BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY OREGON

RESOLUTION NO. 01-109

Providing Policy Direction for the Acute Care Crisis Action Plan (Phase I)

The Multnomah Board of County Commissioners Finds:

a. On December 7, 2000 the Board unanimously approved Resolution 00-194 that directed the Department of Community and Family Services (DCFS) to begin work to transform the County's existing mental health organization to provide a consumer and family-centered mental health system.

b. The Board remains committed to continuing efforts to integrate physical and mental health services.

c. On May 15, 2001, the Board approved a budget note directing the DCFS to present to the Board a revised mental health budget reflecting the redesign no later than July 30, 2001. The Board directed budget modifications to reallocate funding.

d. The closure of the Crisis Triage Center created a gap in the service delivery system for individuals in mental health crisis and has created an urgent need to implement alternative crisis and acute care inpatient services.

The Multnomah County Board of County Commissioners Resolves:

1. Multnomah County will neither delegate nor contract its authority to determine how the clinical and fiscal responsibility for the mental health care of Oregon Health Plan beneficiaries and indigent clients will be assigned to providers.

2. The Board approves the policy direction of the first six action steps of the Phase I Plan, dated August 8, 2001, including phone services, walk-in clinics, mobile crisis teams, secure evaluation facility, acute hospital alternatives and acute care coordination.

3. The Director of the DCFS will clarify system participants, their roles and responsibilities as part of the next steps of implementing Phase I and preparing for Phase II, and submit a report to the Board by October 1, 2001.

4. The DCFS Director and the Director of Support Services will submit for Board approval appropriate budget modifications, in accordance with standard County budgeting procedures, by September 20, 2001.

5. Special Populations:

   a) The Board adopts the Cultural Competency Committee's Position Statement (July 17, 2001) outlining the principles that must be adhered to as the County proceeds with the efforts to restructure the mental health system.

   b) The Board also adopts the Committee's recommendations for establishing culturally competent Crisis Services (July 17, 2001). The County Chair will ensure that the DCFS Director implements their recommendations.

   c) The County Chair will ensure that the DCFS Director enhances existing service delivery capacity by contracting with specialized providers through pre-paid, flexible, limited-risk contracts.

   d) The County Chair will ensure that the DCFS Director engages the specialized providers to guide further development of age and cultural competence expertise within the mental health system.

   e) The County Chair will ensure that the DCFS Director promotes collaboration among all providers to carry out the system mission and values.

   f) The County Chair will ensure that the DCFS Director continues the involvement of the Cultural Competency Committee in the policy development of all aspects of the mental health redesign.

6. The DCFS Director will develop and submit a plan for children's outpatient services, in consultation with stakeholder groups that is consistent with the principles identified in Section 5 above.

7. This Acute Care Services Plan is transitional in nature. Competitive procurement processes for the long-term purchase of clinically appropriate Acute Care Crisis Service components must be conducted no later than July 1, 2002. A single omnibus contract will not be offered to a single provider for mental health services. The structure of the single point of accountability is not meant to imply the creation of a single contract with one provider.

8. The DCFS Director will include representatives from all county departments serving mental health client populations and other stakeholders, including CareOregon, in all planning and implementation teams for the mental health system redesign.

9. The DCFS Director will provide quarterly progress reports to the Board beginning October 1, 2001 regarding the progress of the new and reconfigured Crisis and Acute Care Alternatives. The reports must specifically address the financial status, services outcomes, cultural competency issues, and developments related to a comprehensive outpatient service plan.

ADOPTED this 9th day of August, 2001.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Thomas Sponsler, County Attorney

Resolving the Multnomah County Acute Care Crisis

Action Plan - Phase I

August 8, 2001
Jim Gaynor, Director of Mental Health Redesign, Verity
Peter Davidson, MD, Chief Clinical Officer/Medical Director, Verity
Dale Jarvis, CPA, MCPP Healthcare Consulting, Inc.

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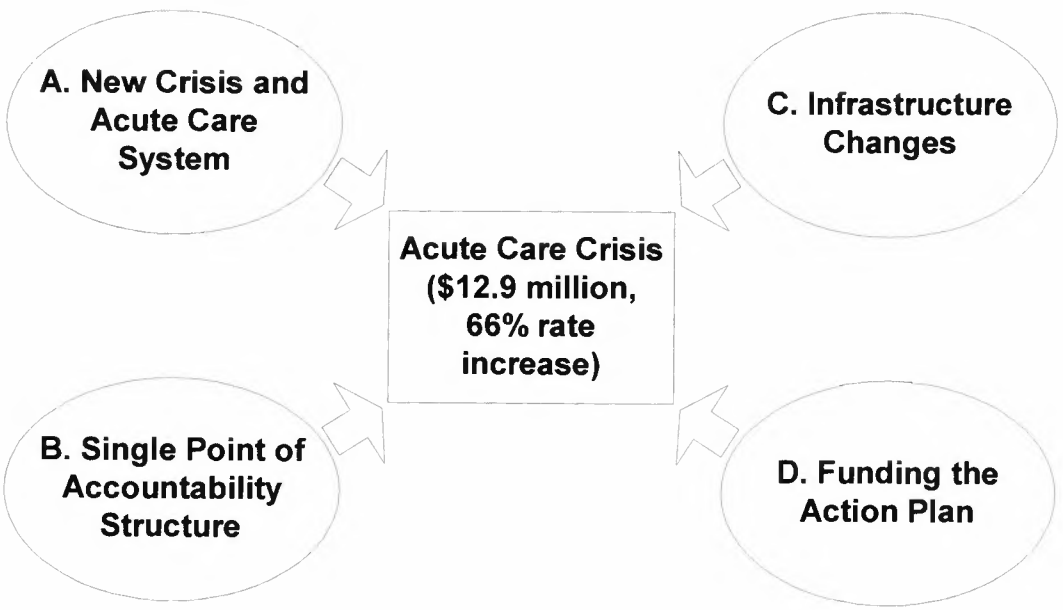
Executive Summary

In the fiscal year that just ended June 30, 2001 the average cost for an Oregon Health Plan acute inpatient bed day was $422.50. With the implementation of the new, per diem arrangement that goes into effect next month, this average rate will increase 66% to approximately $700 per day. Based on a thorough analysis of projected inpatient use, this represents a $2.9 million (29%) increase in inpatient costs from $9.9 million to $12.8 million. This increase is based on the assumption that, as the Crisis Triage Center closes August 1, 2001, new and more comprehensive inpatient alternatives will start being brought online and hospital admissions will begin to decline. If better management of inpatient does not occur during the fiscal year, Multnomah County will spend an additional $1 million or more on inpatient expenses (on top of the $2.9 million planned increase).

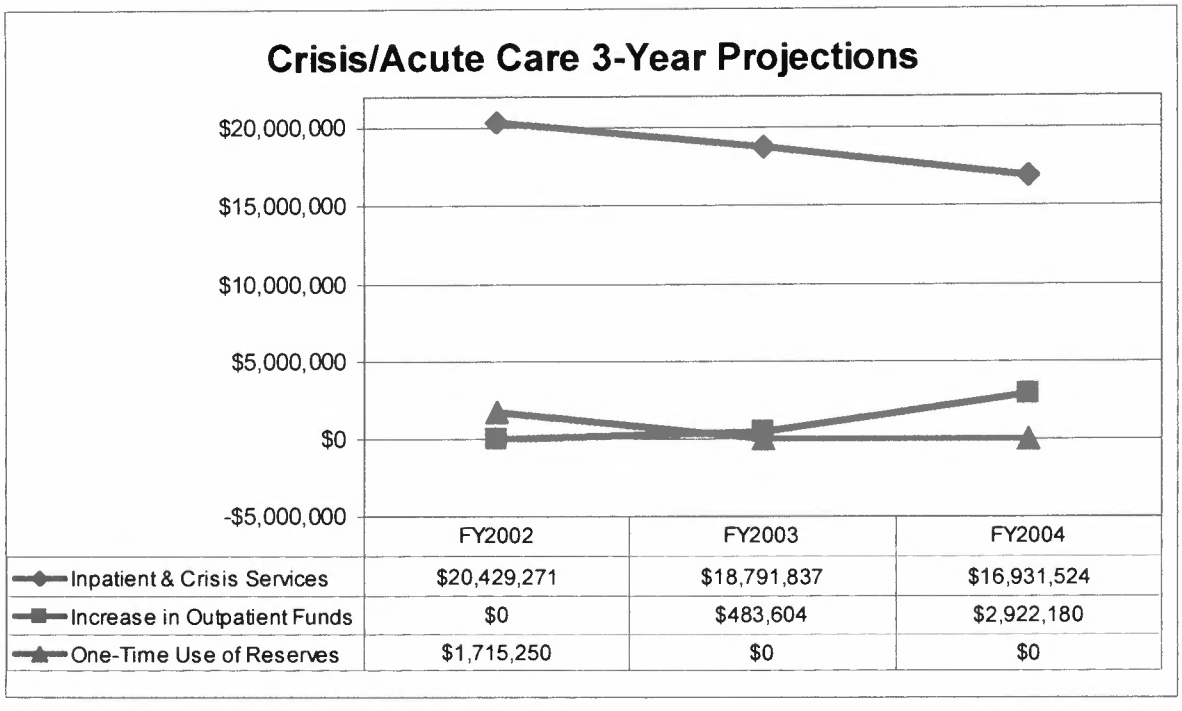
These rate increases mean that almost one out of every five mental health dollars (19.2%) will be spent on inpatient services. These figures do not include state hospital costs, which increase the inpatient percentage. These are the highest costs in the State of Oregon and the Pacific Northwest. For example, King County Washington (Seattle) spends 13.2% of their mental health funds on inpatient services.



Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The Phase I plan that is presented in this report is a 90-day first step towards resolving this crisis. This Action Plan has been designed to reduce inpatient costs over a 3-year period by $3.6 million. Although the plan recommends dipping into reserves for the first year, it is projected

that outpatient service funds can grow $2.9 million by the third year. The following chart illustrates these projections.



	FY2002	FY2003	FY2004
Inpatient & Crisis Services	$20,429,271	$18,791,837	$16,931,524
Increase in Outpatient Funds	$0	$483,604	$2,922,180
One-Time Use of Reserves	$1,715,250	$0	$0

The Action Plan includes the following four areas of intensive activity.

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. Six action-steps must be taken to support the implementation of these services.

1. Access/Crisis Phone System
2. Urgent Walk-In Clinics
3. Mobile Crisis Teams
4. Secure Evaluation Facility
5. Acute Hospital Alternatives
6. Acute Care Coordination

B. Roll-Out of the Single Point of Accountability Philosophy and Structure

Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability

philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. Three action-steps must be taken to support the implementation of this philosophy and structure.

7. Single Point of Accountability Structure
8. Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool
9. Assignment of Existing and New Consumers

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important four are listed below.

10. Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool
11. Rapid Implementation of Raintree Systems Computer Software
12. System-Wide Performance Reporting System
13. Redeployment of Key DCFS Staff

D. Funding the Action Plan

The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $20,429,271. This includes $12,799,261 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently allocated, the Crisis and Acute Care System is currently underfunded by $7,459,962. The following action steps must be taken to resolve this crisis.

14. Reallocation of New OHP System-Wide Funds
15. Transfer of the 3% OHP Incentive Pool
16. Inpatient Contract Negotiation
17. BHD/Verity Reorganization and Budget Adjustments
18. One-Time Use of Mental Health Reserves

Note: It is important to underscore that the consequences of not funding the crisis and acute care services listed in this report creates significant risks for the Multnomah County mental health consumers, the County and provider organizations. If one or more financial recommendations are considered unfeasible and not implemented, the difference should be appropriated from the County General Fund Contingency Pool.

Implications for Phase II

The 90-day Phase I must be followed immediately by Phase II that should run from days 91 – 365. During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes

- Continued reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

Introduction

Resolution of the accelerating acute care crisis is the most critical system initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The current system is fragmented, has the wrong incentives built-in, and perpetuates costly redundancies. This is neither cost effective nor clinically efficient. It also provides unnecessary impediments for consumers attempting to access the right care at the right time. Accordingly, system accountability suffers.

The solutions outlined in this plan:

- Lay the groundwork for the integrated consolidation of system providers, infrastructure, and the blending of funding streams wherever possible.
- Make strategic interventions in the crisis, and acute care, and outpatient systems in Phase I.
- Begin a process that will allow dollars to be freed up for reinvestment in service expansions and capacities that will result in easy access to the right care, delivered at the right time, for the right price.
- Allow us to move to Phase II where further system development will occur and unnecessary administrative overhead is identified and eliminated.

As old silos are replaced with a new seamless array of easily accessible services, true public-private partnerships based on risk as well as gain sharing will emerge. A new era of system accountability will be born that is much more self-regulating, consumer centered, and responsive.

Consumer choice will be enhanced by providing expanded service options that produce good consumer outcomes. Synergies will be achieved through ongoing horizontal and vertical integration initiatives resulting in systems of activities that are complementary, consistent, interdependent, and mutually reinforcing. The finite pool of system dollars will be managed for maximum effectiveness for the maximum amount of consumer gain. This will be achieved by blending funding streams into a single risk pool managed by the MHO. Performance based contracts will be executed and actively managed by continuous quality improvement specialists serving in responsive outcomes management roles. Likewise, County employed Acute Care Coordinators will serve in the capacity of "innovation stimulators" as well.

Providers will be increasingly self-regulated through performance based accountability contracting models that reward the generation of good consumer outcomes while also assuming the risk and responsibility associated with negative outcomes. Any remaining fee-for-service provider contracting will be aggressively managed. Consumers will no longer be "exiled" from treatment options for any reason. The MHO will be a proactive partner in the development and

deployment of productive and innovative systems of care that minimize risk and promote success. Reinvestment plans will be negotiated that result in increased risk reserves, employee compensation, and capacity building.

Background and Problem Statement

The problems in the mental health system are well known and have been well documented over the course of the past 2 years of redesign initiatives. These problems are interconnected and require an integrated approach to solutions. This section will identify the prioritized target issues most in need of immediate turnaround solutions.

ACUTE CARE CRISIS

Escalating Utilization

Multnomah County has an inpatient utilization rate that is more than twice that of the statewide average when adjusted per capita (bed days/month/1000 members). When Multnomah County's utilization data is removed from the statewide aggregate data, we exceed inpatient rates by a factor of almost four (19/1,000 vs. 5/1000). The major reason for this predicament is the lack of less costly and more clinically appropriate sub-acute and crisis response alternatives. It should be noted that risk often motivates the deployment of these types of service alternatives, yet this idea was never pursued by the partner hospitals under the risk partnership contractual arrangements over the past 2 years. Inpatient care should be targeted to stabilize individuals so that they can be more actively engaged in community based recovery oriented treatment. Instead, it is capable of consuming over a third of the total available system treatment resources if left uncontrolled.

Movement to Per Diem Inpatient Vendors

The inpatient providers in the process of severing their current risk contract with the County and return to individually negotiated per diem bed rates. This return to a fee-for-service relationship will result in a significant net increase in the cost of a bed day of an average of 66% over current rates. When factored in to present utilization rates, this could result in an annual inpatient cost of over $14,000,000. Suffice it to say that this development mandates a rapid utilization management solution to reverse this scenario.

Absence of Vital Crisis Response Service Continuums

The Crisis Triage Center (CTC) performed a vital system function but was nonetheless providing significantly fewer crisis response services than it agreed to perform in its proposal to the original RFP. Because of this, the CTC was a very expensive system component. The CTC's efficacy was severely compromised due to the lack of a strongly coordinated system of adjunct crisis services geared toward mitigating the inpatient risk with more appropriate and less costly alternatives. This most critical service element is the most glaring service gap in the current system.

OUTPATIENT DELIVERY SYSTEM

Fragmentation and Market Rivalry

Multiple providers delivering basically the same types of services while looking to protect and expand their historical market share does not drive good collaboration or true partnership. It does drive a lot of expensive window dressing and meeting time, which only resembles true collaborative partnership. Competition for scarce clinical resources across professional disciplines results in added ongoing recruitment costs that could be better spent by providing a more stable integrated workforce at higher wages. The providers could look to create seamlessly integrated niche specialties and clinical centers of excellence that would better benefit consumers and the system as a whole. Historically, there was little financial incentive to explore consolidated service delivery models in an environment of "co-opetition" (cooperation + competition).

Fee-for-Service Program Structure

The current outpatient reimbursement formula pays for services based 50% on encounter and 50% on case rates. This encourages the outpatient system to perform in much the same way as under fee-for-service models. However, under managed care, the case rate portion results in a net loss from those historical Medicaid fee-for-service revenues. Therefore, the outpatient system is experiencing much downside associated with risk while still operating the same way as before. This dual mismanagement rewards the system for focusing on those who are easiest to care for while neglecting the difficult client most likely to need more costly and intensive services. Currently, the outpatient system is financially encouraged to shift the care for difficult clients to hospitals rather then expend the overburdened clinical resources to provide alternatives to hospitalization.

Administrative Redundancy

The current multiple providers separately fund multiple administrative structures that are mirror operational components of one another. These redundancies come at a high cost to the system, whereas, if providers were consolidated, the savings would be reinvested in vital service and capacity expansion. The two major contracting networks (ABH and HSA) show some economies of scale, but they provide yet another layer of administrative overhead. Member organizations must reduce their individual administrative structures to offset the costs the networks charge back to the members.

Low Productivity

Despite feeling genuinely overburdened with huge caseloads and dramatically reduced fiscal reserves, the average time clinical staff spend in direct clinical encounters with consumers averages less than 50% across the system. Paperwork, meetings, lack of automated processes, and antiquated infrastructures are reasons given as to why more direct service time isn't being spent with consumers. Productivity should and can be increased significantly. Nationwide, successful provider organizations have found ways to work smarter, resulting in more effective and efficient clinical service models. Providers must also find ways to reduce their overhead costs. These changes will result in more time for clients and the ability to better meet the needs of the community. It is

also important to note that the MHO must be part of this solution by working to reduce unnecessary paperwork and non-value-added procedures to a minimum.

Access

Waiting times to access outpatient services are too long. Approximately twenty-five percent of all consumers accessing the inpatient system are not assigned to any outpatient provider. This results in a very expensive access system whose doorbell is, by proxy, a bad outcome (i.e. deterioration to the point of requiring an inpatient stay).

The providers, with a combination of poor productivity, greatly increased caseloads, and little incentive to successfully move clients from out the back door (i.e. successful recovery oriented treatment utilizing natural community systems of support), are in fact unwittingly contributing to their own burnout and failure. The bottleneck at the front door is experienced by the providers as being a direct result of a real lack of service capacity to meet the demand needs of clients wishing to access outpatient services. The reality is that as access to less expensive and most appropriate care is impeded at the outpatient level, more and more consumers are deteriorating to the point of having to access the inpatient system. This in turn bleeds more money out of the outpatient pools, which then results in more diminished outpatient capacity. This downward spiral must be reversed. The best way to achieve this is to provide adequate incentives to provide access on demand and to lower hospitalization

BUSINESS MODEL AND ORGANIZATIONAL STRUCTURE

Accountability Alignment

The single variable most responsible for the deterioration of the mental health system with the advent of capitated Medicaid funding is the adverse alignment of risk and reward across the system. Shared risk contracting, when properly aligned and aggressively managed, generates true partnerships and, most importantly, effective, expanded, and seamless clinical care continuums. This is the difference between managed care nightmares and good managed care being synonymous with good and timely clinical intervention. Good accountability-based contracting will result in the right care being delivered at the right time and for the right price. When done effectively, the consumer benefits enormously. Secondarily, so does everyone else.

Contract Compliance Management

The County's contracting and contract management processes are in need of major change. Multiple contracts with multiple terms and expiration dates that get changed, sometimes only verbally, are often signed several months after the services are being delivered. The ongoing management of performance metrics and other contract terms are frequently renegotiated in the direction of less value than the original terms. MHO staff will be focused on performance that generates good consumer outcomes. Contingencies must be considered and acted upon when, despite all efforts otherwise, contract agencies fail to meet necessary conditions specified in the contract.

Role Diffusion

The relationship between the MHO and the Behavioral Health Division (BHD) has been unclear in the past. Clear boundaries and relationships must be defined and operationalized to maximize accountability while maintaining the flexibility to continuously improve in mutually effective ways. As always, assuring that the right care is taking place at the right time and for the right price will be the ultimate yardstick against which any change is made and measured. Fiscal accountability between the two divisions must be reconciled accordingly.

Data Analysis and Infrastructure

Standardized reporting across specified outcomes management targets must be made available through sound database/data warehouse development and ongoing analytical processes that can optimize continuous quality improvement activities.

CONSUMER INVOLVEMENT

Advocacy versus Empowered Ownership

The consumer advocacy landscape in Multnomah County is very impressive. This is due to the inclusive process involvement by consumers throughout the redesign process. This is also due to the level of talent and commitment embodied in the advocacy community. It is time to take advantage of this underutilized resource. We need to provide a conducive platform that shifts the advocacy community away from a reactive mode towards more proactive involvement and ownership in making new solutions work. In this regard, consumers are most likely to become the true partners in crafting the solutions they so desperately deserve. Development of Ombudsman functions, expansion of the office for consumer affairs, and deployment of expanded peer support services will serve to enhance the continued proactive involvement in existing stakeholder forums. Additionally, inclusion as valued contributing members on contract provider Boards of Directors will serve to secure necessary governance representation as well.

Proposed Action Plan: Phase I

The Phase I plan presented below is a ***90-day first step*** towards resolving the acute care crisis in Multnomah County. It includes four areas of intensive activity that must be implemented immediately, including:

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives
B. Roll-Out of the Single Point of Accountability Philosophy and Structure
C. Infrastructure Changes to Support the Action Plan
D. Funding the Reconfigured System

These recommendations are based on a detailed financial and utilization analysis that examined all aspects of the Multnomah County Mental Health System including:

- Detailed review of outpatient **client and service delivery history** for Oregon Health Plan enrollees and indigent consumers;
- Comparisons of **how much service** was provided, in total, and per client at each outpatient provider organization
- Analysis of all Behavioral Health Division and Verity **provider contracts**;
- Examination of all federal, state and local **revenue sources** and funding restrictions;
- **Inpatient projections** based on several years of admissions, days and average length of stay data for all health plans operating in Multnomah County;
- Sophisticated **demand projections** for mobile crisis, urgent walk-in, secure evaluation facility and acute impatient alternative services;

Because of the severity of the financial and client safety crisis facing Multnomah County and the carefully built-in interdependencies of the eighteen strategies, ***all must be implemented within the next 90 days*** if the County hopes to prevent insolvency of the mental health system.

A. Roll-Out of New and Reconfigured Crisis and Acute Care Alternatives

Currently there are significant gaps in the service delivery system for individuals experiencing a mental health crisis. With the closing of the Crisis Triage Center these gaps are going from problematic to critical. Work has already begun on the development and implementation of crisis and acute care alternative services. The following action-steps must be taken to support the implementation of these services.

1. **Access/Crisis Phone Service:** Multnomah County should consider bringing the Access/Crisis Phone Service into Verity as a county-run operation. Centralizing this function can reduce duplication and, if operated effectively, improve coordination between all parts of the mental health system. Providence should continue operating this service while a feasibility analysis is completed to determine if this recommendation can be implemented on a timely basis and is cost effective. If another alternative is selected it should be based on a contract that runs no longer than through June 30, 2002. *First Year Cost: $1,856,067.*

2. **Urgent Walk-In Clinics:** Multnomah County should immediately contract with the identified provider organizations to operate four, regional Urgent Walk-In

Clinics, with contracts that runs through June 30, 2002. These Clinics will use a "no appointment necessary" approach and operate during the highest demand periods from 9:00 am to 5:00 pm Monday through Friday. Additionally, a centrally located walk in clinic will operate from 5:00 pm to 9:00 pm Monday through Friday and 1 to 4 pm on Saturday. This design will dramatically increase access to consumers and provide a more appropriate service delivery environment to individuals who have urgent, but not emergency needs. *First Year Cost: $1,118,434.*

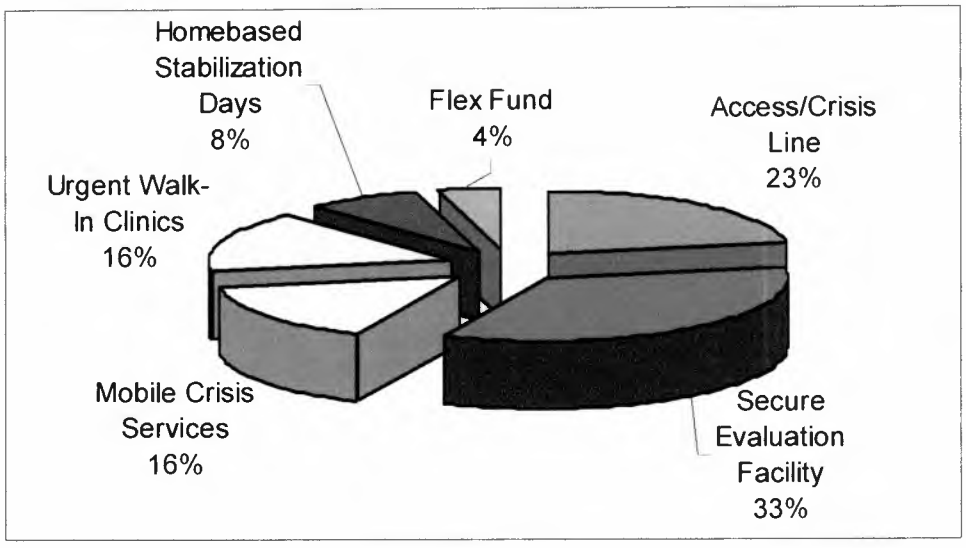
3. **Mobile Crisis Outreach Teams:** Multnomah County should immediately contract with the identified provider organization to operate Mobile Crisis Outreach Teams 24-hours per day, seven days per week, with a contract that runs through June 30, 2002. During hours of operation Mobile Outreach staff will be co-located at the four Urgent Walk-in clinical sites. During evenings and on Saturday, the Mobile Outreach Team will be co-located with the centrally located Urgent Walk-in clinic. *First Year Cost: $939,389.*

4. **Secure Evaluation Facility:** Multnomah County should immediately contract with the designated provider organizations to provide 23-Hour observation capacity for a period of assessment for those patients deemed to have the potential to rapidly regain functioning, and to facilitate their smooth reintegration into the community through optimal discharge planning. The contract is currently being negotiated and the final length of the contract along with other contract terms should be determined as part of that process. *First Year Cost: $2,217,712.*

5. **Acute Hospital Alternatives:** Multnomah County should immediately contract with designated provider organizations to provide additional alternatives to hospitalization capacity including Intensive Home-Based Stabilization services, Respite Beds, Sub-Acute Inpatient services, and "Flex Funds" to support other creative alternatives. The length of these contracts should be consistent with existing contracts that are in place for these types of services. *Annual Cost: $3,148,667.*

6. **Acute Care Coordination:** Multnomah County should immediately complete the development of the Acute Care Coordination Team. Members of this team will work with referring clinicians, discussing treatment options for clients in crisis in the context of the criteria for "medical appropriateness", assisting with referral to the least restrictive and most clinically appropriate care setting. *Annual Cost: Part of Verity's Budget.*

These six changes will result in a system that has many "right doors" and capacity that has been carefully designed to meet the needs of consumers in crisis. The chart on the following page illustrates how financial resources will be allocated to the newly designed crisis system. As the system stabilizes we expect that costs for the secure evaluation facility will decrease and those savings will be redirected towards non-urgent/emergent services.



B. Roll-Out of the Single Point of Accountability Philosophy and Structure

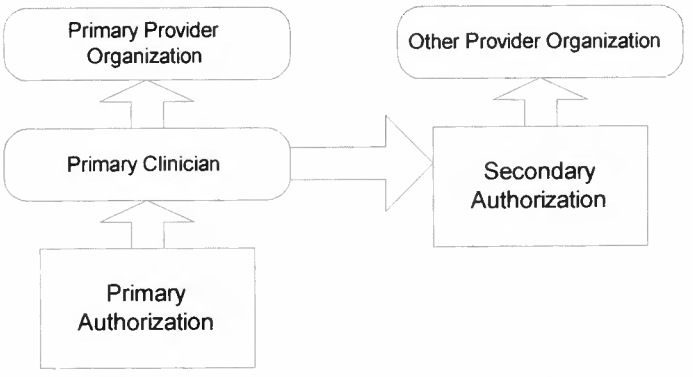
Currently, if an individual who is enrolled with a mental health provider organization has a mental health-related crisis there is no practical way to identify and contact the clinician who has the best clinical knowledge of that individual. In addition, there is no standardized process for identifying individuals who are not currently enrolled and in need of mental health service, and "hooking them up" with a "primary clinician". These circumstances result in the inability of crisis caregivers, including the police, to determine the most appropriate treatment setting for clients in crisis and often results in hospitalization that may have been unnecessary.

These disconnects surrounding crises are just one view into a service delivery system that has not embraced a single point of accountability philosophy and structure, where each consumer of mental health services has a primary partner to assist them in meeting their service needs and aiding in their rehabilitation and recovery. This type of structure is critical to helping prevent crises before they occur. Furthermore, this model is an essential building block for implementing a recovery-oriented care delivery model.

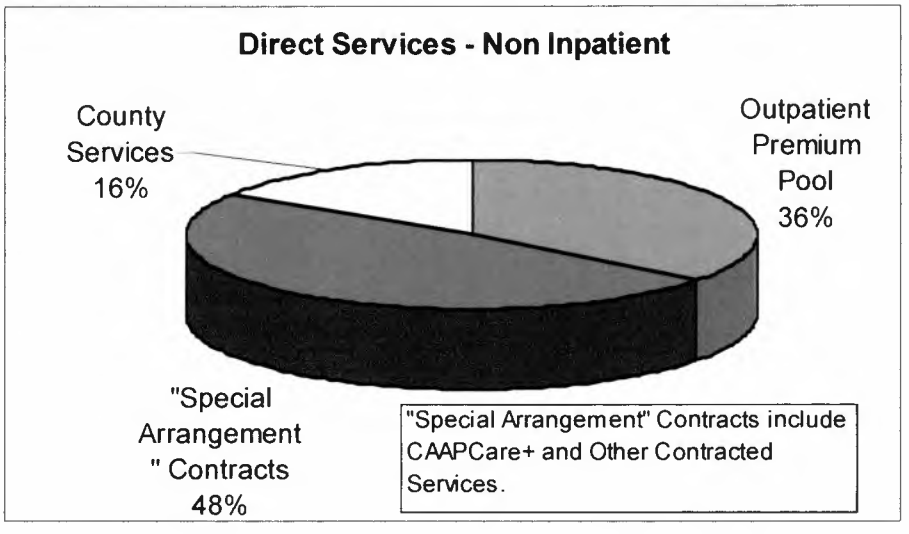
The following action-steps must be taken to support the implementation of this philosophy and structure.

7. **Single Point of Accountability Structure:** Multnomah County should revise all existing outpatient contracts to establish a Single Point of Accountability structure. Under this structure all mental health consumers whose care is financially supported by Multnomah County would be assigned to a Primary Provider Organization and a Primary Clinician through the issuance of an open-ended Primary Authorization. The Primary Clinician will be part of a Care Team (consisting of at least two individuals – the consumer and the Primary Clinician) whose jobs include treatment planning, service coordination, service delivery, and crisis planning and management. The Primary Authorization will "stay open" for as long as the client resides in Multnomah County or until/unless the consumer transfers to a different Primary Provider Organization, regardless of whether their case file is open or closed. Part of this system will include Secondary

Authorizations that support the purchase of evidence-based services or supports for special services not otherwise available from Care Team members who do not work at the Primary Provider Organization. *Annual Cost: Part of the Outpatient Contracts.*



8. **Convert and Expand the OHP Outpatient Premium Pool to an Accountability/Incentive Pool:** The Single Point of Accountability Structure should be supported by a new payment mechanism that increases the flexibility of how monies can be used, provides financial incentives for proper management of the crisis and acute care system and holds providers accountable for poor outcomes. The mechanics of this model are described in Recommendation C10 below.



A financial model that supports the Action Plan is critical to successfully changing the behavior of the provider community. Currently only 36% of the existing funding for the Multnomah County Outpatient System is available for the Single Point of Accountability System – the funds that are in the OHP Outpatient Premium Pool. The other 64% is embedded in "Special Arrangement" Outpatient Provider Contracts (48%) and budgets for County-Staffed Services (16%). The Special Arrangement Contracts are funded through a myriad of case rates and fee

for service arrangements that use "old-style", commercial managed care arrangements that prevent more flexible and creative use of funds and are necessarily outside the Accountability and Incentive Structure. It addition, these contracts require over 20 full time equivalents of County Care Coordinators, whose salary costs alone are over $1.3 million per year.

Multnomah County should immediately convert the OHP Outpatient Premium and CAAPCare+ Outpatient Pools to the new Accountability/Incentive Pool. County staff should also immediately begin an Internal Audit and Performance Analysis of the Special Arrangement Outpatient Provider Contracts and County-Staffed Services to determine which services can be moved into the Accountability/Incentive Pool in Phase II. This analysis should be completed by 10/1/2001. *Annual Costs: Phase I $19,575,316; Impact of Phase II: To be determined.*

9. **Assignment of Existing and New Consumers:** Multnomah County should immediately begin a process to identify the Primary Provider Organization and Primary Clinician for all currently enrolled consumers. This will consist of using historical data in the Verity authorization database to complete a preliminary identification of Primary Provider Organizations. Providers will then review the computer reports, make corrections as needed and identify the Primary Clinician for each consumer. This information will be returned and entered to the County Information System.

   The County should also begin a process to rapidly assign all newly identified mental health consumers to a Primary Provider Organization and Primary Clinician. This will include the development of policies and procedures for all providers in the system. Crisis and Acute Care staff will be responsible for helping "hook" new consumers up with Outpatient Organizations. Outpatient Organizations will have clear guidelines for how and when to assign consumers who are new to their organizations. *Annual Cost: Part of the Existing DCFS IS Budget and Provider Outpatient Contracts.*

C. Infrastructure Changes to Support the Action Plan

There are a handful of "mission-critical" infrastructure changes that are required to support the reconfigured crisis and acute care alternatives and single point of accountability structure. The most important are listed below.

10. **Design and Implement the Business Rules and Contracts for the Accountability/Incentive Pool:** The funding design for the Accountability/ Incentive Funding Pool combines the OHP Outpatient Premium and CAAPCare+ Pools to create a funding stream to be used for OHP and indigent consumers in Multnomah County. Funds will be allocated based on the number of consumers for whom each provider organization becomes the Single Point of Responsibility. If Agency X has taken responsibility for 10% of the consumers they will receive 10% of the pool each month. In return for payment, organizations will be expected to provide all medically necessary outpatient services to their clients. In

addition, use of crisis and acute care services will be carefully tracked and provider organizations will be responsible for covering a portion of those expenses, up to a limit that will be defined by a financial risk corridor. If providers are able to properly manage their caseloads and lower the utilization of crisis and acute care services, incentive payments will be made to the organizations in the form of a rebate on under-spent Crisis and Acute Care System funds. The risk corridor will be designed so that no provider organizations will be threatened with catastrophic losses.

For the first year, smaller providers, who believe that they may not be able to manage under the new funding model, can select a Hold Harmless alternative where their crisis and acute care utilization will be monitored but funding accountability and incentives will not apply.

Multnomah County Board of Commissioners are requested to immediately approve the Outpatient Accountability/Incentive Funding Model and direct staff to develop the Policies and Procedures Manual that includes the detailed business rules for this model. Provider contracts must be revised so that the system can be phased in between July and September 2001, with full implementation beginning October 1, 2001. Later approval will delay these dates with substantial financial and system problems accruing. *Annual Costs per Action Step 8 above: Phase I $19,575,316; impact of Phase II: To be determined.*

11. **Rapid Implementation of *Raintree Systems* Computer Software:** There are nine categories of County and Provider Organization staff that are necessary to support the reconfigured crisis and acute care alternatives. These include staff working with the 1) Call Center, 2) Mobile Crisis Teams, 3) Acute Care Coordination, 4) Urgent Walk-In Clinics, 5) Primary Provider Organizations, 6) Care Coordination, 7) Member Services, 8) Claims Processing, and 9) Quality Assurance. Together these groups require 34 different pieces of computer functionality to support their work. The functionality ranges from Client Lookup to Authorization Entry to Crisis Episode Tracking to Claims Processing.

    A rapid but thorough evaluation was made of existing County computer systems and "off the shelf" packages, covering the areas of Functionality, Architecture, Ease of Implementation, Flexibility, Performance, Security, Reporting, Cost and Vendor Reliability. After determining that existing County systems could not adequately support the 34 functions the Joint County-Contractor IT Workgroup narrowed the field down to two finalists, PH Tech, from Salem Oregon, and Raintree Systems from San Diego California. A final vendor scoring resulted in the recommendation to purchase and implement Raintree Systems.

    Because of the emergent need to implement a new solution within 90 days, Multnomah County should suspend normal contracting requirements and immediately contract with Raintree Systems and begin implementation of the new system within 14 days. The functionality of the system should be rolled out in three phases, October 1, November 1, and December 1, 2001. Five

Implementation Teams should be immediately assembled that will be made up of County and Provider Organization staff – Application Develop, Data Conversion, Infrastructure, Deployment, and Reporting. The rapid implementation project should be co-lead by a County and a Provider Organization staff person. *One Time Costs: $196,500.*

12. **System-Wide Performance Reporting System:** A great deal of effort went into gathering utilization and financial data from a variety of sources to support the development of the Action Plan. Unfortunately, there was a scarcity of standard reports that could be "pulled off the shelf" to support these efforts. Most available reports were ad hoc in nature, so that the system was operating in a relatively "data-free environment". As stakeholders of the mental health system already know, the Multnomah County mental health system can no longer operate under these conditions.

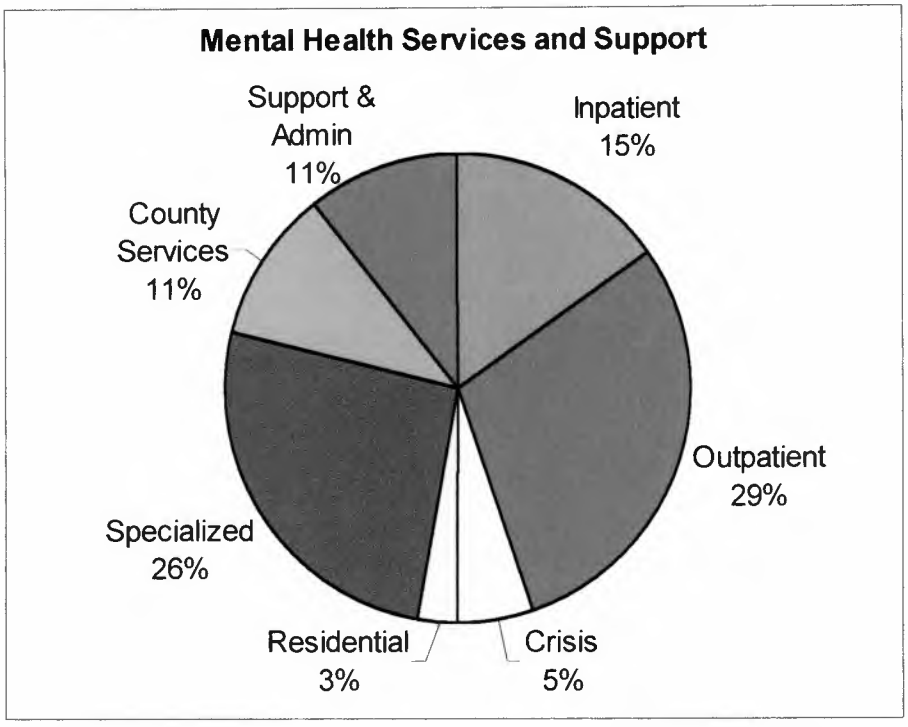
    Multnomah County should immediately begin the development of a System-Wide Performance Reporting System. The design of this system should be informed by key documents including the Utilization and Financial Modeling Tools that were used to support the Action Plan; Oregon Health Plan Mental Health Organization Agreement requirements; existing ad hoc and standard reports; the March 2001 Recommended Mental Health System Performance Measures authored by Jim Carlson, Seth Lyon and Theresa Posner; the 2001 American College of Mental Health Administrators' Proposed Consensus Set of Indicators for Behavioral Health; and the January 2001 State of Oregon Report to the Governor from the Mental Health Alignment Workgroup.

    These efforts should result in a set of regularly produced reports for key managers and stakeholders from the Multnomah Board of County Commissioners to Acute Care Coordinators to Primary Clinicians and their Supervisors that are produced daily, weekly, monthly and quarterly, based on need. The data in these reports should be used to build a "culture of measurement" within the Multnomah County Mental Health System, where meetings regularly include the analysis of data and all-important decisions are informed by this analysis. *One-Time Costs: $50,000.*

13. **Redeployment of Key DCFS Staff:** There are a number of activities that require the involvement of several DSFS staff members. This includes Acute Care Coordination, Accountability/Incentive System Policies and Procedures Development, Provider Contracting, assistance with bringing up the new Crisis and Acute Care Alternatives, Raintree Implementation, Performance Reporting System Development, further Financial and Budget Analysis, Stakeholder Communications, and more. Many DCFS staff have already been intensively involved in the planning activities that have resulted in this report. These efforts must now be followed by the development of a detailed Implementation Workplan and redeployment of DCFS staff to assist in these implementation activities. Multnomah County leadership should direct all DCFS management and staff to actively participate in the implementation efforts, as needed. *Annual Cost: Part of the existing Verity Budget.*

D. Funding the Action Plan

The fiscal year 2002 DCFS Mental Health Budget is $66,735,030. These funds are allocated to several areas, as illustrated in the chart below.



The costs for the Crisis and Acute Care System for the fiscal year are currently projected at $20,429,271. This includes $12,969,309 for Acute Inpatient and Acute Inpatient Alternative Service, which cost approximately $9.9 million in fiscal year 2001. As funds are currently allocated, the Crisis and Acute Care System is currently underfunded by $7,459,962. The following action steps must be taken to resolve this crisis.

14. **Reallocation of New OHP System-Wide Funds:** Currently 16.7% of the OHP Premiums are allocated to a System-Wide Funds Pool. These monies are used to support the Crisis Triage Center and a number of Specialized Services such as Day Treatment, Dual Diagnosis Residential Support, Supported Classrooms and Fee-For-Service outpatient providers. In fiscal year 2001 just over $4.4 million was allocated to this pool, with $1.3 million spent on Crisis and Acute Care Alternatives and $3.1 million spent on Specialized Services. With the addition of a full year of Regence enrolled lives this $4.4 million has grown to $5.5 million.

    Analysis of this fund shows that children's programs could be increased to match the new Regence enrollees (approximately 20%) an, if other services in the fund were maintained at fiscal year 2001 levels, $2.1 could be freed up to support the Crisis and Acute Care System. As the system stabilizes and inpatient costs come down, additional funds should be redirected to prioritized outpatient . *Annual Amount: $2,181,467.*

15. **Transfer of the 3% OHP Incentive Pool:** Currently $998,980, which represents 3% of the OHP revenue, is allocated to a provider incentive pool. These funds should be earmarked for covering the costs of the crisis and acute care system. These monies would then, automatically become part of the Single Point of Accountability, accountability/incentive pool. *Annual Amount: $998,980.*

16. **Inpatient Contract Negotiation:** In fiscal year 2001 Multnomah County was paying an average of $864 per day for emergency-hold inpatient beds, including professional fees. This is significantly higher than rates paid for other Multnomah County inpatient bed days or the rates paid at other Oregon MHOs. These contracts should be renegotiated immediately, combining them with the inpatient contracts for OHP covered clients, to bring the average rate down to $700 per day. *Annual Savings: $365,757.*

17. **BHD/Verity Reorganization and Budget Adjustments:** Currently 11.4% of mental health dollars are spent on county administration ($6.8 million). At the same time the administrative functions are spread out over three reporting areas: Verity, the Behavioral Health Division, and the Department of Community and Family Services. This structure significantly impacts the ability of the 75+ full time equivalent administrative employees to effectively accomplish their work.

    It is possible to reorganize these administrative functions, consolidate duplicate activities, reduce costs and better support the management and operation of the Multnomah County mental health system through the implementation of the following changes.

    Admin Consolidation: Pull the system management activities including Care Coordination, Involuntary Commitment, Adult and Child Contract Management, and DCFS fiscal services out of their respective areas and into Verity. This would allow for the development of a fully functional, self-contained business enterprise with its own fiscal, contract and management capacities, all under "one roof".

    8% MHO Administrative Cap: If the costs of the consolidated system management activities are measured against the total revised budget for this area, including provider contracts, the administrative percentage is 10.4%. This compares with the following:

    - OMAP provides 8% to fully capitated health plans.
    - CareOregon is managed within their 8% rate.
    - The State MHDDSD Department provides 8% to MHOs for administration.
    - Clackamas MHO administration for FFY99/00 was 6.54%.
    - Mid-Valley Behavioral Care Network MHO administration for FFY99/00 was 7%.
    - Accountable Behavioral Health Alliance MHO administration for FFY99/00 was 8%.

As part of this administrative consolidation, Verity should bring its administrative costs down to 8% of total contract and service expenditures. It is anticipated that this will require a reduction of approximately nine FTEs. *Annual Savings: $700,793.*

12% Behavioral Health Administrative Cap: With the transfer of Care Coordination, Involuntary Commitment, Adult and Child Contract Management to Verity, the existing administrative costs for the Behavioral Health Division would total 20.2%. This budget should be reduced to 12%, which "better-sizes" the administrative staffing in relation to the new duties. It is anticipated that this will require a reduction of approximately four FTEs. *Annual Savings: $408,502.*

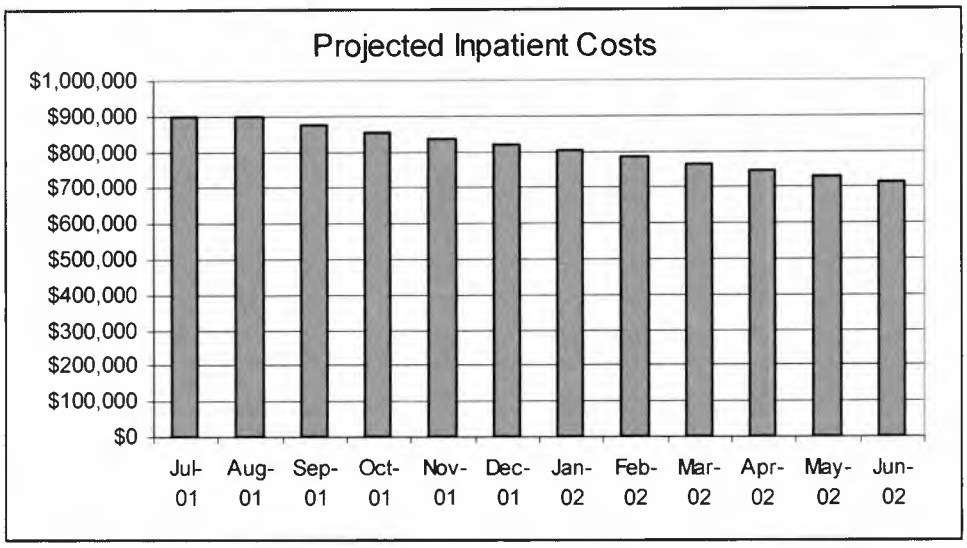
Local Administrative Dollars: Currently $2.1 million is received from the State to administer Mental Health, Alcohol & Drug and Developmental Disabilities. $805,640 is allocated directly to programs, of which only $111,054 is allocated to Mental Health. At the same time $1,310,870 is allocated to DCFS overhead departments. To support the administrative consolidation 30% of the $1.3 million of the Local Administration should be transferred to Mental Health to free up additional OHP and State General Funds to support the Crisis/Acute Care System costs. *Total Amount: $393,261.*

The four parts of this recommendation are interdependent in that shifting or responsibilities must be accompanied by shifting of funds and vise-a-versa. *Total Amount: $1,502,556.*

The four strategies identified in action-steps 14 – 17 represent a $5.74 million shift of funds to the Crisis and Acute Care System. This leaves a remaining shortfall of $1.7 million. After an exhaustive evaluation of all funding sources and programs it is readily apparent that additional cut or funding shifts could severely threaten the already fragile mental health system.

18. **One-Time User of Mental Health Reserves:** The main purpose of Mental Health Reserves is to cover emergencies that threaten the viability of the MHO. The current Acute Care Crisis constitutes such an emergency. Multnomah County should allocate $1.72 million of existing reserves to fund excess inpatient costs that are projected for fiscal year 2002.

    To prevent a similar shortfall in fiscal year 2003, inpatient expenditures must be reduced 21%. The funding model that was used to develop these recommendations assumes that these reductions will begin in September 2001, with the rollout of the Crisis and Acute Care Alternatives and Single Point of Accountability Structure and grow to a 21% savings by June 2002. The graph on the following page illustrates the required change in inpatient expenditures. *One-Time Costs: $1,715,250.*



Note: It is important to underscore that the consequences of not funding the crisis and acute care services listed in this report creates significant risks for the Multnomah County mental health consumers, the County and provider organizations. If one or more financial recommendations are considered unfeasible and not implemented, the difference should be appropriated from the County General Fund Contingency Pool.

What is not included in the Action Plan – Phase I

While stabilizing the crisis and acute care system is the immediate, mission-critical intervention to keep the mental health system solvent, there are a number of equally important parts of the system that need to be protected during the process. These includes:

- **Child and Family Service Funding:** Public mental health began as a system for adults with severe and persistent mental illness. Funding for children came later and in smaller quantities. Multnomah County has made substantial effort to address shortfalls in this area and design service delivery strategies that are relevant and successful for this population. It is important during an acute care crisis, which is substantially related to the adult population, that funding for child and family mental health services are protected and, to the degree possible, strengthened. This Action Plan has been specifically drafted to prevent reduction of service dollars for child and family services during Fiscal-Year 2002.
- **Multi-Cultural and Underserved Populations Funding:** Preliminary analysis of mental health utilization data, by ethnicity, illustrates that non-majority ethnic groups are significantly underserved in Multnomah County. Substantial efforts are underway to develop and strengthen cultural competency in Multnomah County and address under-service to non-majority ethic groups. This Action Plan has been designed to protect existing funding to organizations that specialize in serving multi-cultural and other underserved populations. The Single Point of Accountability structure is being proposed for these organizations on a "hold-harmless" basis, where multi-cultural providers will be identified as Primary Clinicians and receive continuing payments for their clients without the downside financial risk that will be embedded in the accountability/incentive structure.

- **County Mental Health Service Delivery:** Multnomah County staff in the Behavioral Health Division provide mental health services through their Child and Adolescent Treatment unit and School-Based programs. As the outpatient system begins to prepare for additional funding that will be freed up from a successful resolution to the acute crisis, these services need to be included in the analysis of what's available, what gaps exist, what changes in priorities are necessary to best meet the needs of consumers and family members. These efforts are not part of the Action Plan – Phase I.
- **Alcohol and Drug Services and Funding:** Services and funding for the county-supported alcohol and drug system are outside the scope of this Action Plan.

Important Notes about Cultural Competency and Consumer Involvement

The reader will note that there are no *specific* Acute Care Crisis action-steps addressing cultural competency and consumer involvement. Nonetheless, there are many *implicit* actions within the eighteen steps that relate to both.

It is imperative for Multnomah County to ensure that all services are designed with sensitivity and specialization for specific sub-populations including adults, children, older adults and ethnic and cultural communities. Staffing must consistently attend to cultural and special population considerations incorporating bicultural members, bilingual staff and sub-populations specialists into all staff teams. This is relevant for services that are developed during times of relative calm as well as times of crisis.

Design work has already begun towards producing data that will demonstrate how new services as well as existing ones address the needs of different populations; this is an important element of Action-Step 12, System-Wide Performance Reporting System. In addition, Appendix 3 – Detailed Acute Care Design, describes in greater detail how new services will be deployed in culturally appropriate ways.

Consumer Involvement must also be a characteristic that winds its way through all new and existing planning and service delivery activities. Development of the Single Point of Accountability Structure and Philosophy is a critical foundation step towards building a system of care that is based on placing the consumer at the center of the service delivery process.

The Clinical Design Workgroup was well represented with consumers, including a Consumer Involvement Subcommittee. This group has highlighted the need for a consumer-operated Warm Line, which is an important component of the new Access/Crisis Phone Service. Development of an Ombudsperson will occur within the existing Verity budget.

Work in moving these components of a well-functioning system forward will continue.

Implications for Phase II

When all of the eighteen Action-Steps in Phase I are implemented by September 30, 2001, the acute care crisis will have only begun to be resolved. There are numerous additional Action-Steps that should have been implemented as part of a Phase I. Because of the two-year delay in beginning detailed implementation work, this was not possible.

The 90-day Phase I must be followed immediately by Phase II that should begin at day 91. During this second phase the following major activities must occur.

- Completion of the implementation of Crisis and Acute Care Alternatives
- Significant expansion of the Single Point of Accountability Pool
- Completion of the critical Infrastructure Changes
- Continued reorganization of the Behavioral Health Division and Verity to come into alignment with the Action Plan
- Careful Monitoring and Adjustment, as needed of Utilization, Revenue and Expense

It is only after this Phase II work is completed that the mental health system will be able to regain stability and begin to move away from financial insolvency.

Date: July 17th, 2001

TO: Chair Diane Linn, Jim Gaynor and Peter Davidson

FROM: Cultural Competency Planning Committee

RE: Recommendations for establishing culturally competent Crisis Services: The Gap Plan

We are pleased to provide you with a report outlining recommendations for developing culturally competent crisis services in Multnomah County. As you know, our committee was charged with the task of creating a method of incorporating Cultural Competency Standards into all current and future contract language, including contracts related to the Gap Plan. The committee would also like to recognize that allowing sufficient time to thoroughly and thoughtfully address Cultural issues, will result in a successful Mental Health integrated system. As such, this document provides a Position Statement that has four sections:

- ★ Background
- ★ Definition of Cultural Competence
- ★ Principles
- ★ Summary Matrix: Principles, Issues, and Recommendations for Developing Culturally Competent Crisis Services: The Gap Plan

We look forward to your response and working together to identify ways in which we can be helpful in the adaptation of the plan.

Sincerely,

Linda Castillo
Rosemary Celaya-Alston
Jeanne Cohen
Marie Dahlstrom
Avel Gordly
Julie Larson
Holden Leung
Paul Leung
Robin Mack
Jackie Mercer
Corliss McKeever
Shirley Roberts
Stephaine Parrish Taylor
Vikki Vandiver

CULTURAL COMPETENCY FOR CRISIS SERVICES: POSITION STATEMENT

BACKGROUND

In the beginning the work of implementing the re-design of mental health services in Multnomah County, the issue of diversity and cultural competent services was raised by members of the Coordinating Council and the public. This process places the county in a unique position to address the gap in the culturally competent services for clients in Verity. The closing of the Crisis Triage Center (CTC) and the development of the Gap Plan provide us with the first opportunity to address the issues of diversity and culturally competent services. This challenge raises a number of complex issues that have policy, clinical and professional implications. The Cultural Competency Planning Committee has met and identified a set of Guiding Principles to be used in the development of a plan for addressing the need for culturally sensitive crisis services. Additionally, we have identified and categorized seven key issues that are present in this community. Before we can offer recommendations, we feel it is imperative to identify current as well as historical issues that impact the ability of our community to deliver quality, culturally competent crisis services. These issues reflect the observations and experiences of members of the committee and may not be relevant to other counties. Lastly, we offer recommendations for each of these issues.

For your information, this report contains the following elements:

- Definition of Cultural Competence
- Guiding Principles
- Matrix outlining Summary of Principles, Issues and Recommendations for Developing Culturally Competent Crisis Services: The Gap Plan

DEFINITION OF CULTURAL COMPETENCE

We support the definition of cultural competence as put forth in the recent Substance Abuse and Mental Health Services Administration (SAMSHA) Report entitled *Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups*. In this report, " Cultural Competence" refers to "....attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e. to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities." The racial/ethnic groups are African American, Asian Pacific Islanders, Latinos, Native Americans and Eastern European speaking languages.

PRINCIPLES

In order to begin addressing the Issues and develop Culturally Competent Crisis Services (The Gap), we wish to anchor our recommendations in a set of guiding principles considered essential for the development of culturally competent services. These principles also come from the SAMSHA report. We recommend using these principles like a checklist to assess program fidelity to the notion of culturally competent services.

I. PRINCIPLE OF CULTURAL COMPETENCE (Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in: 1) determining and individual's mental wellness/illness and 2) incorporation of those variables into assessment and treatment.).

II. PRINCIPLE OF CONSUMER-DRIVEN SYSTEM OF CARE (encourage self-help and promotes consumer and family involvement)

III PRINCIPLE OF COMMUNITY-BASED SYSTEM OF CARE (continuum of care which includes valued community resources from minority culture, early intervention and preventive efforts and treatment in the least restrictive environment)

IV. PRINCIPLE OF MANAGED CARE (systems acknowledge the importance of added-value inclusion of ethnic/cultural groups as treatment partners in the delivery of effective, quality services)

V. PRINCIPLE OF NATURAL SUPPORTS (traditional healing practices are used when relevant and family is defined broadly and included in service planning)

VI. PRINCIPLE OF SOVEREIGN NATION STATUS (systems of care for Native Americans shall acknowledge the right of sovereign nations to participate in defining culturally competent managed care)

VII. PRINCIPLE OF COLLABORATION AND EMPOWERMENT (consumers/families collaborate with managed care systems and determine the course of treatment)

VIII. PRINCIPAL OF HOLISM (providers recognize and value holistic approaches)

IX. PRINCIPLE OF FEEDBACK (services are open for legitimate opportunities for feedback and exchange)

X. PRINCIPLE OF ACCESS (services are geographically, psychologically, and culturally accessible)

XI. PRINCIPLE OF UNIVERSAL COVERAGE (access to crisis care is not contingent on income)

XII. PRINCIPLE OF INTEGRATION (integration of physical and mental health services)

XIII. PRINCIPLE OF QUALITY (emphasize culturally competent quality services)

XIV. PRINCIPLE OF DATA DRIVEN SYSTEMS (decision-making is based on data - prevalence, incidence, service utilization and other measures of utilization)

XV. PRINCIPLE OF OUTCOMES (measure actual outcomes - satisfaction - for client and family)

XVI. PRINCIPLE OF PREVENTION (education programs on mental illness, risk factors, and early identification)

SUMMARY OF PRINCIPLES, ISSUES AND RECOMMENDATIONS FOR DEVELOPING CULTURALLY COMPETENT CRISIS SERVICES: THE "GAP PLAN"		
ISSUES	**RECOMMENDATIONS**	**PERFORMANCE INDICATORS**
1) ***Philosophy*** - current crisis system modeled on dominant majority perspective (e.g., individualistic, medication oriented, limited family involvement)	→ Create (free standing) Cultural Competence Crisis Advisory Committee consisting of representatives from ethnic service providers agencies, families, and consumers	
2) ***Policy Making and Decision Making*** - majority of culturally specific service providers have not been consulted or included in the implementation of the policy /program development of the new Crisis System even though decisions will directly impact communities of color. • results in feelings of marginalization • Results in poor integration of services with established providers, lack of trust that providers will be able to help clients appropriately.	→ same as above →To include representatives from racial/ethnic communities in design process	
3) ***Client Demographics*** - 3 proposed Crisis sites are not geographically located in sites that reflect population shift for communities of color. There is lack of trust in the "3" clinic's. Can they appropriately handle linguistic and cultural differences? Are the hour's of operation realistic for communities of color to access?	→ expand 1-2 current sites to other locations in N and W Portland → support (financially) ethnic service providers in having in-house crisis services as appropriate → use specific service providers for clinical consultation, case management and when needed clinical assessments and interventions for those times when clients present at other sites	
4) ***Personnel*** - current job descriptions, hiring practices, training and pay do not reflect true picture of qualifications/skills needed for delivering culturally specific services – specifically with interpreter/ linguistic skills	→ encourage hiring and promotion of personnel from within specific ethnic community → mandate ongoing training for all crisis workers	
5) ***Public Relations*** - existing resource manuals often omit the wide list of community based ethnic/diverse service providers/agencies making it difficult for crisis workers (e.g., police) to appropriately triage or refer.	→ need to allocate resources (fund s & personnel) to create and maintain current list of ethnic specific providers; also work with media (radio, TV and newspaper) to educate public on variety of ethnic service providers/agencies	

SUMMARY OF PRINCIPLES, ISSUES AND RECOMMENDATIONS FOR DEVELOPING CULTURALLY COMPETENT CRISIS SERVICES: THE "GAP PLAN"		
Access to care involves the elimination of barriers. Barriers that are within perception of the persons we are serving. Language, cultural understanding, trust and respect. Feedback is necessary to assure quality and continuum of care.	Demonstrates the need for a culturally specific advisory board of community providers and consumers.	
6) ***Services*** - crisis services cannot continue to be delivered solely in traditional mainstream fashion where minimal consideration is given to gender/ethnic specific differences in crisis situations, health status, alternative expressions of care and support, extended family connections, natural support systems and efforts at prevention. Culturally impacted groups are best to identify the natural supports that would support best practices within their communities.	→ hiring and support of local ethnic counselors → require and upgrade culturally competency training of new and continuing employees → involve community of ethnic service providers as consultants and as collaborators in service planning → implement evaluation measures of effectiveness that are monitored by Advisory Committee new and continuing employees → involve community of ethnic service providers as consultants and as collaborators in service planning → implement evaluation measures of effectiveness that are monitored by Advisory Committee	
7) ***Financial Resources*** - proposed funding arrangements has potential to squeeze out the flexibility of local ethnic specific providers ability to provide tailored crisis response arrangements to their clients or new consumers; providers need to have the flexibility to coordinate crisis management services in order to keep families in their own communities.	→ county or new contracting entity provide set aside special funds (i.e., Diversion Funds) that can be flexibly accessed by ethnic service providers to provide individualized crisis services for existing or new clients PRN → Building capacity of ethnic community providers. → Building interface between established acute care providers	
8) **Individuals with Disabilities** – Visual and Hearing impairments including blindness and deafness Autism, DD & Mental Retardation Speech and language impairment Illiteracy Physical impairment Medical impairment and medical disability	forms in Braille, assistance with documentation sign language, understanding of deaf cultural and PCP coordination. Understanding or social interactions and communication barriers. PCP & DD service coordination. Need family involvement understanding and accommodation of communication barriers, stuttering, impaired articulation. Waiting room sensitivity and accommodation	