types of community mental health services available.

Developing and implementing the successful community-based service plans for children with severe mental disorders is similar to the work with the state hospital population discussed above. To create the unique packages of services necessary requires finding and contracting with appropriate traditional and non-traditional providers, and ongoing monitoring of the plans' success. These plans often involve non-traditional services and supports, and are highly dependent on OHP funding. Examples include:

- Family partners and system navigators
- Mentors and skills trainers
- Respite care for caregivers
- Intensive home-based services
- Day treatment
- School-based services
- Subacute treatment
- Treatment foster care
- Flexible supports such as gas cards, activity fees, etc