Mental Health Services Dynamics and Dilemmas

This map was developed by the Multnomah County Task Force on Mental Health. It portrays the way public mental health services are delivered and the major factors that contribute to the problems faced by the different agencies and their customers.

Draft v.12
Please send comments and suggestions to: hornbob@earthlink.net.

KEY

Example: Neighborhood concerns to group homes for mentally ill → Low number of group homes
Neighborhood concerns to group homes for mentally ill "causes" low number of group homes.

Read the arrows on this page as "causes" or "links".

The different colors for the arrows (→ → → →) aid tracing of long causal connections. They do not have any other significance.

This "Fragmented Administration" icon is used by the Task Force as a reminder of areas of mental health administration that could benefit from greater administrative integration.

Commissioners' Dilemma

- More clients eligible for more treatments
- More diverse customers than the rest of the state
- More seriously ill clients
- Less money to serve them
- Huge reduction in services
- Fragmented system administration
- Customer complaints accelerate
- Poor and incomplete data
- Increased administrative costs
- Accountability diffused

Up to $15.3 million less Medicaid funds available for mental health

Not known until September 1999

Oregon State Legislature

Mental Health Goal: To cover treatment of a full range of mental disorders not previously provided by integrating them in the health care priority list.

1. Passed Oregon Health Plan (OHP) to increase health care access by prioritization of treatments by cost-effectiveness. Legislature biannually approves the cut-off line below which treatments are not covered.

FRAGMENTED DRUG AND ALCOHOL PROGRAM. 2. Separated alcohol and drug abuse funding from mental health and redirected to medical/surgical payers and providers. People suffering from mental illness and alcohol and drug abuse cannot be treated within any one system of care.

COST CONTAINMENT FALTERS Medical and surgical costs can't be contained as the Oregon Health Plan was intended to do.

3. Integrated mental health diagnoses and treatment into the priority list of Oregon Health Plan benefits. 24% increase in clients eligible for more benefits.

4. State requires counties to care for those at serious risk of harm to self or others. Counties also must pay for acute hospital care

5. OHP plan is to control costs, provide incentives to manage care by distributing funds on a population (not a per client/patient) basis

Mental health advocates and providers, thinking more money would be available for expanded services, pressed hard for inclusion in OHP.

New eligibles create competition for resources

Dammasch State Hospital closed (1995)

It becomes more difficult to pay the 40 percent federal matching requirement for expanded coverage from limited state resources

Increased assets limits, residency requirements, and premium co-payments to reduce costs by making fewer poor people eligible.

CHILDREN LEFT OUT 6. Intensive treatment services for children (residential) left out of managed care by Legislature, interrupting continuity of care.

Federal Sector
Health Care Financing Administration (HCFA)

Civil rights act requires access for minorities

Medicaid is an entitlement program so HCFA doesn't allow state to implement priority plan by rejecting requests to reduce the number of services to be covered.

The HCFA was indecisive (1995-1998) on allowing managed care of Medicaid for Oregon.

Requires a new, uniform "encounter" data system for all Medicaid services. (An encounter is a one-time visit of a customer to a mental health agency.)

Because Medicaid is an insurance program HCFA needs billing data for cost control

Oregon State Executive Sector

Request 1 : Waivers to implement OHP Priority Plan benefits.
Request 2: Waivers to implement managed care

State Mental Health Agency (MHDDSD)
State Mental Health and Developmental Disability Services Division

Attempted to integrate mental health into full coverage healthcare plans. Required competition for Medicaid contracts.

Stopped requiring existing data system before new system operational.

State Medicaid Agency (OMAP)

Requires "encounter" data system by payers.

Did not initially allocate the funds for setting up the data system (low priority).

ACTUARIAL RATES NOT ADJUSTED Used questionable assumptions in setting managed care rates for mental health benefits. Did not provide "risk adjustments" as was done for physical healthcare for increased severity of illness among urban poor.
(Risk adjustments are differential rates of payment for seriousness of diagnoses.)

Housing Sector

Rentals to mentally ill require case management

HOUSING CAN'T BE USED Subsidized housing is available but unused due to lack of mental health support services.

Greater mental deterioration

People can't be released from State Hospital

Lack of affordable housing

Customers don't have needed supportive services

POSH Portland Oregon State Hospital is full

Low number of group homes

Neighborhood concerns to group homes for mentally ill

Dramatically reduced state hospital population increases demand for group homes

The Medicaid Payment Sector

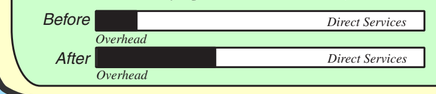
Medicaid pays for about 78% of the $100 million (1998) total mental health services in the County including OMAP fee-for-service. However Medicaid managed care is only about 29% of total mental health costs. Remaining 71% is for extended care and fee-for-service.

The state created mental health "carve-outs" (1997). Carve-outs are new entities, Mental Health Organizations (MHOs), that receive and distribute capitation payments to providers and report data to the state.

Capitation refers to payments based on the number of people who fall into the Federal categories of poverty and those who are newly eligible.
Carving out refers to the separation of mental health from physical health payers.

Increased Administrative Overhead Cost
(Difficult to allocate to cost centers.)

County (CAAPCare) 12% (up fr om 3%)
Insurance Carrier (Regence) 5% (new cost)
Ceres Behaviorial Healthcare 12% (new cost)
Networks of provider agencies 3 - 8% (some new cost)
Non-Profit community agencies est. 10-18% (increased cost)



State Mental Health Agency creates and contracts directly with these payers:

Private Managed Care

Regence and Family Care contract with state, and Ceres Behavioral Healthcare System (affiliate of Magellan Behavioral Health) operates the "carve-out" for them.

Public Managed Care

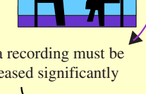
CAAPCare (County Behavioral Health Division, Department of Community and Family Services)

Some other providers (e.g. residential facilities) also receive direct Medicaid payments from the state.

MINORITIES NOT SERVED Accessible services for minorities do not yet exist and data not collected. Affects all sectors.

Non-Profit Community-Based Provider Agencies

The Case Worker Sector
Mostly work for non-profit agencies



Approx. 26% cut in payments during 1997-98.

To be efficient must cut staff

Must amalgamate clinics into fewer sites

Case workers can't keep up with service demand

Case load increase from 35 to 100 per case worker

Experienced case workers leave in droves (From 15% to 40% in one year)

Many new inexperienced case workers

Data recording must be increased significantly

Case workers have to fill out more paperwork in less time

Lack of bilingual staff

Can't provide needed supportive services

Increase in severity of problems

Increased errors

Decreased number of visits and decreased time for each customer visit.

Case workers are paid less than teachers - $25,000 per year

Poor continuity of care

Some agencies are not adequately handling transition to managed care.

Layoffs and reductions in services

MAJOR SERVICE DECREASE Major decrease in access to mental health services.

Multnomah County Sector

Department of Community and Family Services, Behavioral Health Division (BHD)

Up to $15.3 million decrease (in transition to Oregon Health Plan).

There are more clients who appear to have more serious problems than expected when the rates were set (based on anecdotal information).

IMPACT OTHER DEPARTMENTS Increased overhead costs lead to less money for actual delivery of services. These combined factors decrease ability to meet the increasing demand for services and broadly impact other County Departments.

BHD can't control mental health system because state directly funds some services and because of fragmentation of alcohol and drug system.

This diverts county resources that could go to shore up deteriorating outpatient and case-management services.

TRIAGE CENTER OFTEN FULL County contracts for 3 secure beds in Crisis Triage Center (Providence Hospital) to relieve pressure on acute care. But these beds are often full, so police have to find other hospitals. There are complaints about customer treatment.

County Data System Sector

Most programmers are busy fixing the Y2K problem

Scarcity of software programmers

Rapid growth of high tech "Silicon Forest" around Portland

Staffing deficiencies prevent mental health data system from being fixed (at present)

Need to upgrade data system for publicly managed health care

Increased salaries because of scarcity (nationally and locally) of programmers

Dilemma of fragmented and antiquated state data system

Uncompleted contract for encounter data system

Turnover in data management positions

Public contracting is too slow and complex

DATA NOT AVAILABLE Required data not reported to state on a timely basis. Poor accountability.

County Health Dept.

Mentally ill people go to primary care clinics for help and medication. 16% increase in two years.

Pressure on traditional services for women and children for acute primary care and disease control.

County Jail (Corrections Health)

Increased mentally ill inmates from 1500 to 3000 in 2 years. Inmates lose Oregon Health Plan coverage.

Mentally ill inmates often released to street. Difficult to get casework, treatment, and medications from mental health providers.

County Aging and Disabilities Services Department

Increased demands on aging and disabilities services.

Clients discharged from intensive services with no outpatient follow-up.

Poor communication among all sectors, especially with the Crisis Triage Center.

Housing, case management, and social support services inadequate.

24-hour hotline for disabled clients overwhelmed by mental health crisis calls.

Law Enforcement Sector

Officers are often the first treatment providers, sorting out appropriate response to domestic violence, alcohol and drug abuse, as well as mental illness, and sometimes spending several hours with customers, calming people down and trying to find a place for them.

Deliver customers (often repeat customers) to treatment location

Adult Customer Sector

Customers complain and seek other sources of help

Major life crisis

25-35% increase in number of mental health customers

Customer co-payments required

Caretaker families not supported

Lack of employment training and placement support

Family, Child & Adolescent Customer Sector

Schools lack access to community treatment resources

Impact of cultural diversity on service delivery not understood

End of 5-year partnership program funding in 1998 from Robert Wood Johnson Foundation

FAMILIES DON'T GET SERVICES Emotionally disabled children and families lack support services or treatment they need.

Return to fragmented program delivery

No continuity of children's services

Increased long-term residential care

Increased juvenile crime

Increased foster care

Juvenile court often must place emotionally disturbed children in detention

The Street Sector

(The vast uncounted)

STREET NEEDS UNMET Increased homeless street population in which service needs for many are unmet.

2,700 individuals seek shelter every night in Portland. At leasst 30% of homeless people are mentally ill.

Fewer drop-in Centers

Victims of street predators

Increased enforcement of petty crime arrests to protect customers and public (anecdotal evidence)

Alcohol and neighborhood drug dealer provides pharmaceutical relief. Approx. 80% of homeless have alcohol/drug problems.

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