An Example of CMHP Development in a Rural Oregon County

Klamath Basin Behavioral Health

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In 2012, the Oregon Legislature set forth its plan to transform the Oregon Health Plan system through development of global budget-based, integrated Coordinated Care Organizations (CCOs). By June 2013, Klamath County was the only county in Oregon that did not have a CCO in place. There were a variety of reasons why Klamath was the last to come on board. Local resistance to change and political infighting by some played a role. It was a period of time in our community in which there was considerable chaos, confusion and lack of clarity regarding the future of local public health care. The old Fully Capitated Health Plan and Mental Health Organization carve out model had been dismantled as it was replaced by the newer CCO-based global budget managed care system. All Oregon Health Plan behavioral health services for Klamath residents were switched to open card, fee-for-service payment. There was a lot of anxiety among elected officials, providers, consumers, and community members.

Against this backdrop, Klamath County informed the state in June 2013 that they could no longer financially afford to operate a mental health department. The County informed the Oregon Health Authority that they were closing their Community Mental Health Program (CMHP) and they asked the Oregon Health Authority (OHA) for assistance in identifying a new provider. The County also informed the state that they were relinquishing their status as the Local Mental Health Authority, and they issued 30 day pink slips to all county mental health employees.

We were informed on July 12, 2013 that OHA would contract with us to take over as Klamath County's CMHP, and that we would assume operations as the CMHP on July 31st, giving us little over two weeks to prepare.

No county assets were transferred to assist us in the transition. No facilities, no equipment, no furniture, no vehicles, no surplus funding, not even clinical records. Realizing that one county facilities, in particular, was crucial to our future operations we leased from County

the building that houses our civil commitment, crisis respite and adult residential treatment beds, but all technology resources were removed by the county from that facility including computers, servers, phones, security cameras, etc., and we had to replace those items at our cost.

We were able to hire about 30 of the county's 80 mental health department staff in that two week transition time frame, and this was critical in our being able to successfully assume responsibility for CMHP operations. These staff brought with them historical knowledge of county operations, and the patients that we became responsible for, that was invaluable to us. By the time we took over as the CMHP the other former county mental health staff had retired or moved out of the area to take new positions.

By way of background information, our non-profit organization opened in 1980. We were created in response to a community-led effort that included the County Mental Health Department, local physicians, a judge, the District Attorney, and other local leaders to create a child, adolescent and family mental health provider organization. The county mental health department only provided services to adults, and they did not want to expand their services to include children and families. A nonprofit business, which they named Klamath Child and Family Treatment Center, was formed by this community steering committee, and services were implemented. Over the next 10 years this nonprofit child and family provider grew to become the largest provider of mental health services in the region, and it is this nonprofit organization that became Klamath Basin Behavioral Health and the new CMHP for Klamath County.

When we assumed our new role as the CMHP, the best data available to us indicated that the county mental health department had 800 to 900 adults in active treatment. Their service array was limited to Psychiatry, medication management, basic outpatient care, and the safety net services all CMHPs in Oregon are responsible for. Access was limited, there were long wait times for appointments, and it was difficult for unestablished consumers to receive services. Frankly, we knew we were taking over a limited, outdated system of mental health care that did not address the level of community need, and that left behind fractured working relationships with both consumers and community stakeholders.

As is true of many rural areas of Oregon, Klamath County is still climbing out of the economic depression that hit us in 2007-2008. The recession, in conjunction with the loss of timber jobs in the 1980s and 1990s, have taken a significant hit on us from which we have not

yet recovered. Median household income in Klamath County is approximately $42,000 compared to the state average of $54,000. Our local health rankings are among the lowest in the state, while our child abuse and substance abuse rates are consistently among the highest. In short, like other rural communities, we are a very high needs county in terms of behavioral health.

In contrast to the 800 to 900 cases that were seen per year by the former CMHP, in the past twelve months we have provided services to 8,150 unduplicated consumers. We have increased the available array of services by adding a Mobile Crisis Team, Early Assessment and Support Alliance (EASA) services. We have added co-occurring mental health and substance abuse services in the jail. We've added a jail diversion program and a mental health court that has reduced the number of incarcerated mentally ill individuals. We have embedded our mental health staff in local elementary, middle and high schools. We have also worked with our local Department of Corrections to establish an embedded team that delivers co-occurring treatment to post-prison supervision and transitional release consumers, which has reduced re-arrests for new crimes among this population by 35%. We have also established a supported housing program that has reduced the incidence of homelessness for mentally ill individuals. Our county had previously been one of the highest utilizers of Aid and Assist evaluations at Oregon State Hospital, and we now consistently operate at or below Oregon Health Authority's target for Klamath County.

We have established an access model that encourages walk-in traffic for those who desire a quick response, while retaining the ability to schedule appointments for those who wish to do so. Over half of new consumers are seen for an initial face-to-face contact within 5 working days. Working closely with Cascade Health Alliance, our local Coordinated Care Organization (CCO), we have also added Assertive Community Treatment (ACT), Children's Wraparound Services, and we've developed a child and adolescent crisis respite facility, that we call Pine View, which results in very low utilization of more expensive out of area youth residential treatment. Finally, we are one of the 12 designated Certified Community Behavioral Health Centers in Oregon that is participating in this 8 state demonstration project.

The working relationship that's been established with our CCO has been instrumental in the expansion of our service array and penetration rats. Our collaboration with Cascade Health

Alliance (CHA) actually started long before they became a certified CCO. As early as 1997 we collaborated in developing a proposed integrated model that we submitted in response to the application process that established the old, carved out, mental health organizations. While our integrated model application was not chosen, it set the stage for a long-term productive, collaborative working relationship with CHA that has been sustained over the years since.

I can describe several examples of our collaboration with our CCO. When the County decided to end their mental health operations, CHA was instrumental in supporting us to become the new CMHP even though they were not certified as a CCO until after we took over. CHA even asked me to help them develop their mental health plan for their CCO application.

I currently have the honor of serving on the CHA Board of Directors, and we have CMHP staff who serve on their Utilization Review, Community Advisory, and Quality Improvement committees. CHA allocated CCO transformation funds to the start up our Pine View youth respite program, and they helped fund the start-up of our Mobile Crisis Team and ACT. We have also been working closely with CHA over the past few months to develop a value-based contract that will focus on a series of outcome measures that we anticipate will improve behavioral health services even further in our community. In addition, we have joined with CHA to support what we locally call the Klamath Promise, which is a very active, large scale initiative to increase high school graduation rates in our county. KBBH and CHA have both become Blue Zone certified businesses, meaning we have demonstrated our commitment to take a leadership role in promoting social determinants of health in Klamath. I offer these examples to illustrate that as the Klamath County CMHP working in collaboration with our CCO, we have identified many avenues in which we have jointly committed to improving the quality of care, improving the health of our county, and reducing costs.

I often hear the term “specialty behavioral health” applied to CMHPs, and to a certain degree this is an accurate description. Because we are the county’s behavioral health safety net provider, much of our attention necessarily focuses on crisis response, the civil commitment process, mentally ill homeless individuals and other high acuity, high risk cases. At the same time, as the CMHP we are the primary provider of non-medicine based low acuity and prevention services in the community. The data tells the story: 40% of our current open cases are comprised of low acuity, low risk individuals, while 16% are assessed as very high acuity. We

provide a variety of lower acuity basic and preventative services. For example, we deliver home visiting services to new Moms and Dads to ensure they have the resources available to raise healthy and safe children. We consult with schools, law enforcement, Child Welfare, courts, and other local service providers. We are in schools to provide prevention and early intervention services, skills training, support to teachers, and ongoing mental health treatment to students. We are in the process of breaking ground for construction of a new community sobering facility, a first for our county, which we will operate. In short, not only are we tasked with responding to the highest risk specialty cases, we also function as the community's most significant provider of primary behavioral health care, as is the case in most of the rural areas of the state. Primary care physicians prescribe more psychotropic medications to lower acuity cases, but CMHPs are the primary conduit for community-based services.

In conclusion, Even though I'm not here today to present on the proposed co-chair's proposed budget, I believe that it's important to take this opportunity to share some of the likely impacts the proposed reductions will have on community behavioral health delivery. It is very likely that we will have to eliminate some of our more successful and important local programs. I think it's likely we will not be able to financially sustain our Pine View youth respite program. I also believe that our Jail Diversion, Mental Health Court and Corrections-based services will be in jeopardy, as will our school-based behavioral health services. These programs are difficult to sustain now, and it will be very difficult to continue their operations given the likely impacts of direct reductions in funding while also reducing the number of enrolled OHP and CCO members I can also point out that the loss of these services will likely increase costs to the state in other ways. For instance, there is a very good possibility that these reductions and the resulting closures will result in higher utilization of more expensive, more intensive services, such as higher demand for youth residential treatment. It is also likely that more local jail and state prison beds will be needed. In short, the proposed behavioral health cuts will create "hydraulic impacts" in a variety of areas that will very likely increase costs to other systems. At the same time, these cuts will have significant impact on the lives of thousands of Oregonians with mental health and substance abuse problems.