BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

In the Matter of Approval of	)	
Adult Mental Health System	)	RESOLUTION
Design Plan	)	93-352

WHEREAS, The Board of County Commissioners is the Community Mental Health Authority for Multnomah County; and

WHEREAS, The Board approved on April 30, 1992 the MED Task Force Report, requiring preparation of long term plans for efficient and appropriate adult mental health service delivery; and

WHEREAS, The Mental and Emotional Disabilities Advisory Council, representing all parts of our mental health system, has approved a System Design Plan and recommended implementation processes; now

THEREFORE, IT IS RESOLVED the Board of County Commissioners accepts and approves the System Design Plan, and directs implementation planning to commence.

APPROVED this 21st day of October, 1993

MULTNOMAH COUNTY, OREGON

By _____
Beverly Stein
Multnomah County Chair

REVIEWED:
LAWRENCE KRESSEL, COUNTY COUNSEL
for MULTNOMAH COUNTY, OREGON

By _____
H. H. Lazenby, Jr.

System Design Plan

FOR THE

MULTNOMAH COUNTY MENTAL AND EMOTIONAL DISABILITIES SYSTEM

Adopted by the
Multnomah County Mental and Emotional Disabilities
Advisory Council

August 10, 1993

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I. EXECUTIVE SUMMARY

■ MEDAC

The MED System Design Plan has been prepared by the Mental and Emotional Disabilities Advisory Council (MEDAC) in response to a charge from the Multnomah County Board of County Commissioners to develop a strategic plan for adult MED services in the county for the next three to five year period. MEDAC membership includes MED consumers, advocates, service providers, city and county law enforcement representatives, and interested citizens.

■ Purpose and Scope of the Plan

The MED System Design Plan is intended as conceptual framework for the adult MED System. It encompasses values and operating principles which MEDAC believes should guide the system. It describes key consumer needs and proposes a process for prioritizing for the use of limited resources to address these needs. Throughout the planning process, MEDAC has been guided by questions related to consumer needs and consumer ability to utilize the system effectively. The Plan also addresses the management and other structures which must be put in place to manage limited resources effectively to meet consumer needs.

The Plan has been created in an atmosphere ripe with change. It acknowledges that efforts to meet the needs of MED consumers will be constrained by a general lack of adequate funding and recognizes that the current Medicaid payment system creates disparity between what the county is asked to do and what it has control over. It also recognizes the growing need for improved coordination between the MED system and other health and social service systems, particularly the systems dealing with substance abuse.

Significant additional planning will be needed to implement the concepts presented in the System Design Plan. The Plan recommends the creation of an Implementation Planning Process involving MED service providers, other community resources, county staff, and MEDAC representatives in the joint development of detailed steps to make the System Design Plan a reality.

■ MED System Values

The heart of the System Design Plan is the statement of values which the MED System should embody. They express the ways the system should treat consumers and the qualities it must have to succeed. We urge the community and the county to rely on these values in making decisions about how to manage the system and when advocating with others about the system. The values are intended to guide technical and financial choices.

■ **The Multnomah County MED System should embody the following values:**

1. Be **consumer centered** -- place the highest priority on meeting the needs of consumers.

2. Treat consumers, families, advocates, providers, and managers with **dignity and respect.**

3. Protect the **safety** of consumers and the public.

4. **Respond** effectively to **acute need**, and **prioritize** those treatment and serious supports which can help prevent acute episodes.

5. Assure that consumers' **basic needs** for access to health care, food, and shelter are met.

6. Provide **easy access** which eliminates barriers of language, culture, sexual orientation, psychiatric or physical disabilities, education, poverty, social development, personal belief, and past experience, and **reaches out** to those not traditionally served.

7. Provide the **highest quality** range of services.

8. Allow consumers to make **choices** for themselves.

9. Be **easy to understand** for consumers, families, providers, and the community.

10. Be **cost effective** -- strive to do better, not simply to have more.

11. Be **adaptable** to the changing demands of external reality while remaining based in core values.

12. Promote **collaboration** and **cooperation**, both within the MED system and between the MED system and other community resources.

13. Be **community based** in planning and operation.

14. **Treat** all stakeholders/participants in the MED system **as individuals** -- where possible, modify the system to meet individual needs.

15. Hold all stakeholders/participants **accountable** -- define their roles, rights, and responsibilities clearly.

16. Promote **education and training** so that all stakeholders/participants can participate to the best of their capabilities.

17. Involve all stakeholder/participants in **advocacy** for quality services and adequate resources.

■ **Consumer Needs**

Throughout the System Design Planning process, we have recognized that the term "consumer" must include both persons currently receiving services through the mental health system and those in need of services but not receiving them.

The MED system must address the needs of consumers with widely disparate challenges and strengths who experience varying levels of functioning during the course of their illness. The Plan identifies needs held in common by all consumers within all this variation. In addition to these common needs, consumers experience special needs at different times in their illness. The Plan addresses the needs of consumers in crisis, consumers just leaving hospitalization, and consumers who have difficulty seeking or readily accepting help, as well as the needs of consumers who are stabilized and living within the community.

The MED system must take special care to address the needs of MED consumers who have diffculty seeking or readily accepting help. This group of consumers includes both those who drop out of treatment within the system and those who have not yet obtained services from the system.

Services which respond effectively to acute need, and those which effectively prevent acute episodes should be considered the MED system's highest priorities. This prioritization reflects the county's responsibility to protect the safety of the consumer and the general public. It also reflects the financial reality that poorly managed acute needs are extremely costly to the county. Consumers who do not receive effective help to prevent acute episodes frequently require more extensive and costly services to regain their basic ability to function within the community. In fact, poor management of acute needs means that in the end less money is available for other services and people than if acute needs receive appropriate investment up front.

■ **System Management Needs**

New management systems and attitudes are needed to assure the direction of the MED system in accord with the identified values and to provide the services most needed by consumers within severe resource constraints. Management systems must provide competent management of finances, service quality, and service utilization. System managers must be able to clearly state assumptions about what will or should happen and why; to monitor whether the assumptions prove true; and to determine what the system should learn in cases where they do not. In addition to the creation of new management systems, the Plan recognizes the need to create a new atmosphere of cooperation and shared responsibility between the providers and the county. Throughout the system, we must focus on quality improvement rather than blame.

■ Implementation

Multnomah County should initiate an Implementation Planning Process immediately upon adoption of the System Design Plan. The Implementation Planning Process should include consumers, mental health service providers, other community resource providers, and the county MED staff in focused discussions which result in agreement upon specific steps to be taken to implement the System Design Plan.

Strong leadership will be needed throughout the Implementation Planning Process. The county should consider contracting with a consultant or consultant team with extensive experience in the organization of mental health systems, and in facilitation of change in complex public systems.

As part of the Implementation Planning Process, the county must review its own capacity to manage the system. The county must determine the systems and skills which will be required for the county to perform its role in the new MED system and identify specific steps to develop those systems and skills not currently available.

The focus of the Implementation Planning Process should be establishment of guidelines and priorities for meeting the needs of consumers. Consumer involvement in the planning process is essential.

The Implementation Planning Process must also provide opportunities for representatives from community resources which address the basic needs of MED consumers (food, shelter, health care, recreation, education, etc.) to participate as active partners in planning for specific operational relationships within the MED system.

Through the Implementation Planning Process, the system must clearly define the priority populations and the services they should get, explore the costs and benefits of consolidating funding streams, and develop mechanisms which ensure equal access to services for consumers with common needs.

The adoption of the System Design Plan and initiation of an inclusive and well designed Implementation Planning Process will position the county to adapt to a rapidly changing environment, and give the county a strong position from which to negotiate with the State Mental Health Division for approvals of systems changes. The approval of the System Design Plan represents a first step in the development of a partnership which links consumers, advocates, providers, other interested agencies and institutions, and the county MED staff in a common effort to continuously improve the services for MED consumers. This partnership is essential to ensure the wise use of limited resources and the development of essential new capacities and services.

II. ACKNOWLEDGEMENTS

The **System Design Plan for the Multnomah County Mental and Emotional Disabilities System** has been developed by the Mental and Emotional Disabilities Advisory Committee (MEDAC) through the tireless efforts of its members, and with much welcomed assistance from MED service providers, MED consumers, parents and advocates for MED consumers, the broader social services community, and the staff of Multnomah County Mental Health MED Division.

MEDAC wishes to acknowledge the work of the Mental and Emotional Disabilities System Review Task Force. The Task Force's April 1992 report to the Multnomah County Board of County Commissioners recommended the expansion of MEDAC and the assignment of responsibility to it to undertake strategic planning for the MED System.

Throughout the System Design planning process the work of MEDAC was facilitated by Kay Sohl of Technical Assistance for Community Services. She drafted and revised the plan document at the direction of MEDAC.

During the 10-month planning process which resulted in the **System Design Plan,** several MEDAC members concluded their terms and left the group. We wish to acknowledge the contributions of these members:

- Anh Bui, *OHSU Indochinese Psychiatry Program*
- Sgt. Brian Grose, *Portland Police Bureau*
- Vivian Grubb, Senior Activist
- Dorie Lash, Advocate
- Doug Montgomery, Advocate
- Judi Smith, *Holladay Park Hospital*
- Jerry Wang, Consumer

The continuing members of MEDAC include:

- Kevin Fitts, Chairperson - Consumer
- Greg Henson, Secretary - *Housing Authority of Portland*
- Trish Backlar, Advocate - *Dept. of Philosophy, Portland State University*
- Carol Boos, Advocate - *Alliance for the Mentally Ill*
- Mary Byrkit, Consumer
- Rod Calkins, Executive Director - *Mt.Hood Community Mental Health Center*
- Carol Chism, Executive Director - *Center for Community Mental Health*
- Sharon Comstock, *Multnomah County Sheriff's Office*
- Nellie Fox-Edwards, Advocate
- David Green, Consumer
- Laura Jeibmann, Executive Director - *Metro Crisis Intervention*
- Robert Joondeph, Advocate - *Oregon Advocacy Center*
- Jonna Schuder, Advocate - *Oregon Advocacy Center*
- Margaret Strachan, Citizen Activist

III. CURRENT MULTNOMAH COUNTY ADULT MED SYSTEM

The adult MED system is complicated. It has many players, diffuse authority, multi-streamed funding, and a wide variety of organizations and individuals who deliver services. This description provides a road map to key players, authority, finances, service delivery, and key issues confronting the system.

■ Key Players

The State of Oregon, with roles for the legislative and the Mental Health Division, Multnomah County, with roles for the Board of County Commissioners and the Mental Health Youth and Family Services Division of the Department of Social Services, and twenty independent mental health service agencies.

■ Authority in the System

The **State** functions as the primary policy setter, determines allocation of funding, manages federal Medicaid funds, and plans and manages state-wide resources such as State Hospitals.

The Board of County Commissioners functions as the **County Mental Health Authority**, delegating responsibilities to the Department of Social Services, Mental Health, Youth and Family Services Division, and its MED Program. **County** responsibilities include:

- Managing contracts with residential care providers;
- Managing contracts for outpatient services;
- Managing utilizing of State Hospital beds by Multnomah County residents;
- Investigation of individuals considered to be a danger to themselves or others as part of the involuntary commitment process;
- Payment for services for individuals involuntarily held as part of commitment investigations;
- Management of placements within the community of individuals under the supervision of the Oregon State Psychiatric Review Board.

In addition to these adult MED responsibilities, the Mental Health, Youth and Family Services Division is also responsible for children's mental health, substances abuse, and MRDD services.

The **independent mental health service providers** are responsible for the services they provide to the clients and the communities they serve, and for continuous evaluation of the quality of their services.

From the point of view of the consumer -- who might need commitment, state hospitalization, residential, and outpatient services -- the system has no single point of accountability. The difficulties inherent in the current diffuse distribution of responsibilities and authority is apparent in a closer look at the financial and service delivery issues.

■ **Finances**

In fiscal year 92/93, the Multnomah County Adult MED program budget included $1,882,676 in county general fund dollars, $11,043,383 in state general fund dollars, and $70,095 in City of Portland funds. In addition to the state, county, and city dollars administered by the county MED program, the community based mental health service providers participate in the federally funded and state administered Title XIX Medicaid program. Eligible individuals with documented disabilities who meet federal low income guidelines and who have been enrolled in the Medicaid program are entitled to receive certain mental health services for which the state makes payment through the Medicaid program. In fiscal year 92/93, over half of the consumers served by the community based mental health service providers under contract to Multnomah County for state and county general fund dollars were enrolled in the Medicaid program. Consequently, the full public funding investment in MED services in Multnomah County for 92/93 will include approximately $8,565,375 in Medicaid dollars in addition to the $12,996,154 in state and general fund dollars.

The community based mental health service providers, which have worked to develop additional resources to address those needs of MED consumers not funded through the county contracts. The providers have obtained foundation and other governmental funding to develop and operate subsidized housing programs, employment programs, and a variety of other specialized services for MED consumers. The resource development efforts of the community based providers have expanded the resources available to MED consumers beyond the level available through county and state general funds.

The Medicaid services are currently reimbursed directly by the State of Oregon Office of Medical Assistance. Multnomah County MED plays no direct role in management of these reimbursements. The County does grant vendor numbers to mental health providers, certify staffing of providers, and play a role in monitoring Medicaid participating providers. However, the County has limited access to data about utilization of Medicaid dollars by Multnomah County providers. The nature of the Medicaid program does have a substantial impact on the use of dollars by the county MED program. However, the county has no control over the use of Medicaid dollars by certified providers, or over the types of services provided, or the consumers served through Medicaid.

The Medicaid program requires the matching of federal dollars with state dollars. For each $.63 provided in federal dollars, the state must provide a $.37 match. The state pre-matches a pool of Medicaid dollars which are then drawn upon by all the counties, within a state-established allocation formula. When Multnomah County Medicaid billings exceed the pre-matched Medicaid dollars allocated to the county, additional match must be submitted to the state to "purchase" additional Medicaid dollars.

Multnomah County MED contracts require mental health service providers to use state general fund dollars to purchase these additional Medicaid dollars. In recent years, the increased enrollment of MED consumers into the Medicaid program has

resulted in an increasingly rapid utilization of the pre-matched Medicaid dollars, and consequently, in the conversion of an increasingly large proportion of state general fund dollars into Medicaid purchase dollars. A key consequence of this conversion process is the resulting limitation on the availability of general fund dollars to provide services for consumers who are not eligible for or are not yet enrolled in the Medicaid program.

Dammasch State Hospital has functioned as the primary resource for inpatient services for Multnomah County consumers. The costs of operation for Dammasch have been born through the State Mental Health Division, and not included in Multnomah County's allocation of state funds. In the 91/93 biennium, under strong pressure from the state, Multnomah County has reduced the number of Dammasch beds occupied by county residents from 242 to 137. This reduction has been achieved through movement of some state funds to the county, and through extraordinary efforts by the mental health service providers, county MED staff, law enforcement agencies, advocates, and Dammasch State Hospital personnel.

To enforce its plan to drastically downsize Dammasch, the state notified the county mental health authorities in fiscal year 92/93 that each county would be held financially responsible for each Dammasch bed utilized in excess of the state established county quota. Multnomah County passed this potential financial responsibility for over-utilization along to seven of its subcontractor mental health service providers, establishing maximum utilization rates for each of the four geographic quadrants of the county and for the population served by the consumer directed Mind Empowered, Inc. For the purposes of determining over-utilization, each of these seven agencies has been held responsible for hospitalizations of any individual residing within the agency's designated geographic or other catchment area, regardless of whether the individual was being served by the agency at the time of hospitalization. Thus, if utilization of state hospital beds by residents from a given catchment area exceeds the established quota, the county contract allows the county to assess the sub contract agency affiliated with the catchment area for the penalties assessed to the county by the state for over-utilization.

Approximately 3,125 individuals were placed on involuntary holds and examined to determine whether they pose sufficient danger to themselves or others to warrant commitment. Of those being examined for involuntary commitment at this time, nearly 85% are not current clients of any county contracted mental health service provider.*[1] The county is the payor of last resort for the cost of hospitalization of individuals on involuntary commitment holds, paying for the care of those individuals with no insurance or other entitlement to care. The cost to the county for hospital care for involuntary holds will exceed $1,900,000 in fiscal year 92/93 (i.e. hospitalization in the community while the judicial process determines whether the individual should be committed to a State Hospital).

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[1] *Note: The 85% includes individuals who may be receiving treatment from a private provider outside the MED system.*

The county's potential liability for the costs of state defined "overutilization" of Dammasch and its responsibility as payor of last resort for involuntary commitment hold patients are problematic in relation to the county's lack of authority over the allocation of Medicaid funds and the direction of Medicaid funded services. The county holds financial responsibility for the impact of the management of services without holding authority to direct the use of over 60% of the funds available to provide services.

- **Service Delivery**

The State of Oregon operates the State Hospital system to provide in-patient treatment for individuals with severe mental and emotional disabilities. The state is actively working to significantly reduce the number of individuals cared for in State Hospitals through severe restrictions on admissions and increased efforts to identify appropriate community living and treatment arrangements for persons currently hospitalized.

The county MED staff estimate that approximately 8,000 individuals received services through county contracted MED service providers in fiscal year 92/93. The county currently contracts with: four core service agencies to provide comprehensive outpatient services and 24 hour crisis coverage; five additional outpatient service providers for non-crisis services and with five residential care facilities for housing of severely impaired clients; a 24 hour crisis telephone and transportation service to handle MED emergencies outside of business hours; a 22 bed acute residential treatment facility; and has preferred provider agreements with three hospitals for pre-commitment hospitalization.

In addition to the services to the general population described above, Multnomah County MED is responsible for contracting for services for approximately 50 individuals who are under the supervision of the Oregon State Psychiatric Security Review Board. These individuals have been committed to the State Mental Health system as a result of having been found "guilty except for insanity" for various criminal offenses. County contracted services include both residential care and outpatient treatment.

In fiscal year 92/93, the county began direct operation of two service components in response to the recommendation of the Multnomah County MED System Review Task Force and to increased pressure from the State Mental Health Division to reduce the number of Multnomah County residents at Dammasch State Hospital. The county now employs two discharge planners who work directly with the staff of the State Hospitals to connect clients being discharged from the hospital to appropriate community resources. The county also employs nine involuntary commitment investigators who prepare reports and make recommendations to the court regarding involuntary commitment of approximately 275 persons placed on involuntary holds each month.

The picture of publicly funded services for individuals with mental and emotional disabilities would not be complete without recognition that the Multnomah County jail now serves the second or third largest caseload in the state of individuals with persistent mental and emotional disabilities. Approximately 100 individuals with mental and emotional disabilities will be treated in the jail in-patient psychiatric unit in fiscal year 92/93. Many more will be treated while remaining in the general jail population. Jail unit staff report considerable difficulty in obtaining appropriate services in the community for individuals released from the jail psychiatric unit.

Comparison of charges shows that persons in jail with mental illnesses have committed as serious criminal offenses as those in the jail population not identified with mental illness.

■ **Other Key Issues**

At present, there is no central collection of data regarding the number of individuals who have sought MED services and been turned away, either for lack of funding for their treatment or lack of appropriate services. However, there seems to be substantial agreement among mental health consumers, advocates, providers, and the county staff that substantial numbers of individuals in need of help do not presently receive it. Among the reasons cited are: 1) lack of resources at the mental health service provider level; 2) lack of appropriate treatment resources for those with dual diagnoses of mental or emotional disability and substance abuse or mental retardation/developmental disabilities; 3) lack of appropriate resources within the community for individuals with extremely violent behaviors; 4) lack of resources to provide sustained outreach to individuals who, because of the nature of their illness, do not voluntarily seek treatment and refuse treatment when offered but cannot readily be committed under current legal standards.

Beyond the human suffering represented by these problems in provision of treatment to those in need, there is considerable concern about the financial impact on the county of the current lack of services for individuals such as those described above. For example, the involuntary commitment process is costly both to the MED program and the court system. Individuals placed on involuntary holds utilize police time, court time, and substantial county MED dollars both through the involuntary commitment investigation process and through payment for hospitalization during the hold period. It seems highly likely that provision of outpatient services prior to crisis incidents would better meet the needs of these individuals and be significantly less costly to the county. The fact that 85% of those placed on holds are not receiving treatment through the MED system is startling in this light. County staff believe that substance abuse plays a major role in many of these involuntary commitment holds. The county's alcohol and drug program has no independent commitment process. Consequently, the MED system provides all investigation services and payments for hospitalization even when the individual's problem is primarily related to substance abuse.

Each player in the MED system confronts limitations which arise from the current fragmentation of authority and responsibility. Consumers and their advocates are frustrated by the lack of a single point of accountability, an institution or body which can not only accept full responsibility for problems, but also has the full authority to resolve them. Mental health service providers must manage multiple funding streams, confront financial uncertainty, and make difficult decisions regarding priorities for services without consistent guidelines. The county confronts financial risk for overutilization of State Hospital beds and hospitalization of involuntary hold individuals with limited ability to control the use of significant portions of the dollars spent for services.

IV. SYSTEM DESIGN PLANNING PROCESS

In April, 1992, the Multnomah County Mental and Emotional Disabilities System Review Task Force recommended that the Mental and Emotional Disabilities Advisory Council (MEDAC) be expanded and charged with responsibility for developing a strategic plan for adult MED services in Multnomah County for the next three to five year period. The Board of County Commissioners accepted this recommendation and directed that the expanded MEDAC group work with an outside facilitator to develop such a plan.

MEDAC membership which had included MED consumers, advocates, and interested citizens, was expanded to include MED service providers and representatives of both city and county law enforcement agencies. The expanded group began meeting in October, 1992, and re-characterized its task as System Design Planning. MEDAC developed a profile of current MED services; conducted a MED consumer and advocate survey; and was briefed on the Oregon Health plan and other anticipated funding and policy changes by representatives of the State Mental Health Division.

Through its efforts to understand the scope of needs and the availability of services to address those needs, MEDAC learned that some important data is not readily available. The MED system does not currently maintain a waiting list for services, nor collect data on individuals who have requested and been denied services. Nor is there readily accessible system-wide data on grievances and/or exclusions from services. Data on participation in the Medicaid payment system administered by the state (described in greater detail in Section I) is difficult to correlate with data maintained by the County. Confronting these limitations in data, MEDAC was fortunate to have among its members providers, consumers, family members, and others with direct experience in the system. We drew heavily on their experiences when numerical data was not available.

In January 1993, MEDAC members used a two day planning retreat format to generate key concepts for the system design. In March 1993, MEDAC distributed a Draft System Design Plan to providers, consumer and advocate groups, law enforcement agencies, social services, and a variety of neighborhood and citizen groups.

MEDAC representatives held three public meetings, and met with mental health providers, MED staff, and members of the Oregon Alliance for the Mentally Ill to discuss the draft plan. MED staff conducted related focus groups with consumers at five health treatment locations. Written input was received from 16 individuals. In May 1993, MEDAC convened a two day planning retreat to discuss the input received from various segments of the community and develop revisions to the draft plan. This revised draft will be circulated for comment to all groups and individuals who were asked to review the first draft plan and all others who submitted comments on that draft.

In July 1993, MEDAC reviewed the input received on this revised draft, made further revisions, and completed the final System Design Plan to be presented to the Department of Social Services and subsequently to the Board of County Commissioners.

The MED System Design Plan is intended as conceptual framework for the adult MED System. It encompasses values and operating principles which MEDAC believes should guide the system. It describes key consumer needs and proposes a process for prioritizing for the use of limited resources to address these needs. Throughout the planning process, MEDAC has been guided by questions related to consumer needs and consumer ability to utilize the system effectively. The plan addresses the management and other structures which must be put in place to manage limited resources effectively to meet consumer needs.

Throughout the System Design Planning process, we have recognized that the term "consumer" must include both persons currently receiving services through the mental health system and those in need of services but not receiving them.

Significant additional planning will be needed to implement the concepts presented in the System Design Plan. The Plan recommends the creation of an Implementation Planning Process involving providers, county staff, and MEDAC representatives in the joint development of detailed steps to make the System Design Plan a reality.

V. CONTEXT FOR THE MED SYSTEM DESIGN PLAN

Multnomah County, like most local governments functioning as mental health authorities, confronts turmoil, uncertainty, and opportunities for change in state and federal health care policies and funding mechanisms and levels. The System Design Plan has been created amidst this atmosphere of uncertainty. MEDAC has designed the plan to provide relevant guidance within a number of possible health care realities likely to emerge within the next 3 to 5 years. Among the changes considered in the MEDAC planning process are: (1) the Oregon Health Plan; (2) the move toward managed care and capitation as a payment mechanism; (3) the potential role of HMO's in the management and delivery of mental health services; and (4) the state's continuing commitment to downsizing State Hospitals.

Oregon has received a federal waiver to allow the state to implement the Oregon Health Plan developed by the 1989 Oregon Legislature. The Oregon Health Plan is designed to reduce the number of Oregonians lacking basic health insurance coverage. It accomplishes this goal through increasing the number of low income residents eligible for the federally assisted Medicaid program and initiating requirements for employer purchase of health insurance coverage for virtually all employees or payment into a state organized pool to ensure those whose employers do not provide coverage. The Oregon Health Plan faces several significant obstacles to implementation. First, the Legislature must find funds to provide the state matching dollars required for additional Medicaid coverage. Secondly, the Legislature is encountering resistance from employers with regard to the "pay or play" requirements for additional health insurance coverage of employees.

The original Oregon Health Plan called for delay in the inclusion of mental health services in the plan's array of covered services. There is currently discussion of more rapid inclusion of mental health services in the plan. Inclusion of mental health services in the plan is likely to end the current practice of budgeting for state contributions to Medicaid for mental health services separately from the budget for health services. This could increase the overall state dollars utilized for Medicaid match for mental health services. The impact of the inclusion of mental health services in the Oregon Health Plan is not entirely clear at this time. The State Mental Health Division would apparently still have the ability to select care management mechanisms for mental health separately from those selected for other health services.

While much remains unclear about the final implementation of the Oregon Health Plan (including the question of whether it will ever be implemented or will be supplanted by some national health care initiative), we have identified several key impacts of the most likely implementation models. First, the increase in the number of Oregonians eligible for Medicaid should result in MED service providers being able to receive Medicaid payments for services to newly eligible consumers. Secondly, the expansion of health insurance coverage for the working poor through the employer "pay or play" requirements may provide resources for MED services for a group of consumers currently covered only through state and county general fund dollars. Both of these assumptions require significant qualifications due to the uncertainty of the types of mental health services which will be included in either the Oregon Health Plan Medicaid guidelines or in the new basic health insurance coverage.

Even greater uncertainty exists about the care management mechanism to be adopted by the State Mental Health Division. In general, the Oregon Health Plan proposes a capitated care management model in which the state would purchase care for Medicaid eligible individuals from a care management organization similar to today's HMO's. This approach would involve negotiating rates with the selected care management entities which would then assume financial responsibility for provision of care to the covered individuals. If this model were extended to include mental health as well as health services, it is likely that the general health care management entities which would contract with the state would enter into subcontract agreements with mental health service providers, or in some cases provide mental health services

through their existing organizations. Some have suggested that this model would leave very little role for the county mental health authority. However, unless statutes were changed, the county would continue to be responsible for the involuntary commitment process and its associated costs of placing individuals on holds in hospitals.

The State Mental Health Division has suggested that it is considering alternative models to the one described above which would involve negotiation of separate contracts for mental health services outside the primary health managed care agreements. In this approach, the state might offer counties the option to act as a care management entity, with a negotiated capitated payment for assumption of full financial responsibility for mental health services to eligible individuals. If the county declined this option, the state would negotiate with other care management entities.

In addition to ongoing changes in the structure of federal and state health and mental health systems, Multnomah County in recent years has experienced a set of changes similar to those experienced by mental health systems around the country. These changes include continually evolving approaches to treatment and community support, ongoing shifts in responsibility for particular services, attempts to change contract and financial arrangements, and attempts to develop new management information systems. Multnomah County is not alone in facing these difficulties, nor does it have to completely re-invent the wheel as we seek to implement the vision and values expressed in this plan.

In considering all of these possible outcomes, MEDAC perceives the System Design Plan as applicable in its clarification of values underlying use of public dollars for mental health, its consumer centered focus, its priorities for the use of limited resources, and its recognition of the need for strong management systems. While the specific implementation mechanisms would vary significantly within the different outcomes, the core values and priorities of the System Design Plan seek to guide for the use of public funds for MED services in Multnomah County.

VI. MED SYSTEM VALUES

Section IV above outlines the uncertainty and opportunity facing the MED system. We believe this plan can provide the foundation upon which to build or negotiate within any potential new system. *The values are the heart of the plan. They express the ways that the system should treat consumers and the qualities it must have to succeed.*

We urge the community and the county to depend on these values in two areas: when making decisions about how to manage the system, and when advocating with others about the system. Multnomah County can use these values to guide our technical and financial choices, and to advocate with others to ensure that whatever technical and financial structures emerge, the MED is guided by our values.

■ **The Multnomah County MED System should embody the following values:**

1. Be **consumer centered** -- place the highest priority on meeting the needs of consumers.

2. Treat consumers, families, advocates, providers, and managers with **dignity and respect.**

3. Protect the **safety** of consumers and the public.

4. **Respond** effectively to **acute need**, and **prioritize** those treatment and serious supports which can help prevent acute episodes.

5. Assure that consumers' **basic needs** for access to health care, food, and shelter are met.

6. Provide **easy access** which eliminates barriers of language, culture, sexual orientation, psychiatric or physical disabilities, education, poverty, social development, personal belief, and past experience, and **reaches out** to those not traditionally served.

7. Provide the **highest quality** range of services.

8. Allow consumers to make **choices** for themselves.

9. Be **easy to understand** for consumers, families, providers, and the community.

10. Be **cost effective** -- strive to do better, not simply to have more.

11. Be **adaptable** to the changing demands of external reality while remaining based in core values.

12. Promote **collaboration** and **cooperation**, both within the MED system and between the MED system and other community resources.

13. Be **community based** in planning and operation.

14. **Treat** all stakeholders/participants in the MED system **as individuals** -- where possible, modify the system to meet individual needs.

15. Hold all stakeholders/participants **accountable** -- define their roles, rights, and responsibilities clearly.

16. Promote **education and training** so that all stakeholders/participants can participate to the best of their capabilities.

17. Involve all stakeholder/participants in **advocacy** for quality services and adequate resources.

VII. MED SERVICES FROM THE CONSUMER POINT OF VIEW

MEDAC members considered our primary responsibility to be the articulation of a set of values (Section IV above) and of a clear view of what consumers should experience in the MED system. Too often, planning efforts focus on administrative, technical, and political issues. Our purpose is to ensure that the necessary administrative, technical, and political discussions have a clear guide.

Together with the values, we intend this description of services to be that guide -- Multnomah County and the community should make the administrative and other choices that will most clearly strengthen or create the services described below. Strengthening and creating these services, within the framework of our values, should be the purpose of all actual planning and implementation activity. Equally as important, the county, providers, and the community should expand their understanding of responsibility and their own missions to include whatever activities are necessary to create or expand the services described here.

The Multnomah County MED system addresses the needs of consumers with widely disparate challenges and strengths who experience varying levels of functioning during the course of their illness. Within all this variation, several common consumer needs are apparent.

A. Common Needs of MED Consumers

1. A full range of treatment options appropriate to the varying needs and preferences of consumers.

2. A primary contact person for each consumer, with responsibility to see that the consumer receives the services they need.

3. Education for consumers about their illness, treatment options, and effective self-management techniques.

4. Clear, understandable information for consumers about their rights and responsibilities.

5. Treatment plans developed with the consumer, which have received true informed consent from the consumer, and which are revised to reflect changes in the consumers' needs and ability to participate in planning.

6. Treatment which responds to the needs of the individual consumer, including the need for effective substance abuse treatment for consumers with dual diagnoses of mental illness and substance abuse, and the need for coordination with specialized resources for consumers with dual diagnosis of mental illness and mental retardation/development disabilities (MRDD).

7. Access to medications management only treatment services when desired by the consumer and considered appropriate by the mental health services provider. Medications management only services may be appropriate both for consumers whose illness makes more extensive contact with service providers unacceptable to the consumer, and for consumers who are well stabilized, have established support systems, and are able to cope well with community living with only assistance with management of medications.

8. Treatment which is culturally appropriate and addresses the consumers' needs for communication in languages other than English.

9. Treatment which is appropriate and accessible to consumers with physical disabilities such as hearing impairment, mobility problems, blindness, etc.

10. Consumer choice of treatment providers should not be limited by strict geographic boundaries. While in most instances consumers will be best served by providers located in their geographic area, the system should permit consumers to access the services which they perceive as most appropriate to their needs. Such consumer choice must necessarily be made in concert with the selected provider which must consider whether or not services can be provided effectively to individual consumers living outside the provider's primary service area.

11. Intake and non-crisis services available outside 9-5 work day schedules for consumers who are working.

12. Access to adequate housing, income, food, and health care, including assistance accessing medical benefits and working with health and dental care providers. Varying levels of assistance should be available, including options for assistance with: locating and renting commercially available housing; accessing publicly funded low income housing resources; supported independent living programs; adult foster care; and residential care facilities. Assistance in obtaining public benefits (SSI, VA, etc.) and when needed by the consumer, assistance with the management of funds which assures that after the consumer's basic needs have been met, the consumer has ready access to their funds.

13. Assistance in selecting and accessing activities which enhance life, such as day treatment, college classes, leisure activities, and vocational training and employment opportunities.

14. Opportunities for peer support.

15. Support for family members of the MED consumer who are willing and able to provide support and assistance for the consumer, to the degree to which the consumer consents to their involvement.

16. Assistance for consumers who wish to formulate Advance Care Directives to express their wishes for treatment and decision-making should they become unable to participate in treatment decisions at some stages of their illness.

17. Ready access to information about the services available through the MED system and screening to determine whether the consumer is eligible for services. The MED system should continue to offer multiple access points so that consumers are free to contact the mental health service provider nearest their residence or another provider with whom the consumer has had a previous positive relationship. In addition to these provider access points, the MED system should provide a well-publicized resource and referral telephone service which will accept calls from both consumers themselves and from social services, law enforcement personnel, family members and others seeking assistance for consumers. The central resource and referral service should utilize trained mental health professionals to perform triage functions, identifying consumers who appear to be appropriate for services within the MED system and connecting them directly to appropriate mental health service providers. Calls from individuals who do not appear to be appropriate for services within the MED system should be referred to other appropriate community resources.

18. Ready access to appropriate investigation of reports of abuse and to protective services when needed.

In addition to these common needs, consumers experience special needs at different times in their illness. The MED system must address the needs of consumers in crisis, consumers just leaving hospitalization, and consumers who have difficulty seeking or readily accepting help, as well as the needs of consumers who are stabilized and living within the community.

B. MED Consumers in Crisis Need:

1. Twenty four hour access to trained professional help, both in person and by telephone.

2. Twenty four hour access to the state's central database which identifies the provider currently serving the consumer. This information is needed by law enforcement, emergency room, and other social service staff attempting to aid consumers in crisis who cannot identify their service providers due to their crisis condition. Providers serving consumers in crisis should make provision for access to consumer medical and advanced care directive information during hours outside normal operation of the mental health service agency.

3. Options for treatment which will ensure the safety of the consumer and the community, including options for intensive residential treatment outside of a hospital setting.

4. Treatment in a secured setting for care when exhibiting symptoms of danger to self and/or others.

5. Thorough and fair investigation of the consumer's ability to function, including the degree to which the consumer is a danger to himself/herself or others.

C. MED Consumers Leaving Hospitalization or Other Treatment in a Secured Setting Need:

1. Specialized assistance to return to community living, including assistance identifying and obtaining appropriate housing and treatment services.

2. Careful follow up to be certain that the consumer is receiving the assistance needed to prevent re-hospitalization or re-entry into other treatment in a security setting and to live safely within the community.

D. Consumers Who have Difficulty Seeking or Readily Accepting Help Whether Because of Illness or Other Barriers

The MED system must take special care to address the needs of MED consumers who have difficulty seeking or readily accepting help whether because of illness or other barriers. This group of consumers includes both those who drop out of treatment within the system, and those who have not yet obtained services from the system.

These consumers need:

1. Prioritization for the provision of services to those in acute need, and to those for whom MED services can help prevent acute episodes.

2. Outreach services through which mental health service providers make contact with consumers at places which are comfortable for the consumer, (including at home, in shelters or other social service agencies, at public health clinics, or on the streets).

3. Repeated contacts with consumers through which the consumer can build trust in the mental health service provider.

4. Respect for the consumer's reluctance to seek/accept services and reassurance of the consumer's rights within the MED system.

5. Opportunities for support from peers as well as providers.

6. Support and assistance for family members, friends, and other community agencies which have relationships with the consumer and are willing and able to assist the consumer to obtain MED services.

E. Consumers Who are Stabilized in the Community Need:

1. Opportunities to participate actively in development of treatment plans which support continuing stability and independence through utilization of appropriate services.

2. Continuing access to medication management assistance.

3. Ready access to additional support from the MED system when the consumer or their family or advocates determine that the consumer's stability and ability to cope with independent living are diminishing.

4. Assistance accessing appropriate community resources for recreation, education, and vocational opportunities.

F. Key Concepts for the System's Response to Consumer Needs

The MED system values identified in the System Design Planning process (Section V) should inform all aspects of the services provided by the system. Central to these values is respect for the consumer as an individual and commitment to treatment of the individual with dignity and respect. The system should focus on support for the consumers' ability to participate in planning and decision-making about the treatment they will receive. It should facilitate consumers' access to the full array of resources necessary for meaningful life in the community and develop supportive relationships with potential sources of assistance for consumers including, when appropriate, their families, their neighbors, community recreation and vocational programs, law enforcement personnel and systems, and housing resources. Based on respect for the individual, the system should strive to provide the services most effective for each individual consumer within the constraints of available resources.

In considering the needs of MED consumers in the context of extremely limited resources, we seek to replace the current inconsistent and unsystematic rationing of resources with a planned and consistent approach. Through a joint implementation planning process (described in Part VII of this report), providers, the county, consumers, and advocates should establish system-wide priorities and criteria which will ensure that individuals in similar circumstances with similar needs will be able to receive similar levels of services. These priorities and criteria will then form the basis for screening requests for MED services, both through the central resource and referral service and at participating service provider agencies.

Services which respond effectively to acute need, and those which effectively prevent acute episodes should be considered the MED system's highest priorities.

This prioritization reflects the county's responsibility to protect the safety of the consumer and the general public. It also reflects the financial reality that poorly managed acute needs are extremely costly to the county in the form of hospitalization charges for consumers placed on involuntary holds, and the cost of the involuntary commitment investigation process itself. Consumers who do not receive effective help to prevent acute episodes frequently require more extensive and costly services to regain their basic ability to function within the community. In fact, poor management of acute needs means that in the end, less money is available for other services and people than if acute needs receive appropriate investment up front.

VIII. MAKING IT HAPPEN: KEY FUNCTIONS WITHIN THE SYSTEM

Services for consumers do not just happen. They are the products of carefully crafted and managed systems of care. The following sections outline the type of management functions that the system must have to ensure the effective and efficient delivery of services and ongoing attention to the values outlined earlier in the plan. We have grouped these functions in three categories:

- *Service Delivery* provides high quality care to consumers. The service delivery function is the most important function in the system -- the other functions exist to ensure its smooth and effective functioning.

- *Management* of finances, service quality, and service utilization ensures that consumers achieve the best possible outcome as efficiently as possible within the resources available. The management functions ensure that the system understands where it wants to go, clearly states assumptions about how to get there, and continuously learns how to do better.

- *Technical functions* include contracting, information services, human resources, and program planning and development. These link service delivery and the management functions, ensuring that the system has the resources (people, data, services) to continually improve. Technical functions are not ends in themselves, and their performance and design must always be judged in light of the degree to which they enhance service delivery and system management.

A. Service Delivery

In most cases, the services described in Part V above will be most effectively provided by community based mental health service providers. The county should continue to contract with a variety of community based providers to assure provision of the full range of services needed by consumers. Some of

the services described in Part V are not currently available, or are not sufficiently available. In these instances the county will need to identify both current and new service providers willing and capable of developing the additional services. The consumer/community survey (completed as part of the MEDAC planning process) revealed significant levels of consumer satisfaction with current providers and services. As the System Design Plan is implemented, it will be extremely important to maintain continuity of services for consumers currently utilizing the system.

The county should continue to directly provide involuntary commitment investigation services and hospital discharge planning services. Both functions are directly related to the county's responsibility for protecting public safety, and also are critical to cost control activities which must prevent unnecessary hospitalization and move necessarily hospitalized consumers back into the community as quickly as possible.

Clearly, the county and its contract providers must remain committed to the provision of the highest quality of care for all consumers. Adequate training and supervision will be needed for staff at all levels. Training should include regular updates on the system's values, organization, and management systems. The values identified in Part IV of the System Design Plan should inform all services and relationships. The system should focus clearly on meeting the needs of consumers, both those actively requesting services and those whose illnesses result in difficulty in seeking and/or accepting services.

B. Management of the System

New management systems and attitudes will be needed to assure the direction of the MED system in accord with the values identified in the plan and to provide the services most needed by consumers within severe resource constraints. Management systems must provide competent management of finances, service quality, and services utilization. System managers must be able to clearly state assumptions about what will or should happen and why, to monitor whether the assumptions prove true, and to determine what the system should learn in cases where they do not. In addition to the creation of new management systems, we must create a new atmosphere of cooperation and shared responsibility between the providers and the county.

1. Financial Management Systems

Stronger financial management systems are needed to ensure that the clinical, systems management, and fiscal needs identified in this plan are met. Financial management systems should allow the county and providers to project costs and revenues; to understand the financial implications of various service choices, and to set priorities when resources are limited.

Financial management systems must be designed to facilitate development of a seamless system in which MED consumers are able to obtain appropriate services whether or not they are eligible for Medicaid. The current financial management system separates responsibility and authority for management of state and county general fund dollars from responsibility and authority for management of Medicaid dollars. It also currently drains state general fund dollars away from services for non-Medicaid eligible clients to provide matching dollars to obtain additional Medicaid dollars which can be expended only to treat Medicaid eligible consumers.

Further study is needed to determine whether the most effective way to implement the priorities established in this plan is to move toward a management system which places a single entity in control of all public dollars available for MED services. The overall objective of the study should be determination of the most effective way to assure that consumers who meet the priority criteria are able to receive the services which are most appropriate to them individually regardless of their eligibility for Medicaid or the current limitations on the types if services which can be billed on Medicaid.

The evaluation of potential approaches to fiscal management should include consideration of the costs of alternative approaches and the effectiveness of each approach in achieving the goals identified in this plan. The study should include specific evaluation of the costs and benefits of utilizing the county as the single entity responsible for management of state, county and Medicaid dollars for MED services. It should determine the costs of converting to a system of county management of all funds and compare the costs of ongoing operation under that system and under the current dual system.

In evaluating the feasibility of the county assuming responsibility for management of Medicaid dollars, it will be extremely important to determine whether the county can also assume authority to control these dollars. Care must be taken to avoid exposing the county to financial risk without obtaining the authority necessary to control the use of funds and avoid losses.

2. Priority Setting and Management of Services Utilization and Quality

In addition to improved financial management, the MED system must improve its capacity for quality management to set standards for care, identify intended outcomes, and continually monitor services to determine whether standards are being maintained and desired outcomes achieved. We believe that standards for care will be most appropriately established through joint planning which involves consumers, providers, advocates and the county. The MED program must take responsibility for managing its own operations in ways that will ensure strong consideration of MED consumer needs in the planning and management

of other county systems, especially alcohol and drug, jail, public health, and housing programs.

A key component to improving the county's capacity for quality management is the development of effective feedback loops. System-wide tracking of grievances, involuntary terminations of services, denial of services, and consumer concerns is needed to identify service gap areas and service delivery problems. The county should contract for the performance of a problem resolution function by an entity independent of both service providers and the county. While the primary goal of the problem resolution function would be assistance to consumers and providers in the resolution of difficulties using a mutual problem solving approach, the collection of data on system-wide problems will be an important secondary goal. The county should also collect additional data on service denials, involuntary terminations of services, and grievances directly from providers for use as part of continuous evaluation of service delivery issues. In both the problem resolution function and the county's own data collection activities, a focus on quality improvement rather than blame is essential.

The primary goal in developing stronger management of services utilization should be the provision to consumers of the most effective services consistent with the values and priorities of the system and the funds available. As the manager of the MED system, the county must also develop its capacity to manage utilization of services. Working with providers, consumers, and advocates, the county should define both priority populations and service packages needed to meet standards of care for consumers with specified characteristics and needs.

3. Planning and Advocacy

The MED system will require continuous re-evaluation and re-design as the external funding and service environment changes and as the system gathers more information about service gaps and service delivery problems. MEDAC should continue as an ongoing planning body which brings together consumers, advocates, providers, and other interested parties to regularly evaluate the system's success in meeting the needs of consumers and maintaining the system's values and priorities.

In addition to system-wide planning through MEDAC, the individual elements within the system should develop ongoing planning and evaluation processes. One outcome of such planning and evaluation efforts will be the identification of service gaps and of areas in which new or additional resources are required to effectively meet the consumer needs described within this plan. While the county should accept primary responsibility for coordinating the development of additional resources, individual providers should be encouraged to

continue and expand their current efforts to develop innovative programs and obtain additional funding outside the mental health system.

Multnomah County confronts an ongoing need for advocacy within the state mental health system to obtain adequate resources to meet the needs of the county's consumers. The county should provide leadership, coordination, and support for the full range of advocacy organizations and groups which can carry the message of consumer need to the state level.

C. Technical Functions

The development of new contract mechanisms will be of critical importance once service delivery and management functions are refined. These contract mechanisms must focus attention on priority populations and on the critical issues necessary for quality service delivery and management, including consumer outcomes and the achievement of quality standards. This focus will come from a clear statement of contract performance requirements, from the use of payment mechanisms (perhaps including capitation, or payment on a per-person basis for a negotiated benefit package meeting certain quality standards) that direct attention to important clinical and service issues, and from the development of prices that clearly pay the same amount for the same service county wide.

Availability of information about consumer needs, services provided, service gaps, and costs is central to the success of efforts to continuously improve the MED system. The county needs to develop its capacity to collect, analyze, and share information needed by system managers, MEDAC planners, providers, advocates, and others working to improve the service delivery and the availability of resources within the MED system. The development of flexible and responsible management information systems is essential.

In developing its capacity to manage information, the county should focus on the key concepts of outcomes measurement. While descriptive data regarding numbers of consumers served and numbers and types of services provided are also needed, the system must develop the capacity to define desired outcomes and measure the degree to which they have been achieved.

IX. IMPLEMENTATION PLANNING

The System Design Plan has been developed as a framework to guide the Multnomah County MED system. It makes explicit shared values, goals, and priorities. Additional planning will be required for successful implementation of the System Design Plan.

An Implementation Planning Process should begin immediately upon the adoption of the System Design Plan. It should include consumers, advocates, mental health service providers, other community resource providers, and the county MED staff in

extensive, focused discussions which result in agreement upon specific steps to be taken to implement this plan. Throughout the implementation planning process, the planning group will need access to individuals with great expertise in the operation of MED systems, delivery of MED services, managed care systems, the management of change in systems, and models for public mental health services tested in other comparable communities. The Implementation Planning Process should involve mental health professionals who work directly with consumers, including participation from the full array of mental health disciplines, social workers, nurses, psychologists, psychiatrists, rehab specialists, and others.

The System Design Plan calls for increased collaboration and cooperation between the MED system and other community resources such as law enforcement, recreation programs, vocational training programs, and basic needs social service providers. The Implementation Planning Process must provide opportunities for representatives of these community resources to participate as active partners in planning for specific operational relationships with the MED system.

The focus of the implementation planning process should be establishment of guidelines and priorities for meeting the needs of consumers. Consumer involvement in the planning process is essential. Consumers currently participating in a variety of services in the MED system as well as consumers not currently receiving services should be invited to become part of the planning process. The planning process should include training which will enable consumers and advocates to work effectively with the "experts."

Because much of the implementation planning will deal with complex technical issues, we envision the involvement of a variety of work groups composed of individuals with appropriate direct and/or technical knowledge. The overall planning effort must coordinate the work of these work groups and provide an understandable, comprehensive plan document which can be reviewed carefully by MEDAC.

Strong leadership will be needed throughout the Implementation Planning Process. The county should consider contracting with a consultant or consultant team with extensive experience in the organization of mental health systems, and in facilitation of change in complex public systems.

In developing the Implementation Planning Process, the need for an iterative approach to planning is acknowledged. The process will lead to the implementation of changes through which stakeholders in the system will learn what further changes are needed, and thus begin to plan again. The Implementation Planning Process will require an openness to trying approaches with an understanding that mistakes can be corrected and that joint progress rather than assignment of blame is the goal of efforts to monitor and evaluate the impact of changes.

As part of the Implementation Planning Process, the county must review its own capacity to manage the system. The county must determine the systems and skills which will be required for the county to perform its role in the new MED system and identify specific steps to develop those systems and skills not currently available.

The Implementation Planning Process should establish a realistic timeline to allow adequate lead time for service providers and the county to develop needed new skills and capacities. The Implementation Planning Process should define key service elements, develop requests for qualifications to identify providers (through a provider selection process) to engage in more detailed negotiations, and develop contracting approaches to be implemented, at least in part, by July 1, 1994.

The adoption of the System Design Plan and initiation of an inclusive and well designed Implementation Planning Process will give the county a strong position from which to negotiate with the State Mental Health Division for approvals of systems changes. The approval of the System Design Plan represents a first step in the development of a partnership which links consumers, advocates, providers, other interested agencies and institutions, and the county MED staff in a common effort to continuously improve the services for MED consumers. This partnership is essential to ensure the wise use of limited resources and the development of essential new capacities and services.

MENTAL AND EMOTIONAL DISABILITIES ADVISORY COUNCIL
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REVISED September 28, 1993

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VACANT		
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