Children's Mental Health: Ensuring Access and Sustaining Services

Summary

Studies estimate that about one in five children nationally has a diagnosable mental health disorder and one in ten children has mental health challenges that negatively impact their ability to function at home, in their schools, and in their communities. In most cases, timely appropriate mental health services can help mitigate the effects of these conditions. However, some children in Oregon may not have ready access to needed mental health treatment.

Many publicly funded mental health services for children are provided through the Medicaid program. The Oregon Health Authority (OHA) administers the state Medicaid program, part of which is known as the Oregon Health Plan (Plan).

The Plan’s mental health system for children is managed through OHA’s Division of Addictions and Mental Health (Division). To receive mental health services through the Plan, children and their families must apply and be found eligible for Medicaid. The mental health services provided to children are managed by regional managed care mental health organizations (MHOs).

The purpose of this audit was to determine the extent that Medicaid eligible children are able to access and continue with needed mental health services.

Oregon has made progress towards meeting its goal of bringing as many eligible children into the Plan as possible, an important first step in making sure they receive needed mental health services. The Healthy Kids program has helped identify and enroll previously uninsured children into the Plan.

In our review of children covered under the Plan who utilize mental health services, we noted that certain demographic populations utilized mental health services less than others. These included Hispanic children, children age 0-6, and girls age 2-13.

We also noted the Division could provide better information on service utilization by these populations. This data could be used to compare the
effectiveness of strategies designed to engage these populations in services.

We reviewed 90 case files of children with apparent breaks in documented services. Case files were selected from four MHOs covering the time period January through June 2010. We found that more effort was needed to better ensure the continuity of mental health services for some of these children. In several instances, service breaks occurred during transitions from one type of mental health service to another. We also found case files that lacked sufficient information to identify the reason for the service breaks and/or the efforts made to re-engage the child in mental health services.

We recommend that the Division develop better information on service utilization by population. Division efforts could include improvements in developing and reporting comparative data, and identifying and disseminating best practices for increasing the use of mental health assessments for younger aged children.

We also recommend that the Division improve the continuity of mental health care for children by ensuring that assessed children who need and desire mental health services receive services in a timely fashion, and by ensuring that the reasons for children experiencing lengthy breaks in services are captured in case file documentation. This documentation should be periodically analyzed by the Division to identify and address the reasons behind these breaks. The Division should also ensure that providers make adequate efforts to re-engage children when unplanned service breaks occur and that they document these efforts.

**Agency Response**

The agency response is attached at the end of the report.
Background

Early Treatment Has Large Benefits For Children With Mental Health Needs

Studies estimate that about one in five children nationally has a diagnosable mental health disorder and one in 10 has a mental health need that is severe enough to negatively impact how these children function at home, in their schools, and in their communities.

Children with untreated mental health needs experience many negative consequences. Experts indicate that elementary school children with unmet mental health needs are more likely to have excessive school absences and their suspension and expulsion rates are three times higher than that of their peers. High school youth with untreated mental health needs are more likely to drop out of school. Children and adolescents with unmet mental health issues also tend to have greater involvement in the criminal justice system and, without appropriate treatment, can become adults who battle chronic mental illness, at a large cost to themselves, their families, and society.

However, research indicates that many children in need of mental health services are not receiving those services. One national survey of children with special health needs covered by public insurance found that 65% did not receive needed mental health services during a one year period. Another national survey found that 73% of respondents with public health insurance had children (ages 6-17) with unmet mental health needs, and that 88% of Hispanic respondents had children with unmet mental health needs.

Publicly Funded Mental Health Services For Children

Many publicly funded mental health services for children are provided through the Medicaid program. Medicaid assists eligible children with their mental, physical, vision, and dental healthcare needs. The Medicaid program in Oregon includes the Oregon Health Plan (Plan).

Plan funding for children’s mental health services totaled $240 million in 2010, with federal funding providing the largest portion. For the 2009-11 biennium, federal Medicaid funds covered 63% of Plan costs, the state General Fund covered 26%, and the remaining 11% was covered with other state funds.
The Plan is administered and supervised on a statewide basis by the Oregon Health Authority (OHA).

A child is generally eligible for coverage under the Plan when the household income is 200% or less of the federal poverty level. In the 2011 U.S. Department of Health and Human Services Poverty Guidelines, the maximum allowable income was $44,700 for a family of four, and $29,420 for a family of two. As of October 2011, there were 366,810 children enrolled in the Plan.

The Division of Addictions and Mental Health (Division) manages the children's mental health component of the Plan. The Division’s responsibilities include developing state and federal plans for mental health services, implementing the plans and related laws, and directing services for persons with mental illness. Among the Division’s goals are increasing the availability, utilization, and quality of community-based, integrated health care services; increasing the effectiveness of the integrated health care delivery system; increasing the accountability of the health care system; and increasing the efficiency and effectiveness of the state administrative infrastructure for health care.

The Division currently contracts with ten regional mental health organizations (MHOs) to provide mental health benefits to enrolled members. Each MHO contracts with a network of licensed and certified individuals and organizations to provide mental health services to Plan members in that MHO service region.
The Division of Medical Assistance Programs compensates MHOs through a managed care approach, providing monthly capitation payments for each child enrolled in the MHO. The capitation rates paid to the MHOs are calculated from a variety of factors including statewide average capitation rates adjusted for geographic and population risk differences.

Under managed care, MHOs pay contracted providers for the mental health services delivered. The managed care approach is intended to focus on overall client wellness while discouraging reimbursements for unnecessary services. Containing costs is to be balanced with an assurance that Plan members receive all necessary and appropriate services from providers.

Parents, teachers, and health care professionals, among others, can refer a child for a mental health screening or assessment by a mental health provider or Community Mental Health Program. If mental health care is found to be needed, and the child’s family agrees, the provider and family then formulate treatment goals and a treatment plan, including the types of services, their frequency and the duration of care. The child then receives mental health services from the provider, who records the services in the state’s Medicaid Management Information System. The provider is paid by the MHOs out of the MHO’s capitated funds.

The Children’s Mental Health Care System Is Changing

Mental health care for Oregon’s children is undergoing substantial change within the shift of children’s health care toward increasing affordable coverage. More broadly, the state healthcare system for children and adults is undergoing a major transformation that includes incorporating Coordinated Care Organizations. These organizations are intended to integrate addiction and mental health services with physical health care.

The Division has already made efforts to provide more integrated community-based systems of mental health care for children and their families. One such effort is the Children’s System Change Initiative. Its goal is to increase the availability and quality of individualized, intensive, and culturally competent home and community-based services to enable children to be served in the most natural environment possible and with minimal use of institutional care.
Audit Results

The purpose of this audit was to determine the extent Medicaid eligible children are able to access and continue with needed mental health services. We examined children's access to mental health services, as well as the continuity of their mental health care.

Oregon has had recent success in enrolling uninsured children into the Oregon Health Plan, which is the first step in ensuring children receive the mental health services they need.

We also analyzed data for children enrolled in managed care to determine if there were differences in utilization of mental health services by different populations. We found that demographic populations varied in their mental health service utilization. This indicates that access to mental health services for some children needs further analysis and may require specific actions to ensure appropriate services are provided. In addition, we identified individual children who had time breaks between documented mental health services. Many of these instances had little or no supporting case file documentation of the reasons for the breaks in services or the efforts undertaken to re-engage the child in mental health services.

Uninsured Children Are Successfully Enrolling In the Oregon Health Plan

Identifying uninsured children is the first step in increasing enrollment in the Plan and making sure eligible children receive mental and other health benefits. Enrollment in the Plan involves an application process that determines the Medicaid-eligibility of the child, considering the annual income of the family.

*Oregon Has Had Recent Success Bringing Eligible Children into the Plan*

The OHA has a goal of decreasing the number of uninsured children by expanding the percentage of people covered by the Plan. The OHA has worked to increase and improve its outreach efforts directed at identifying uninsured children, determining eligibility for the Plan, and pursuing strategies to increase enrollment.

For example, more children were insured by the Plan after eligibility requirements for children were expanded from 185% of the federal poverty level to 200%. In addition, OHA launched the Healthy Kids program in 2009 to identify and enroll uninsured and eligible children. The program's statewide efforts helped enroll a significant number of previously uninsured children into the Plan.
In January 2008, children (18 years and younger) enrolled in the Plan totaled 225,529. In January of 2011, children’s enrollment totaled 342,272, an increase of about 50%.

Management Has Taken Steps to Address Plan Enrollment Delays

Barriers in the application and approval process can create delays in obtaining services. We reviewed a log maintained by Healthy Kids staff that chronicles problems, issues, and questions forwarded to the central office from intake staff at DHS field offices. Two common issues we identified in this log relate to intake staff training and insufficient documentation supporting proof of eligibility provided by potential clients. Applicants with insufficient documentation seemed to be the biggest source of delays in the application process. We noted in at least 17 of the 147 log entries we reviewed, applicants submitted insufficient documentation resulting in a delay in the application process. To counter this barrier, Healthy Kids management reported they are requiring applicants to provide income verification documentation for one month instead of two months.

In addition, Healthy Kids management reported that training in eligibility determination was provided in 2010. Healthy Kids has also developed posters as an instructional aide in communicating program policy to program staff, and routinely communicates new and changed policies to staff as well.
We examined utilization of children’s mental health services by various demographic populations to determine those that may have less representation than others. Since the need for these services may vary by population, identifying differences in need can help the State focus efforts to better serve all children. A national study conducted by the Centers for Disease Control and Prevention that was released in February 2012, reported that the need for services varied by age, gender, race and ethnicity, family structure, family income, and insurance status.

**Hispanic Children, Younger Aged Girls, and Young Children Appear to Have Less Utilization of Mental Health Services**

Hispanic children comprise about 30% of children in managed care, making them the second largest race/ethnicity group. However, only 3% to 4% of Hispanic children in managed care are receiving mental health services. This is in contrast to the nearly 10% of all white children in managed care receiving mental health services. Although the percentage of American Indian/Alaskan Native children receiving mental health services is relatively high compared to other populations, the numbers of these children in managed care is the lowest of the race/ethnicity populations. It is important for the Division to provide close monitoring to ensure that low utilization rates among populations are a result of lower mental health needs rather than a weakness in outreach efforts and diagnoses.

![Graph showing percentage of children receiving mental health services by race/ethnicity. Text: Source: Oregon Health Authority](image-url)
We also found that relatively fewer girls aged 2-13 receive mental health services compared to boys of the same age, despite comparable numbers of enrolled male and female children. However, by the time girls reach 15-18 years of age, their proportional representation in mental health services exceeds that of the same aged male adolescents.

Research indicates that boys generally have higher service needs than girls. However, younger girls may also be less likely to exhibit the overt behaviors indicating a mental health need compared to younger boys. This could make their mental health issues more difficult to identify and result in delayed treatment.

Younger children (0-6 years of age) make up almost half of the children in managed care. However, these children appear to utilize mental health services less than other age groups. This could be the result of mental health issues that may not be readily apparent, may not receive adequate diagnosis at earlier ages, or occur with less frequency than for older children.
Efforts Have Been Made to Address Service Utilization Differences Between Populations

MHOs identified several populations that appear to have less utilization of mental health services than other populations. MHOs have also developed and implemented strategies to address service utilization differences among populations. However, we noted that these strategies vary among MHOs.

MHOs reported using several strategies to better serve Hispanic children. These include using focus groups to gain information about Hispanic families with young children, and providing culturally specific, community-based outreach workers. One MHO reported employing a community-based outreach worker who specialized in mental health.

Because girls may be less likely than boys to exhibit behaviors signaling possible mental health needs, different strategies are needed. MHOs reported partnering with school staff to identify girls who could benefit from mental health services. One MHO trains school staff to spot potential mental health issues and reports an increase in referrals for female clients.

For young children, a method piloted in Oregon and utilized in other states is to include mental health assessments as a component of pediatric care. Adopting this method throughout Oregon could increase the number of children receiving mental health assessments at younger ages and allow for more timely identification of mental health needs.
**Better Comparative Data is Needed to Evaluate Efforts to Increase Service Utilization**

The Division maintains a children's mental health performance dashboard that is available publicly. This dashboard appears to be updated on a quarterly basis. However, the data in the most recent dashboard is from the third quarter of 2010. This information is not broken down by age groups or by race/ethnicity. In addition, breakdowns of information by MHO are not provided, so comparisons among MHOs are not possible.

For example, while MHOs have implemented strategies that target the Hispanic population, the dashboard does not set utilization goals for this population making it more difficult to determine the effectiveness of these strategies.

By comparison, the State of California provides publically available reports that calculate targets for utilization by race/ethnicity, gender, and retention in services.

For young children, MHOs have focused on the training needs of providers. One MHO has also focused on parent education and consultation to better serve this population. However, in order to determine the effectiveness of these approaches for this age group, better comparative data is needed.

The Division previously provided more in-depth utilization information in report form, but these reports were discontinued in 2008.

**More Effort Needed to Ensure Continuity of Treatment for Children**

A managed care system focuses on prevention and coordinated treatment as a means of reducing health care costs. In Oregon, providers involve the family in the development of treatment plans, deciding from a variety of services what would be most beneficial for the child. Adherence to a treatment plan can contribute to improved mental health outcomes.

Most mental health services are voluntary and the child or child's family may choose to leave services at any time. However, in our review of case files, we noted little or no documentation of the reasons for the service breaks and/or the efforts undertaken to re-engage the child in mental health services.

Other cases indicate that problems can occur in the transitions from one type of mental health service to another. These may be instances
where greater effort or attention could have resulted in fewer and shorter breaks in service continuity.

**Many Breaks in Service Resulted from Actions by the Child or Child’s Family**

Instances of service breaks occurred as a result of actions on the part of the child or the child’s family. The reasons for these breaks were often documented in the case file. For example, we saw a break in service when a family moved outside their MHO’s coverage area. In other cases, parents or guardians decided they would rather not continue mental health services for their children.

Certain situations or circumstances outside the control of the child, the child’s family, or the provider, may also precipitate service breaks. For example, some of the breaks we noted resulted from the juvenile justice system taking custody of the child. We also identified instances where families became ineligible for services under the Plan.

Children must receive a mental health assessment before receiving Plan-funded mental health services. In some instances, an assessment for mental health services was given, but it was determined that the child did not need services at the time. These could still show as breaks in the service record.

**Some Breaks in Service Continuity Occurred During the Transition from One Type of Mental Health Service to Another**

During our case file review, we found some cases involving higher service needs children where a break in service continuity occurred during the transition from one type of mental health service to another.

Higher service needs children generally are eligible for more intensive mental health services and are assigned care coordinators to manage their service provision. These children may also be subject to more changes in their care providers, such as when moving from residential-based treatment to community-based treatment. We noted two instances in our review where there appeared to be an opportunity to better serve high needs children.

In one instance, a child had finished treatment in a residential care facility, but apparently no assessment was conducted to determine the level of service needed after discharging the child. The assessment would have engaged the child and family with appropriate service providers soon after discharge. However, in this instance the child had a three month break in service.

Another child with an assessed high level of need was recommended for developmental disability services instead of intensive, community-based mental health services. The MHO did not provide mental health services and, as a result, the child went nearly three months without treatment.
Case Files Often Had Little Explanation for Breaks in Service Continuity

In our case file review, we found children who received mental health services but experienced breaks in the continuity of services. We noted that many case files lacked sufficient documentation of the reason for breaks in service continuity and/or the efforts made to re-engage the child in mental health services.

For example, one case file we reviewed provided no documentation explaining the lack of services for a child during a three month period. The MHO initially told us this was probably because the therapist was popular and the family wanted to wait for an appointment with him. Later, the MHO said the family didn’t call to set up an appointment. In this case, the MHO could not definitively identify the cause of the break in services, we found no indication of the cause in our case file review, and no follow-up action was taken by the MHO to engage the child and family in services.

In another instance, the family decided not to engage in mental health treatments at that time, but the family and provider agreed that services would be re-considered. The provider noted he would contact the family at a later date. However, we found no documentation in the case files indicating that this subsequent contact ever took place. This case was closed after we inquired about it, nearly a year and a half after the last case note.

Because MHOs and providers were often unable to provide documentation of the cause for lengthy service breaks and the efforts made to re-engage the child in services, determinations on whether these children were actively involved in services were difficult to make. In these situations, some children may not be receiving the services they need and are entitled to under managed care, and complete information is not available on the treatment outcomes generated by mental health service purchases.

Less Emphasis is Placed on Efforts to Resume Services

As many as a third of the case files we examined had little or no supporting documentation of the reasons for the breaks in service continuity, or of efforts to re-engage children in mental health services. There are several possible reasons this may be occurring.

Generally, providers are not reimbursed by the Plan for making or documenting outreach efforts, unless the outreach efforts include services that match a mental health service procedure code description.

We noted that cases are often left “open” in the event the child or family decides to resume services at a later time. A case is generally “closed” only when it’s clear the child won’t be returning for services. Though this makes it difficult to assess the ability of clients to access
services, the Division has noted that this practice can lessen the administrative time and effort that comes with repeatedly “opening” and “closing” cases.

However, we also found opportunities for the Division to better track the access provided to children throughout their mental health treatments. For example, at least two MHOs have instituted performance measures that track the number of clients who start treatment and continue for a designated number of sessions, but the use of this performance measure is not consistent across all MHOs.
Recommendations

We recommend the Division, in its administration of mental health services, develop better information on service utilization by population. These efforts could include:

- developing and reporting comparative data to monitor service utilization by population, including Hispanic children, girls aged 2-13, and younger children;
- reviewing and comparing strategies that address utilization differences;
- developing targets that assist in addressing differences between populations; and
- identifying and disseminating best practices for increasing the use of mental health assessments for younger aged children.

We recommend the Division improve the continuity of mental health care for children by:

- ensuring that assessed children who need and desire mental health services receive services in a timely fashion;
- ensuring that the reasons for children experiencing lengthy breaks in services are captured in case file documentation;
- periodically analyzing the reasons for service breaks; and
- ensuring that providers make adequate efforts to re-engage children when unplanned service breaks occur and that they document these efforts.
Objectives, Scope and Methodology

The purpose of our audit was to determine the extent Medicaid eligible children are able to access and continue with needed mental health services. Our focus was on managed care mental health services; we did not analyze the fee for service payment process.

We first reviewed how readily eligible children were able to gain entry to Plan covered services. To accomplish this, we interviewed and gathered documentation from staff of the Oregon Healthy Kids Program and the Division of Oregon Health Policy Research. We also reviewed the methodology used in the Oregon Health Insurance Study for estimates of uninsured children in the State of Oregon, and concluded that the methodology appeared appropriate.

We used a number of sources for information on children’s mental health practices. We interviewed management and staff at the Addictions and Mental Health Division of the OHA, Community Mental Health Programs, mental health organizations, and contracted providers. We also reviewed reports concerning children’s mental health practices, including those of other states.

We sent two sets of electronic surveys to mental health organizations operating in Oregon. The surveys helped us identify problems within Oregon’s mental health system and how these challenges are being addressed at the local level. In addition, we reviewed the 2010 Youth Services Survey, 2010 Capacity Assurance Reports provided by the Division, and grievance logs maintained by providers and MHOs.

We obtained Medicaid billing data from the Division’s Decision Support Surveillance and Utilization Review System (DSSURS). This download contained information on children’s mental health service encounters for the time period January 1, 2010 to June 30, 2010. We obtained a second download from the Division containing information on all children who were evaluated during the first six months of 2010 as to their eligibility for high level intensive mental health services.

We used demographic information contained in the DSSURS download to determine populations that may be underutilizing mental health services. We analyzed gender, race/ethnicity, and age populations for their representations in the overall Plan population for children, and in the population of children receiving mental health services.

We also reviewed individual case files to determine the reasons why children who previously received mental health services may experience lengthy time breaks between billable services. We first created mental health service aging schedules for three populations of children based on the length of time between a service event and subsequent treatment. These populations were post residential care children, children who received an evaluation for intensive mental
health services, and children who received a mental health assessment of any kind.

We judgmentally selected cases from four of the ten Oregon MHOs. The four MHOs contributing cases were Verity Integrated Behavioral Healthcare Systems, Washington County Mental Health Organization, LaneCare, and Mid-Valley Behavioral Network. Cases were selected that had breaks in documented services occurring between January 1st and June 30th of 2010.

The 90 cases initially selected were further defined by considering only those with breaks greater than 28 days for Integrated Service Array and post-residential children, and 90 days or more for the other cases. We reviewed clinical case files and gathered additional information from the MHOs and providers to formulate our conclusions. It should be noted that results cannot be projected to the entire population.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.
May 14, 2012

Gary Blackmer, Director
Oregon Audits Division
255 Capital Street NE, Suite 500
Salem, OR 97310

Re: Oregon Health Authority’s Response to the *Children’s Mental Health: Ensuring Access and Sustaining Services* Draft Audit Report

Dear Mr. Blackmer:

Thank you for the opportunity to respond to the draft audit, entitled *Children’s Mental Health: Ensuring Access and Sustaining Services*. We appreciate the dedicated attention that the Oregon Audits Division staff gave to reviewing the children’s mental health system. The Oregon Health Authority (OHA) generally agrees with the recommendations made in the draft report. Per your request, below is our response.

As mentioned in the report, the Addictions and Mental Health Division (AMH) has and continues to implement changes in the children’s mental health system. It is our hope that implementing the recommendations in the draft report will provide us additional information to continue improving the system.

**Recommendation:**
We recommend the Division, in its administration of mental health services, develop better information on service utilization by population. These efforts could include:

- developing and reporting comparative data to monitor service utilization by population, including Hispanic children, girls aged 2-13, and younger children;
reviewing and comparing strategies that address utilization
differences;
• developing targets that assist in addressing differences between
populations; and
• identifying and disseminating best practices for increasing the use
of mental health assessments for younger aged children.

Agency Response:
OHA agrees with this recommendation.

In our current and ongoing work, we address these issues in a variety of
ways.
• AMH collaborates with the Department of Human Services Child
Welfare on issues affecting both systems, including measures to
increase the assessments for children in foster care within 60 days of
placement in out-of-home care and the Statewide Children’s
Wraparound Initiative.
• Through the Community Mental Health Block Grant, AMH reports to
the Substance Abuse and Mental Health Services Administration
(SAMHSA) on a number of National Outcome Measures. One of
these measures is to maintain or increase the proportion of children
from Native American, Hispanic, African American, or Asian ethnic
backgrounds receiving publicly funded mental health services, so that
the proportion of the population receiving services will match or
exceed the proportion of the State’s children within the same ethnic
population.
• AMH staff developed a collaborative training with the Mental Health
Organization (MHO) children’s systems coordinators focusing on
assessment and evidence-based treatment of young children birth
through 5 years of age using Child Parent Psychotherapy.
• AMH participates in the Coalition of Advocates for Equal Access for
Girls. The mission and activities of the coalition aim to ensure that
girls receive equal access to all of the appropriate gender specific
support and services they need to develop to their full potential.
Coalition membership includes representatives from AMH, other state
agencies, and private non-profit organizations. This coalition also has
legislative support.
- AMH will continue disseminating Parent Child Interaction Therapy (PCIT), the evidence-based practice for young children 2-7 years of age with disruptive behavior disorders with a focus on serving children from Hispanic families in proportion to their presence in the county population.

AMH will work with the Office of Equity and Inclusion (OEI) to initiate the following to provide better information on service utilization by population:
- The AMH Program Analysis and Evaluation unit will develop quarterly reports reflecting utilization of mental health services by population specific data, including Hispanic children, girls aged 2-13, younger children, and other demographic groups. The new reports will be available by November 1, 2012.
- AMH will establish targets for each MHO/Coordinated Care Organization (CCO) based on local performance. AMH will work with OEI to identify strategies in communities that are more successful in serving the identified populations. These strategies will be disseminated to communities which are less successful. Targets will be established by November 1, 2012.
- Identify strategies and targets in collaboration with MHOs and CCOs based on community assessments or other means by November 1, 2012.
- Within available funding, AMH will support a Local Mental Health Authority to coordinate and oversee training on early childhood mental health assessment and the evidence-based practice Child Parent Psychotherapy by November 1, 2012. This contract will support the development of an early childhood mental health network to provide clinician technical assistance and support to implement this practice.

**Recommendation:**
We recommend the Division improve the continuity of mental health care for children by:
- ensuring that assessed children who need and desire mental health services receive services in a timely fashion;
- ensuring that the reasons for children experiencing lengthy breaks in services are captured in case file documentation;
- periodically analyzing the reasons for service breaks; and
- ensuring that providers make adequate efforts to re-engage children when unplanned service breaks occur, and that they document these efforts.

**Agency Response:**
OHA agrees with this recommendation.

OHA agrees that for children with unmet service needs, it is important to ensure that gaps in service provision are identified and addressed so they can continue making progress at home, in school, and with friends.

The following are examples of our current and ongoing efforts to address these issues:

- AMH reviews Community Mental Health Programs through site reviews and issues Certificates of Approval for one, two or three years for programs that are in substantial compliance with the Oregon Administrative Rules. These site reviews address issues of access to services, engagement and follow up for initial approval or renewal of Certificates of Approval for Community Mental Health Programs.
- Mental health providers follow a standardized process for identifying children with high mental health needs and providing a comprehensive, coordinated array of services that are family and youth driven. The Level of Service Intensity Determination Process is to determine the intensity of service needs for children and adolescents with emotional, behavioral, and developmental challenges and to identify children and adolescents who would benefit the most from intensive service coordination planning. The Level of Service Intensity Determination Process provides a uniform and common framework to identify service intensity needs that can be used to inform service planning.
- Families, children (when appropriate) or adolescents receiving the Integrated Service Array develop their own teams which coordinate their services.
AMH will also initiate the following additional actions to improve the continuity of mental health care for children.

- Prior to each site review, AMH Compliance Specialists will review service utilization data to identify gaps in accessing services following a mental health assessment, service breaks or during transitions from one type of mental health service to another. They will follow up by reviewing documentation in client charts. AMH’s goal will be to incorporate the review of service breaks, engagement and documentation into the regular site review schedule by November 1, 2012.

- Through CCOs, the system shifts to outcome-based performance rather than management of processes. The OHA Outcomes Group will establish monitoring mechanisms for CCO compliance with the outcome measure for clinical follow up within 14 days of transition from a hospital or residential treatment program. Mechanisms will be established by November 1, 2012.

- AMH and the Office of Information Services (OIS) initiated the web-based Children’s Progress Review reporting system for children enrolled in Intensive Community-based Treatment and Support Services and the Statewide Children’s Wraparound Initiative project sites. Subject to the availability of OIS resource this system will be upgraded to include the Level of Service Intensity Determination Process which will provide real time data for individual’s receiving services, at the clinic, MHO or CCO and state levels. This will provide the opportunity for more detailed analysis of services, services breaks and recipients. This system should be ready by November 1, 2012.
Thank you again for the opportunity to address the recommendations included in the draft audit report. Please feel free to contact Bill Bouska, Children’s Mental Health System Manager or Linda Hammond, Interim Director, AMH for additional information if you have any questions regarding this response.

Sincerely,

Suzanne Hoffman,
Chief Operating Officer
Oregon Health Authority

cc: Bruce Goldberg, OHA Director
Linda Hammond, Interim Director, AMH
Bill Bouska, Children’s Mental Health System Manager
Dave Lyda, Chief Audit Officer, DHS and OHA
About the Secretary of State Audits Division

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The courtesies and cooperation extended by officials and employees of the Addictions and Mental Health Division during the course of this audit were commendable and sincerely appreciated.