

Coos
County

2013-15

Biennial Implementation Plan

System Overview

1a) An Overview of County's Addictions and Mental Health services and support system

Coos County provides the majority of addictions and mental health services through its Mental Health Department (CCMH) in conjunction with a variety of sub contractors. CCMH is also the primary provider of mental health services for Oregon Health Plan members within the county under an agreement with Western Oregon Advanced Health (WOAH), the local Coordinated Care Organization. CCMH had similar responsibilities under the previous MHO – Jefferson Behavioral Health – and does still provide some services to the remaining JBH members. Overall, operational funding for MH services is split with about 25% coming from State general funds and 75% from OHP. This plan specifically addresses the use of the State general fund dollars.

In terms of MH services, a robust crisis response and management remains as one of the highest priority areas for many in our community including consumer, families, law enforcement, hospitals and others. Despite ongoing efforts, Coos County has continued to have one of the highest suicide rates within the state. CCMH retains a primary responsibility throughout the community in the management of psychiatric and behavioral crisis. We operate a 24/7 MH crisis service as required by our licensure utilizing an onsite team during normal business hours and an afterhours Portland-based crisis line with available local on-call clinical staff. Our crisis team also provides services on an outreach basis often in conjunction with law enforcement, DHS and other community partners.

The community also has access to facility based crisis care through one of 3 emergency departments located throughout the county. The area also has a 10 bed behavioral health unit located within one of these hospitals - Bay Area Hospital - as well as a 6 bed crisis resolution center run by Columbia Care. CCMH has contracts with BAH, the Coos Crisis Resolution Center, and many hospitals throughout the state to meet the acute care needs of the indigent and OHP population. CCMH manages both costs and ensures quality through an ongoing utilization management program.

For children, there is local crisis respite option available, Pony Creek, which is a joint effort with CCMH, Kairos and Columbia Care. However, there are no local options when a child needs acute behavioral care. Often these children are placed temporarily on one of the pediatric units at BAH until arrangements can be made for transfer to a Portland based hospital or alternate sub acute placement in the Portland or Eugene area.

CCMH actively coordinates care with BAH and other acute, sub-acute or respite care options. CCMH staff complete all the civil commitment tasks both at the hospital and within the community, and actively participate in hospital staffing and discharge planning meetings. At a State level, CCMH has both designated AMHI and children's ICTS coordinators to manage transitions to State and regional programs, participate in ongoing treatment planning and arrange for appropriate discharge and transitions plans. Close management of high needs individuals has allowed CCMH to divert nearly all adults from the State Hospital with an ADP consistently under 1. We have also managed to keep our use of residential care

for adults at very low levels with a good track record of being able to return these individuals back to Coos County with a strong support plan in place.

As another community priority CCMH operates a walk in clinic with immediate access to both crisis services and routine service requests, available to all county residents regardless of circumstance. Scheduled appointments are also available and completed within 24 hours of the request. If indicated, initial MH assessments are usually completed within one week. CCMH does provide a standard set of outpatient mental health services utilizing both employees and a large contract provider network.

Coos County is a designated Health Professional Shortage Area and the recruitment and retention of quality providers has remained a top priority. We continue to successfully use our status as a HPSA in our recruitment efforts. We also expand our provider base to include as many private and group practices within the region as well as the use non contracted providers when appropriate. We currently have contracts with the majority of area counselors, therapists, psychiatric providers, FQHCs. In general CCMH retains the higher needs, more acute cases due to a better ability to access the whole range of available resources and more easy coordinate care with other involved agencies/partners.

CCMH primarily utilizes a brief solution focused approach to individual therapy as it best meets the needs of the largest segment of our served individuals. Longer term approaches are also used especially in conjunction with Dialectic Behavioral Treatment and more disturbed children/families. CCMH continues to try and innovate our delivery model: last year we imbedded therapists within a pediatric setting and are planning to expand this model over the next biennium in conjunction with our area CCO; we have also imbedded therapists in many of the area schools for a number of years.

Psychiatric medication services continue to be an area of highest demand and we anticipate this trend to continue into the foreseeable future. The push by individuals, family members, and community representatives for a medication solution presents an ongoing challenge and even with attempts to modulate the requests through the use of education, cognitive therapy and behavioral intervention the demand remains high. We have typically recruited a mix of PMHNPs and MDs to address this need as well as the use of tele-med, contactor, out of network or Locum Tenens providers. CCMH has finally hired a Child Psychiatrist due to start in July 2013 after a year and a half recruitment effort. Area pediatricians have had to reluctantly fill in the gap in terms of these services.

CCMH has an extensive range of services for individuals with severe and persistent mental illness. Our community support unit has a mix of therapists, case managers, nurses, peer supports and others to assist individuals to successful community living. Lower caseloads with averages of approximately 25 have been prioritized to be able to deliver an intensive level of service when needed. A variety of skills training both individual and group, co-occurring disorder treatment, intensive case management are available. We also run an Enhanced Care Outreach Program that delivers an intensive level of care to individuals with both physical and mental health conditions that can make local placements particularly difficult to maintain.

Housing has remained a consistent priority. CCMH has developed and will continue to support several supportive housing options with varied level of service to assist individuals in managing basic ADLs,

effective interpersonal relations, and behavior support. We maintain 4 adult foster homes, a 20 unit HUD 811 project, 10 studio units with intensive supports and another 4 units of permanent housing. We also coordinate with our local Community Action in a specialized project for the homeless mentally ill. We operate a Real Choice Loan program that has assisted a number of individuals in managing move in costs and other housing related expenses that otherwise could not be managed. We also provide grant money to one of our homeless shelters that provides longer term shelter to individuals with mental illness. CCMH operates a Rep payee program that services approximately 50 consumers with no charges to participants.

Served individuals have continued to rank both employment and peer delivered services as being highly valued. CCMH, through the Mental Health Association, runs a Supported Employment Program – Working Wonders- that serves approximately 50 individuals at any given time with a nearly 50% employment rate and consistently high fidelity reviews. Grant assistance is also provided to our local consumer Clubhouse – SHAMA - which provides a number of supportive and therapeutic activities around skill building, advocacy and empowerment. CCMH is working on developing a peer mentoring program with consumers who have completed a series of trainings to help their peers.

Consumer and family involvement and advocacy in operational decisions is a vital responsibility of our organization and CCMH has taken the lead in working with our CCO around the development of the Community Advisory Council with its majority consumer representation. While this role is unfamiliar to the physical health system, it is one we know and embrace. Served individuals and family members participate in all the required advisory bodies, including the MH Advisory Board, the Quality Assurance Committee, the Children’s council and others. We also have promoted a strong consumer advocacy and a peer led group – CAOS (Consumer Advocates for Optimal Services) – that has been meeting for a number of years to advise the CCMH Director and management as to the service needs and responsiveness of the agency.

Coordination efforts with the local courts continue to be well valued. CCMH supports a Mental Health Court which serves about 15 individuals at a time, with a highly successful “graduation” rate and a low rate of recidivism. We are a key player in the Zero to Three Court Team along with the courts, CWS, Adapt and others that works to quickly reunite families where Child Welfare has assumed custody of a young child or infant or move to quicker permanent placement if reunification is not feasible. CCMH also supervises several individuals within the community that are under the Psychiatric Security Review Board and also work with a 5 bed PSRB residential facility - Cedar Bay – that operates within the County and is managed by Columbia Care, Inc.

CCMH as a long term strategy has prioritized efforts towards improving the health of children within our community. If positive effects can be gained with younger age groups then there will be clear benefits across the rest of the lifespan. This approach has focused both on promotional and prevention messages and on service efforts with younger children and their primary supports. A recent integration of the County’s health and mental health departments should but further these efforts toward early intervention.

In terms of promotion and prevention activities, Coos County's primary contractor is the Commission on Children and Families (CCF) which in conjunction with the LADPC recommends, coordinates and provides a variety of activities, trainings and educational efforts for the County. Other county partners are also key in these efforts including local city and county law enforcement, area schools, our local drug and alcohol provider and literally hundreds of volunteers. The CCF also receives additional funding from a Drug Free Communities Grant that expands the ability to deliver a strong message. The Commission utilizes a Certified Prevention Specialist to coordinate the prevention activities.

Currently identified community priorities include eliminating under age alcohol use and abuse, eliminating under age drug use, eliminating tobacco use (in conjunction with the area Tobacco cessation coordinator) and strengthening community engagement. The primary means utilized to achieve these goals include promoting youth involvement and empowerment, delivering clear, targeted prevention messages, providing and marketing alternate activities and growing and nurturing community based projects.

Youth involvement and empowerment is critical in the local prevention efforts and we continue to advocate for youth to deliver their message to each other and the greater community. Coos County does run an annual Youth Summit which delivers both prevention messages and also provides break out groups to allow youth more opportunity to explore issues that interest them and become involved in meaningful ways. We have also revitalized our Youth Council which gives individuals the opportunity to assume leadership roles within their schools and communities. These youth gain training in coalition building and leadership and then use these skills in a variety of contexts. One such youth effort is the promotion of "Rachel's challenge" – an anti-bullying message – with the local high schools.

Prevention messages are delivered in a variety of contexts through the area schools, local AYA, media, social and other events. Coos County continues to utilize "Project Toward No Drug Abuse," a 12 week curriculum based program within the area schools. We use local print, TV, radio and other media to deliver ongoing prevention and health promotion messages often involving youth in the message delivery. These messages often correspond to such things as National Alcohol Awareness Month, Recovery month, etc. Community events such as the County Fair and Recovery month events such as the annual parade are also excellent forums for including health promotion and prevention messages.

Support of alternate activities for youth continues to be an effective strategy, promoting healthy, clean and sober venues. Annual events such as a "Teen Idol" competition run by Bay Area Together, "Teenopoly," an experiential opportunity for youth, and "Project Graduation," a healthy post graduation party, have continued to be very effective and well attended, as well as drug/alcohol free Teen dances run in conjunction with local law enforcement. These alternate activities are truly a community effort involving the support of local schools, law enforcement, A&D providers, youth and other community members.

Coos County also utilizes larger community wide forums for delivering health promotion and prevention messages. These include such efforts as the "National Night Out" with area law enforcement and a Family Fun Day at John Topits Park with a focus on improving child safety.

Outpatient treatment options for children are varied and include various forms of Cognitive Behavioral Therapy, family treatment, play therapy, Art Therapy, Parent-Child Interaction therapy, EMDR, a Nurturing Parent Program, DBT for Adolescents and others. Treatment for younger children and even “bonding” strategies with infants/toddlers and the primary caregiver has been a higher demand and prioritized service. CCMH also contracts with Kairos to provide in home skills training to assist families in learning new skills and ways to interact with their children in a very hands-on manner – another high demand service. Due to our presence in many of the area schools we are very able to be involved in addressing needs within the educational setting, participating in IEPs and delivering direct service to both the child and family. Since the last biennium CCMH has also developed a Transition age youth track with an assigned case management role to provide additional services and supports to Youth who are anticipated to have significant struggles with the move to the adult system and adult roles.

Higher levels of care are also available with the Children’s Program. CCMH works with approximately 40 children with Child-Family Teams delivering Wraparound services through an ICTS level of care. We also offer Day Treatment programs for both younger and older children within a school based environment in conjunction with Kairos Inc. These Day Treatment programs provide a multidisciplinary team of professionals to meet the needs of these higher needs children.

Residential and inpatient services are also available and coordinated by an ICTS coordinator. Locally we operate the Crisis respite facility – Pony Creek. We work with the local Children Welfare Service office and others to assist Treatment Foster Care homes to manage acutely disturbed children. Our ICTS coordinator assists in arranging referrals to PRTS facilities throughout the state as well as other care options including Sub acute care, SCIP/SAIP, BRS placements and others. Historically, CCMH has very high usage of residential care for children and this is an area of priority for CCMH. As a prioritized area, CCMH is in current discussion with our child providers and partners to try and develop plans to deliver more effective local interventions to reduce the usage of out of area residential beds.

Drug and alcohol treatment services are another high priority for our community. While Coos County’s rate of alcohol and drug abuse and dependency are near state averages - 8% of adults having an alcohol abuse disorder, 2.5% with a substance abuse disorder - the related mortality rates are significantly elevated. The rates of associated conditions including liver disease and hepatitis C are also significantly higher within the local CCO population.

Outpatient treatment and access to residential services are available within the County, through a sole provider, Adapt. Adapt is also contracted with the area CCO to deliver A&D services to the OHP population, having its main office in North Bend and satellites in Reedsport, Bandon and Coquille. Areas of specialization include a “MOMS in Recovery” program in conjunction with BAH to assist pregnant women to stay clean and sober, both Men’s and Women’s specific groups, an ART or Addictions and Recovery Team that works with CWS involved individuals, DUII level 1 and 2, Adolescent groups, Co-Occurring disorders, a Seeking Safety group for individuals with Trauma issues, Smoking cessation, relapse prevention, methamphetamine specific treatment, and an aftercare program; use of evidenced based practices include Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Community

Reinforcement Approach, ASAM, Motivational Incentives, Seeking Safety, the Change Company and Mayo Clinic’s Nicotine Cessation.

Adapt is also the County’s provider for both Problem Gambling prevention and treatment. Current preventions efforts include use of print materials, media coverage, a 24/7 informational hot line, and a variety of community presentations within area health fairs, youth activities, tribal forums, hospitals, etc. Treatment is provided by a Certified Gambling Addictions Counselor and offers both a Walk-In group as well as formal assessment and individualized care.

Other treatment supports are available within the community. Transitional A&D housing options are provided by Bay Area First Step which also runs several more permanent housing options in addition to a range of supportive services. The area also has an Oxford home as well as a strong twelve step community. Services to individuals with co-occurring disorders are also available through CCMH. The LADPC serves as the primary advisory body for the community’s treatment and prevention efforts. There continues to be no local option for alcohol or drug detox, either social or medical and while there is periodic discussion of this need the associated costs and relatively low utilization consistently rules this out as a viable option. Bay Area Hospital will on occasion do a detox in conjunction with an associated medical or behavioral problem that is the primary focus of care.

1b) Subcontractors

Contractor	Services
<i>ADAPT</i>	Outpatient Alcohol and Drug Treatment Provider
<i>Bandon Schools</i>	Counseling/therapy services within the school district
<i>Bay Area First Step</i>	Alcohol and drug transitional housing; case management/supportive services
<i>Belloni's Children's Shelter</i>	Children’s shelter and behavioral rehabilitation services placement
<i>Columbia Care</i>	Supportive Housing – Bay Apts; Adult Crisis Respite – CCRC; Children’s Respite – Pony Creek; Case management and related services for PSRB, intensive needs individuals
<i>Christian Counseling</i>	Outpatient MH services
<i>Coastal Center</i>	Outpatient MH services
<i>Commission on Children & Families</i>	Alcohol and drug prevention activities
<i>Coos Bay Schools</i>	Counseling/therapy services within the school district
<i>Curry Health Dist.</i>	Outpatient Psychiatric services
<i>David Bertapelle LCSW</i>	Outpatient MH services, DBT
<i>Harmony Estates</i>	Residential services
<i>Janice Petrie CNS</i>	MH prescriber
<i>Kairos</i>	Psychiatric day treatment services; skills training; crisis respite services; treatment foster care
<i>Locum tenens</i>	Temporary/ tele-med psychiatric services
<i>North Bend Schools</i>	Counseling/therapy services within the school district

<i>Protocol Inc.</i>	MH crisis line for “off hours”
<i>Richard Bossardt LCSW</i>	Outpatient MH services
<i>Sally Koogler</i>	Support services at HUD 811 project
<i>SHAMA</i>	Clubhouse, peer supports/advocacy services; Supported Employment through Working Wonders program
<i>Susan Dimock</i>	Outpatient MH services
<i>Syd Wiesel LCSW</i>	Outpatient MH services
<i>T.H.E. House</i>	Bed space for homeless mentally ill
<i>Waterfall Clinic</i>	Outpatient MH counseling & medication management services
<i>West Wind Court</i>	Residential Mental Health Housing

1c) LMHA collaboration with local CCO/Western Oregon Advanced Health

CCMH has worked closely with our area CCO Western Oregon Advanced Health (WOAH) since the beginning of the RFA process and continues to be actively involved in the ongoing planning, implementation and quality assurance efforts.

Currently, both the CCMH Director and Public Health Administrator are on the governing board of WOAH. Additionally, one of the County Commissioners is the chair of the Community Advisory Council (CAC) of the CCO and also serves on the governing board. CCMH currently is working under an MOU with WOAH to continue delivery and coordination of the mental health services and needs for WOAH members. Part of this support also allows CCMH to continue to provide the necessary community safety net for all Coos residents that would not otherwise have access to emergency and urgent mental health care.

CCMH is working with the Public Health department who has been contracted by WOAH to complete the community needs assessment in conjunction with a variety of community partners, OHP members and other community leaders. CCMH has also taken a lead role in the development and mentorship of the CAC. Due to our experience in having MH consumers involved in all facets of operations from the provision of care, to advocacy for services, to leadership in the planning and quality assurance process, we are working with the CCO in this area which is new to them. Currently, the CAC is largely composed of OHP members that have had MH involvement due to their familiarity with these kinds of leadership roles but we would expect that gradually OHP members with more physical kinds of problems would begin to assume similar roles and level of comfort as do their MH counterparts.

CCMH has also been very active in the QA process development in conjunction with the CCO - again because this is an area in which CCMH has had considerable experience and expertise. Currently CCMH is working with the CCO in terms of identify a specific performance improvement project around service integration. There are several projects currently underway including an effort to look at possible formulary for MH drugs to help guide practice and reduce costs. We are also looking at possible ways to further expand the use of behavioral therapists within physical health settings. There are some early efforts in this direction with the use of therapists in a limited manner within a pediatric setting and in an

integrated screening clinic for children under DHS custody. CCMH will also be working with the CCO around another PIP involving reduction in hospital readmission rates as well as the performance measures that relate specifically to mental health.

1d) Mental Health Advisory Board and LADPC membership

MH Advisory Board:

Pamela Rangel	Consumer/family
Yvonne Livingstone	Coquille Indian Tribe
Gary McCullough	Coos Bay Police
Steve Scibelli	North Bend Police
Betty Albertson	DHS District Manager
Ned Beman	North Bend Housing Authority
Anna-Marie Slate	Consumer/advocate
Dee Strader	Consumer/advocate
Mike Marchant	Aging and People with Disabilities
Ginger Swan	CCMH Director
David Geels	CCMH QA Manager

LADPC Membership:

Andrew Combs	Private Attorney
Earl Boots	Supervisor, Child Welfare
Dick Leshley	Business owner
Jeff Whitey	SOCC Director of Housing
Jessica Patterson	Juvenile department
Patty Sanden	Director, Maslow Project
Paula Bechtold	Circuit Court Judge
Rev Chris von Lobedan	Shutter Creek Correctional Institute
Shirley Farmer	Private Attorney
Steve Scibelli	NB Police Chief
Summer Schwinniger	OLCC
Tom Shine	Community Member
Barbara Bassett (staff)	Prevention Coordinator
Deidre Lindsay (guest)	Director, Adapt
Ginger Swan (guest)	Director ,CCMH
Sally Baird- Scott (guest)	Community member
Stephen Brown (guest)	Health department
Steve Sanden (guest)	Director, BAFS
Tracy Muday (guest)	Medical Director, WOAHA

2. Community Needs Assessment

2a) The Community Needs Assessment process

The Community Needs Assessment process for Coos County has undergone significant change from the previous biennium with the creation of the CCOs, and it likely to continue to evolve well into the next year as the CCO transformation plan, the community health improvement plan and the Community Advisory Council take shape and assume a better developed prospective.

The current plan has its roots in the needs assessment that was submitted with the approval of Western Oregon Advanced Health as a CCO in the Spring of 2012. This assessment included much of the current demographic, area health statistics, diagnostic and treatment services, local service and provider capacity. It also used a fairly limited number of consumer focus groups to flesh out the assessment and personalize the report. The CAC also reviewed this initial assessment and made comments and recommendations based on its results and conclusions.

CCMH also took a more detailed approach to address the specific additions and mental health aspects of the community health assessments by conducting a series of focused surveys and interviews with a sampling of CCMH consumers, community members and community partners. Additional input was sought from the consumer advocacy group that routinely advises the MH Director, the Coastline group that meets regularly to advise the region on children's mental health needs and the LADPC regarding addiction needs.

As the CCO has begun to take shape this Community Needs Assessment is changing as well. The CCO has an agreement with the Coos Public Health Department to coordinate work on the next Community Needs Assessment by May of 2013. Currently the Health Department is holding a series of meetings with service consumers, providers and area stakeholders to develop this assessment. Out of this assessment the CCO will then develop the community health improvement plan to direct the local efforts around improving health outcomes. The oversight of the assessment process and plan development will be directed by the CAC which is composed of a majority of consumers and family members. This new process should better insure consistent consumer/ stakeholder representation through all phases of the process.

2b) How is data used to evaluate prevalence, needs and strengths in the local system

The assessment data currently contains significant information regarding the prevalence of certain conditions and occurrences within the county's population. This includes information regarding county demographics, prevalence of various health conditions by diagnosis, epidemiological data regarding alcohol use, drug use, mental health behaviors, adverse events such as suicide, accidents, employment rates, incarcerations, school data such as graduations rates, test scores, school ratings and more. We also have access to treatment or encounter data, hospital/acute care/residential usage, OP treatment/utilization that enable us to see what kinds of services are being provided, where the costs are and what are the treatment outcomes being obtained as they relate to the prevalence information.

In addition to the aggregate, data is also parsed according to identified target groups and population that have been determined over time. Some of these groups relate to required or specialty populations that have been identified by the community in previous Biennial Plans as needing increased focus and resources. Examples of this include individuals involved with the criminal justice system, treatment of the uninsured, services including supportive housing options to those with severe and persistent mental illness. Other priorities are identified by the other major community players, such as: law enforcement's consistent focus on availability of crisis services and crisis response for the mentally ill; physical health provider's prioritization of access to psychiatric assessments and medication management; Child Welfare's focus on availability of family and child therapy to assist in reunification and to help direct their efforts in ensuring a safety net for children.

The assessment process then proceeds from two fronts. One is in a more global manner where CCMH and the major partners look at all the collected data and information and evaluate the overall mental health system in terms of its priorities, needs, strengths, and responsiveness. With this basis we then narrow the data into more focused areas such as children services, acute care/residential usage, crisis response, coordination with physical health. This focused data is then presented to smaller subgroups that have particular expertise and responsibility within the specific area who can then evaluate the information and make specific recommendations for improvement within that context.

2c) Use of feedback from advisory and quality assurance groups

Despite the requirement for a formal Community Needs Assessment, the real process for assessing, planning, implementation and evaluation is one that occurs throughout the Biennium in a continuous fashion as new data and information is gathered based on ongoing quality improvement efforts. This process of continual evaluation and improvement occurs specifically through a number of advisory and quality improvement groups.

Overall, CCMH direction is provided by the Mental Health Advisory Board and the Community Quality Assurance Committee. Both of these groups consist of a broad representation of the key players and stakeholders including consumers and their families, health providers, social service agencies and business and community leaders. As the Local Mental Health Authority, feedback is also gained directly from the public as a whole through the County Commissioner's efforts, community meetings and other governmental forums.

There are also a number of advisory and working groups that specifically address children's services. The main body is the Coastline Group/MH Council which consists of all the main service providers and stakeholders involved with Children's mental health care. This group has been the main advisory board regarding the development of a new services and models including a new effort aimed at reducing need for out of county placements which is a part of the CCO Transformation Plan. Other efforts include the Early Learning Council and the Commission on Children and Families that helps direct and coordinate the local prevention activities. There are also regular meetings with DHS, schools, juvenile, children's advocacy through the Adolescent and Child multidisciplinary teams that serve in an advisory capacity at times as well as the Juvenile Fire Setting and Community Care Coordination Committees.

The main advisory group for adult services is the CAOS group (Consumer Advocates for Optimal Services). This group meets weekly in conjunction with the MH Director and advises CCMH as to the needs, priorities and strengths of the current system. This group has historically prioritized peer delivered and support employment services in addition to crisis, supported housing and medication services. Other efforts include the peer run clubhouse's (SHAMA) member council, Supported Employment (Working Wonders) Advisory Workgroup, and the local Homeless Council.

Drug and alcohol treatment and prevention efforts are coordinated in conjunction with the Local Alcohol and Drug Prevention Council (LAPDC) which again consists of a broad cross section of community providers and stakeholders. The Local Public Safety Committee, though not always very active, also provides guidance in some of the same areas as well as mental health crisis services.

With the advent of the CCO's, the Community Advisory Committee is becoming more of an active body in the direction of both physical care as well as mental health. CCMH is not only facilitating input from this group regarding the strengths and needs of the current system but is also working with the membership to strengthen its ability to advocate for necessary changes. The CAC will continue to direct the community health improvement plan based on the needs assessment and other community input.

3. Strengths and Areas for Improvement

3a) Mental Health Promotion

Historically, Coos County has had little role in general MH Promotion within the Community. Rather, SE funds have been designated for treatment and prevention activities only with little discretion for promotion use. This has also been the case for OHP funds as well which generally were earmarked for OHP member services as they related to medically necessary activities.

With the new health transformation efforts this is beginning to change. Currently CCMH is working with our local CCO, Western Oregon Advanced Health, our area Health Department and the majority of community partners and health consumers to identify the target areas for Health and mental health promotion. It is likely that these promotional efforts will not relate initially to specific mental health objectives but rather to general health factors that contribute in more indirect ways to mental health.

These identified health factors relate to an analysis of the primary health behaviors that contribute to higher rates of conditions. These behaviors relate primarily to smoking/tobacco use, eating habits and lack of physical activity. These two behaviors contribute to very high rates of diabetes, COPD, asthma, hypertension and other conditions within our community. These health behaviors and their associated health conditions do affect individuals with mental illness at significantly higher rates than the general population.

Current promotion efforts relate to developing incentive models within the health care system towards maintenance of these healthier habits. Some of these strategies may relate to finding ways to pass back

to individuals the savings they generate from maintaining positive health habits. Since we know these behaviors result in less health care costs to our systems if we can pass these savings back to the healthcare consumers they may respond accordingly. These ideas are likely to be controversial and not without resistance so it is likely we will see smaller scale, piloted efforts that if efficacious will be saleable on a larger scale. These efforts will continue within the ongoing context of other promotion efforts such as educational and training efforts already in effect such as a “Living Well with Chronic Conditions” training effort, Tobacco Cessation classes, a “Healthy Lifestyles” curriculum for individuals with mental illness and others.

b) Mental Illness prevention

The majority of the prevention work around mental illness is done within the school setting by CCMH staff working at the various school districts. Clinicians, in addition to the direct service work with children, families and school person also serve a general role in the promotion of healthy emotional and behavioral expression as well as in the area of prevention around depression, anxiety, suicide and other occurrences. Some of this work may be done in more of a milieu setting while at other times it is an aspect of a school assembly or other event.

While this service is a strength within our system it has been a struggle to maintain stability in funding. Usually these efforts involve joint funding between the County and the specific school district and while County’s funding has been prioritized to support this service, this is not also the case for the schools. The Bandon school district relationship is one that is longstanding and quite stable; but last year North Bend school district decided to stop their support and so there are no clinical positions operating within their schools; Coos Bay schools cut one of their positions and is having some debate whether to continue and in what capacity; recently a new position was just created with the Lighthouse School.

This kind of fluctuation does not lend to good, consistent efforts in regard to treatment, prevention or other efforts. It would be a goal to achieve a stable funding source that would allow this valuable service to continue.

The other area of focus around prevention relates to transitional periods between childhood emotional and behavioral disturbance and adult conditions. Many State and National Organizations have identified the need to better transition individuals to the adult care system as well as do a better job identifying individuals earlier that need psychiatric intervention.

As such CCMH has developed a specific transitional age youth program to address the unique needs and challenges of this group and to try and positively impact some of the usual outcomes such as dropping out of care, ignoring mental health needs and others. CCMH has seen some initial successes around these efforts but there remains significant challenge especially around assisting the “system kids” that have had little experience with choice and self directed activities. CCMH continues to also assess the usefulness of EASA and similar programs. We have not identified a high level of need within our

community for this level of service intensity given the smaller size of our community but we are open to moving in this direction as our assessment changes.

c). Substance abuse prevention

Over the next biennium prevention efforts will continue to focus in the areas of existing strengths, especially in the areas of youth advocacy and empowerment and taking advantage of area coalitions and partnerships in delivering effective messages.

It has already been clearly demonstrated that youth peer to peer messages gain better traction than more traditional modes of messaging. Coos County will continue to utilize formats such as the Youth Summit and Youth council to support and grow these efforts. Over the last year, the Prevention Coordinator has effectively revitalized the Youth Council with good results. Allowing youth to gain regional and even national training in leadership and coalition building will further serve to energize the movement and provide a larger sense of purpose. Youth will then be able to better identify and address the most salient prevention needs.

The ongoing maintenance and strengthening of community partnerships will also remain a priority as it is these connections that create healthier community norms and environments. For youth this necessarily involves family, schools, churches, businesses, health providers, public safety and community members as a whole. Efforts such as National Night Out, Family Fun Day, Teen Idol, Art on the Boardwalk, and the County Fair all become opportunities to strengthen our community, and better care for all of its citizens.

Coos County is planning to reduce some of its traditional prevention efforts around reducing underage drinking to its lack of effectiveness. The underage drinking statistics have basically remained unchanged over the last decade despite consistent prevention efforts. Statistics indicate that prevalent family and community normalization of alcohol use may render these efforts of less value. The value of using alternate messaging to parents around the legal consequences of allowing youth to drink will continue to be evaluated.

d). Problem Gambling Prevention

Coos County will largely maintain the current prevention efforts around problem gambling prevention including print, media and public presentations of material. These efforts will continue to be rolled into other prevention messaging in conjunction with other addictive behaviors when relevant and feasible. Given the higher prevalence of gambling amongst youth, increased focus will be paid to the delivery of prevention efforts within school based activities and assemblies.

e) Suicide prevention

Suicide remains a significant problem within Coos County and it has continued to be difficult to identify an approach that will have at least moderately effective outcomes. The rate of suicide in Coos County is nearly 70% higher than the State; this is in addition to a rate in Oregon that is elevated 35% above the National average. These numbers have remained fairly consistent over the last decade.

These elevated numbers are at least partially attributable to several factors. Coos County has an older adult population that is 60% higher than the State average. The suicide rate among these older adult men is up to eight times higher than the national average (at age 85 and older), which would bring up the overall rate. The lack of cultural diversity also has an impact given that the rate by white males is 2.5 times higher than the average. The widespread presence of firearms within our rural community also contributes to higher rates given that lethality is significantly increased as compared to other means.

Several years ago, after a spate of suicides, CCMH, APD, Hospice and several community partners met to review the facts. These suicides (5 or 6 occurring over the space of 1-2 months) were all completed by white males over the age 75. The primary means was by firearms. There were no noticeable signs or red flags prior to the event. Some were married and in relationships and gave no indication to their partner of their intent. Several of them had had recent medical visits within the prior weeks with no indication of depression or concerning presentation. None had any kind of terminal health condition. In the end the conclusion of our group was that these men had decided to end their lives on their own terms and by their own choice rather than by waiting for a factor outside of their control to make this decision. It was also the conclusion of our committee that it would be very difficult to devise an intervention to impact this behavior.

Apart from this subgroup of suicides, Coos County will continue to maintain the strength of its community safety net in order to reduce self harming events within our population. A 24 hour crisis line, on demand response team, presence within the schools and general community, properly trained staff, strong community partnerships all contribute to an environment that nurtures its members.

Coos County along with WOAHA is also looking at completing routine depression screenings within primary care settings to better identify individuals who would benefit from mental health treatment but may not seek care out of their own initiative. The CCO transformational plan contains this plan as one of its elements. CCMH hopes to initially pilot these efforts with a couple of motivated primary care providers to help guide us in a larger implementation strategy.

f) Treatment

Use of flexible funds to provide treatment has been identified as a very high needs area especially with the adult population. While children have had the benefits of increased access to healthcare with an estimated 66% of children eligible for inclusion under the Children's Health Insurance Program, this has not been the case with adults with 24% of adults being uninsured and approximately another quarter

significantly under insured. These adults have few if any options for gaining any kind of mental health or substance abuse treatment outside of the kind of emergency care available when there is eminent risk of self or other harm as a result of mental illness (priority 1 status).

While CCMH does perform routine screens and brief interventions for all requesting community members (approximately 500 per year), the majority of non OHP adults are not opened for ongoing services due to the limited funding and need to prioritize only those at the highest level of need. Generally 10-15% of our overall enrollments receive services that are paid for through general fund dollars – nearly all of them are priority 1 enrollees or have a chronic mental health condition. While some of these non-prioritized individuals are able to gain services from our local FQHC (which we assist through a referral agreement), most are not. Consistently these individuals voice a request for services that we are not providing. Many community partners through the CAC, MHAB and other venues expressed a similar sentiment that if feasible CCMH should serve individuals that though not in immediate crisis are at higher levels of need such that some level of mental health service would provide significant and substantial improvement to their well being.

It is also clear that the delivery of these lower level services, however, cannot lessen the ability of CCMH to attend to the critical/emergent situations which pose danger to an individual or others. Truthfully, there remains little available resource to fund anything but critical care.

Another identified area of treatment priority relates to the providing medically necessary services to individuals whose insurance does not cover a given procedure. CCMH currently serves about 60 individuals with chronic kinds of mental illness whose Medicare insurance does not cover case management, skills training, and other supportive services that allow successful community living. Medicare also requires often significant out of pocket expenses for covered services which are not affordable for individuals making just over the SSI benefit amount. A similar event occurs for individuals covered under policies with very high deductible amounts or for specific service types such as children's day treatment or residential care that are routinely ignored by commercial products. Universally, stakeholder groups and consumer advocates have prioritized these services.

Addictions treatment for individuals involved in the Correctional system is also a part of the current planning process. The Community Correctional Treatment Center has been closed for nearly two years now due to funding considerations and other prioritization but the lack of this resource has been significant and noticeable. Adapt has been approached and has agreed to develop specific programming for this population in the shorter term while the County continues a longer process of evaluating how to best address the ongoing needs and integrate the available resources to provide treatment. This will likely include a blending of State correction funds, addiction treatment funds and other local resources.

g) Maintenance/recovery support

This is an area that CCMH has made specific improvement over the last year with an increased focus on addressing consumers whose level of care needs falls within the Health Maintenance and recovery range. This part of CCMHs effort to align itself more closely with the level of care descriptions as indicated by the LOCUS, CASII and ECSII. This is also a significant treatment group with approximately 50% of adult consumers falling within this grouping.

These individuals are as a whole receiving ongoing medication management, usually on a monthly to quarterly basis. These individuals are also assigned to a medical service coordinator who is available as needed to problem solve any issues or concerns that may arise between visits. Nursing services area also available along with crisis response.

Over the last 6 months CCMH has also added a staff therapist and community case manager directly to the team serving these individuals. Previously, if these services were indicated it would be necessary to make specific referrals to the case management or brief therapy team to get them in place. This consequently could slow down the delivery of the necessary service and result in potentially poorer outcomes. With the changes, therapy can be immediately added, as indicated, to help an individual or if case management is needed it too can begin without delay. Additionally, if the service needs are assessed using the LOCUS/ ECSII/CASII as requiring higher intensity this transfer to a higher level can occur in a more planned, stepwise manner.

CCMH will continue to monitor the success of these changes over the next year and make necessary improvements to increase the overall responsiveness of services while maintaining sound fiscal policy.

Consumers with more severe mental illness have continued to prioritize ongoing access to other recovery support outside the formal mental health system through the local Clubhouse and Advocacy program both of which are supported by CCMH. The Clubhouse offers a variety of peer support services and activities which consumers may utilize. Overall though, these programs are utilized by a relatively narrow group of individuals, and the vast majority of consumers rely on natural supports such as family, friends, church, employers and other community groups to maintain their recovery.

Addictions treatment will continue to provide ongoing Aftercare support groups as well as an open Drop-In Gambling group through Adapt. Adapt also provides home visits, case management, transportation assistance and other services to ensure that individuals are able to get access to the necessary recovery supports. Community 12 step groups also continue to be well supported by Adapt, Bay Area First Step and other providers.

h) Quality improvement process/ procedure

CCMH has a well established QA/QI process; elements of which include routine chart audits, supervision and training schedules, utilization review procedures, community and consumer advisory input, critical incident reviews, and risk management.

There are no recommended changes to this process, though there are efforts underway to better integrate the QA/QI efforts of the various entities including the health department, local alcohol and drug providers and CCO in a manner that will improve our coordination of efforts while reducing duplication of efforts. It is anticipated that these efforts will include looking at utilizing a community wide QA plan in conjunction with the CCOs. CCMH will have specific elements that it will incorporate into its QA plan as a result of its relationship with WOA. These efforts will include information on such things as hospital readmission rates, follow up after acute care events, access measures – many of which were already apart of the MHO requirements. CCMH will also be working with WOA in terms of identifying a specific performance improvement project that involves the integration of physical and behavioral health. Previous integration projects related to increasing communication/coordination among providers and tobacco cessation.

The other integrated QA effort will relate to the shared effort to develop a true community health assessment which will then result in a health improvement plan. It is anticipated that aspects of this plan will relate to specific mental health measures and efforts.

i) Service coordination and collaborations with corrections, social services, housing, education, employment

One of the ongoing strengths for the County in terms of its operations is its coordination and collaboration with the community. Due to the smaller size of our community and the historic lack of resources Coos County has necessarily had to closely work with other community partners to best meet the needs of our community. It is a matter of routine for Directors, administrators and line staff from local agencies to be in many of the same planning, oversight and governing bodies. We all know each other and are used to pooling our resources and working together to solve the difficult problems.

Examples of such collaboration include MH Court with DOC and the Municipal Court; Zero to Three Court with Family Court, Child Welfare Services, Adapt; an Addictions Recovery Team with Adapt and DHS; a Nurturing Communities Project involving the area Community College and a host of community partners. There is a monthly Coastline Meeting involving all area Child service providers. We are involved with a joint effort with a local pediatrician, dental provider to complete the required screenings for children entering DHS custody. We have an Enhanced Care Outreach program run in conjunction with Aging and People with Disabilities. We have arrangements with Bandon, Coos Bay and the Lighthouse school to provide therapy within the school settings. We have arrangements with North Bend school and Kairos to provide Day Treatment services to both younger and older children. On the adult side we run a Supported Employment group that works closely with Vocational Rehabilitation and a variety of area employers and community leaders. We collaborate with Columbia Care Services to provide supported and transitional housing options for consumers and work with NB housing authority and local Community action as well. All of our boards including the Advisory boards and QA committees contain a broad representation of community players.

Our area of focus over the next biennium will include our work with the Physical Health providers. Coos County currently has significant representation on the governing board of the CCO/WOAH and we are working on the elements of the transformation plan. This plan likely will include a greater presence of behavioral health within primary settings. Currently we are collaborating with two of the health clinics to provide MH evaluations to pediatric patients. We are hoping to develop a pilot project with one or more adult PCPs to complete some of the routine screening around depression, substance use which could in turn lead to treatment interventions/ recommendations. We are also proposing to look at the feasibility of co-locating a physical health provider within our mental health setting to better serve individuals with chronic mental illness to improve health outcomes related to diabetes, obesity, smoking and life expectancy.

CCMH is also engaged in a project with CWS to better collaborate around managing the mental health needs of children within DHS custody and their families and supports. We have identified 2 areas of focus. One relates to appropriate utilization of individual/family therapy especially as it relates to longer term treatment, treatment with low/minimal response, behaviors/issues which are little above normative. CWS is citing the need for MH expertise in terms of guiding care, support to respond to Court/advocate pressure for MH care, better communication/understanding around utilization decisions.

The second relates to the high use of out of county residential care for CWS kids especially of long term nature (CCMH expenditure for ITS services is estimated at \$1.4 million annually). CCMH is taking a harder line regarding not authorizing residential care when it appears to be ineffective in terms of making substantial and permanent changes to a child's behavior/ presenting problem. This makes it imperative to develop more appropriate local resources to manage these issues. Currently CCMH is involved with KAIROS and other community partners in planning and developing these resources – this efforts is included as a part of the WOAH's Transformational Plan.

It is the expectation of CCMH that we will have achieved success at initial implementation of plans to achieve both of the objectives within the next biennium.

J). Behavioral health equity

Overall, health equity in service delivery is deemed a relatively low priority area. Ethnically and culturally Coos County is an extremely homogenous population with 93% Caucasian of European descent; Hispanics of any race represent just under 5.6% of the population, while American Indian/Alaska native are just over 1.5%. Given this homogeneity, CCMH does serves a statistically higher minority group with 4% of enrollees reporting they are Native American, 2.5% Hispanic and another 2.5% of more than more race (88% are White/non-Hispanic).

It does appear likely that individuals of Hispanic origin are underserved within the community. While Native Americans have access to services both through the CCMH and the tribal health clinic for mental health, substance abuse, Hispanics with lower incomes or covered under OHP would be seen by CCMH.

As a whole, this is a group that has been identified as being more reluctant to seek out MH services and previous outreach attempts have not proven particularly successful. CCMH has moved towards delivering services more directly within the schools and also more into primary care settings – this shift into less traditional mental health settings may increase service delivery to this group.

CCMH does maintain policies requiring non discrimination in terms of all of our service delivery along with necessary accommodations to best serve the needs and requests of our community. Printed materials are available in Spanish and interpreter services are available free of charge to individuals needing these services, though in actuality the use of these services is rare.

CCMH also continues to strive to recruit MH professionals with a higher level of diversity and language skills to best serve these minority communities as a best practice. However, given the difficulty in recruiting high quality mental health professionals in general this additional goal has not been attainable.

k) Meaningful peer and family involvement

This has been an area of strength and priority for CCMH for the last several biennium. CCMH has consistently funded the consumer Clubhouse to support and grow the consumer voice within our community and over the years this has borne significant fruit. Consumer's are now very involved in the planning and development off CCMH services. The CAOS group (Consumer Advocates for Optimal Services) has now been running for about 5 years. This weekly consumer run group directly advises the CCMH Director as to priorities, changes and new programs/services. The Mental Health Advisory Board also has a robust consumer/family representation and is chaired by a MH consumer. This is true for the Community Quality Assurance Committee as well. CCMH also has a responsive QA process that quickly addresses and resolves consumer complaints and issues, utilizing this information in the planning of future services.

For the next biennium the CCMH priority is to try and bring some of this consumer advocacy and involvement into the development and growth of the CCO. Already MH consumers have become an active part of the CCO's Community Advisory Committee and are making an impact in terms of the transformational planning and development of the community needs assessment and health plan. This group is also making plans to increase the future involvement of consumers of physical health care by opening up the CAC to public comment and developing a survey instrument to more broadly poll the community. Over time it also the expectation that consumers will begin to assume the leadership roles within the CAC as a level of comfort and understanding is achieved. This concept of consumer involvement is less understood within the physical health community but is one that our MH system can and is providing guidance.

l) Trauma informed service delivery

CCMH has long recognized the impact of trauma on those that we serve in all aspects of our operation and has incorporated best practice models into our work with consumers. Overall, CCMH treats trauma related conditions with the highest rates of occurrence compared to all other diagnostic groups. PTSD has a dramatic impact on both child and adult consumers.

CCMH has no plans to alter our treatment and care related to trauma. We will continue to screen all assessed individuals for trauma and trauma related conditions. We will continue to utilize evidenced based treatment approaches to the treatment of trauma including cognitive based treatment, DBT, EMDR and the like. We will continue to empower consumers in taking control back of their lives and exercising choice. CCMH has continued to adopt the AMH Trauma guide within its own Policies.

m) Stigma reduction

CCMH plans to continue its current efforts around stigma reduction recognizing that the task requires long term efforts on several different fronts. One of these efforts involves specific educational and promotional efforts. Another relates to the building up of the voice and presence of the recovery community for self- advocacy. A third relates to the community integration of these groups within the larger society so that stigma is replaced more and more by personal experience.

In terms of education and promotion, CCMH and its partners will continue to work with the local schools in areas related to alcohol and drug dependence, depression, suicide and other emergent issues. We will also continue to participate in community events such as the annual Fun festival, the County Fair and other Wellness Fairs. As always these events are manned by a variety of partners such as Bay Area First Step, SHAMA, CCMH, Adapt, and the recovery community.

Self- advocacy and expression also are extremely powerful in breaking down barriers. CCMH will continue to support the recovery community and find forums for expression. The SHAMA Clubhouse will continue its efforts by utilizing the local news media to report member success and other relevant information to the public. Working Wonders will continue to hold supported employment parties along with involved employers and business leaders inviting both the public and news media to hear that we too can work, overcome limitations and be productive.

Finally, CCMH will maintain its strong commitment to providing the supports and services necessary for individuals with mental illness and substance misuse to live within our community, to work alongside their neighbor, to attend the same churches, to shop at the same stores. It is truly, this living within the community that will over time eliminate the remaining stigmas. These efforts relate to such things as providing a range of supportive housing options, using in home supports, provide effective medication and other treatment options, and delivering crisis services within the least restrictive/disruptive setting.

n) Peer delivered services, drop in and paid peer support

CCMH will continue with its strong history of support for peer delivered services both in its current forms and also in some of the current planning efforts related to CCO development and the training and use of paid peer specialists.

CCMH will continue to provide some financial and technical assistance to our local Clubhouse- SHAMA House – which has operating for nearly 14 years and is a model within the region. Funding that had previously come through the regional MHO will now come directly from CCMH. SHAMA house operates a variety of support groups, activities, and trainings both within the Clubhouse and at CCMH. They have a long track record for advocacy and a number of its members and trained support providers.

CCMH will also continue to work with SHAMA house, and AMH around the use of peer supports. Currently, the adult program manager and clubhouse representatives are holding a workgroup to evaluate the rules regarding the use of paid peer supports and specialists to evaluate how best we can utilize these positions within our care system. Issues related to training, supervision, pay and documentation will need to be clarified other the next several months.

CCMH is also working the CCO/WOAH regarding the issues of non-traditional workers and CCMH is identified in WOAH's transformational plan as having a primary role in identifying the use of Peer Wellness and Patient Navigator roles within the healthcare system. CCMH was given this role due to its experience in effective utilization of peers/ consumers within its current system of care.

o) Crisis and respite services

CCMH will continue to utilize its current well established crisis delivery system into the next biennium. CCMH utilizes an onsite crisis response team within normal business hours and a Portland based Protocall Services for after-hours calls with local on call clinical availability. Given, the limited call volume outside of normal business hours this continues to be the most viable means of providing crisis coverage. CCMH will be working out a new contract with Protocall as the current contract was directed within the regional MHO.

CCMH does plan to make improvements in our ability to respond to crisis situations in a more mobile, active manner with increased focus on to outreach services. This need has been clearly identified by our main community partners. While traditionally it have been more difficult for us to dedicate the resources necessary to run a Mobile Crisis team due to both cost and more limited call volume, CCMH is currently in the planning stages of a reorganization to allow us to more closely mimic this crisis response model. Tentative plans are to split our crises personnel into 2 groups. The first of which will continue with current responsibilities such as monitoring the crisis hotline, responding to crisis walk-in appointments and completing routine screens and assessments. The second team will be mobile, out-stationed in the community, and able to do outreach to community members, work along with law enforcement, Child Welfare and Aged and People with Disabilities to assist in MH crisis assessment and management and to routinely provide services to homeless shelters and other venues.

It is truly a strength that Coos County has the benefit of both an adult Behavioral Health Unit with a hospital and an effective, established Crisis Resolution Center – there are very few rural areas that have both resources. There are challenges to this as well, making integration more difficult and inhibiting the ability to move individuals seamlessly from one to another based on medical and behavioral needs. Under the CCO model it is hoped that specific improvements can be made in this regard. Currently there are plans to intervene more directly within the hospital emergency department so that CCO staff can both help direct individuals to the most appropriate level of care as well as ensure critical aftercare and outpatient follow up. The overall goal is to provide high levels of care within the least restrictive setting.

Children’s emergency care continues to present a significant challenge with no local acute or sub-acute MH bed availability. Typically a child presenting to the ED in a MH crisis is held at the hospital in a medical bed until an appropriate disposition can be arranged - often within the Portland metro area. Some of these kids can be successfully diverted to our children’s crisis respite home – Pony Creek – as long as they are under enough self restraint to not pose a higher risk to themselves or others. CCMH is currently working with Columbia Care, Kairos, and community partners to re-evaluate the service model at Pony Creek and identify how to achieve a higher level of containment within the home to manage children with higher levels of need. The CCO Transformational Plan also contains detailed information about a planned project to better serve children within their own home and community, reducing the overall need and use of all out of home placements including acute and sub-acute care .

Part II: Performance measures

1. Current data

a. Access/ number served:

- CCMH does have data available related to access/number served for most of the targeted areas though what this information actually means does vary significantly based on the particular service. It is also the case that some clarification may be necessary in terms of what kind of access data is requested for a given service e.g. available measure could include # of individuals served over a given time period; # currently enrolled; # of specific kinds of service delivered within a time period.

Adapt- Alcohol and Drug Treatment services	average 270 individuals served/mo. 50 assessments/month
ITRS	average census of 24 clients
PSRB monitoring/ supervision	average census of 8-10 individuals
Housing supports	
THE house	1500 bed-days per year
BayBridge Apts	21 units
Bay Apts	8 units transition/ 2 permanent
Belloni Ranch	1 bed
MH Court	average census of 15 participants

Zero to Three Court	average census of 3 children
SHAMA house	daily average of 20-30 members
Warmline	not known
Rep Payee program	average of 50 enrollees
Civil Commitment activities	80-90 investigations; 10-15 commits/ yr
Protective services Invest.	50 critical invest; 5-10 PSIs/yr
Foster home/residential licensing	license 4 AFHs/ 2 RTFs
Treatment services	census of 110-125 indigent enrollments
Initial visits/brief intervention	600 visits/year
Medication/psychiatric care	710 visits/yr
Therapy services	400 visits/yr
Case Management	570 visits/yr
Skills training	500 visits/yr
Other	125 visits/yr
Crisis services (OHP+indigent)	400 crisis contacts/yr
Protocall after hours (OHP+indigent)	150 crisis calls + unknown # of routine
Prevention activities	
Youth summit	5000 students/yr
Project Toward No Drug Abuse	50 students/yr
Teenopoly/Proj Graduation/alternate activities	1000 students/yr
National Night Out/Family Fun Day/etc	10,000 county residents/yr

- Other access information may not be as readily available. Crisis services for instance is not easy to separate out by payer source – e.g. OHP, vs. indigent, vs. commercial insurance – since this is not always known. Crisis coverage too includes a lot of costs that relate to providing an overall safety net which may not necessarily be attached to the actual usage. Other items such as QA processes, service coordination, behavioral health equity, meaningful peer involvement, trauma informed services, stigma reduction also do not have clearly identified access measures and it is not clear how they would be operationalized across organizations.

b. Initiation of treatment services – Timely follow up after assessments

- This data is not currently tracked though certain encounter data would indicate time between an assessment and next service. Internally CCMH does have a process for intake staff to gain additional staffing if assessment scheduling increases to more than 2 weeks from initial request. This is very infrequent occurrence. Previously CCMH in conjunction with the MHO tried to track initiation encounter data but this was not highly successful due to several complicating factors including repeated use of assessment codes for annual assessments, use of assessment code when more than one visit was needed to complete an assessment, no indications for follow up care based on assessment. No shows for appointments also significantly skewed data.

- If encounter data is available for indigent services data should be available but with same issues as with MHO attempts.
- c. Treatment service engagement – Minimum frequency of contact within 30 days of initiation
- This information is not currently tracked but we would anticipate some of the same issues as in b) would make understanding data difficult. Also it is not clear what the standard would be regarding a minimum frequency since this would vary significantly according to the needs of the individual. This information is in our EMR but we would need to develop specific reports to pull the requested information.
- d. Facility-based care follow up - % of individuals with follow up visit within 7 days after (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential
- Hospital follow up has been tracked traditionally by MHO for OHP enrollees and will be done under the CCOs in same manner. Indigent tracking is not currently available but would be available when indigent visits are “encountered” similar to plan member visits. Obviously hospital stay would need to be covered/paid for by CMHP to track follow up. This data is currently in our EMR but we would need to develop reports to “pull” the information out in an informative format.
 - Follow up regarding residential care would be more difficult given that encounter data is not submitted through the CMHP. We do track individuals in residential care that are our responsibility within our system. Follow up care would be tracked if it was provided by us but may not if provided outside of our system of care – eg. Medicare, private insurance, individual did not return to area after discharge
- e. Readmission rates 30 and 180 day: (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential
- CCMH has not routinely tracked hospital readmissions though given existing data sets it would not be difficult to do so. To provide measurements hospital data would have to be submitted as claims data. Some data would be submitted under CCO as OHP data; others submitted to AMH as indigent funded; other admits under Medicare/commercial are not reported.
 - Residential data would be harder to track since claims data is not submitted in same manner as hospitals. Could possibly track using AMHI forms but this would be less accurate than utilize State data as tied to funding.
- f. Percent of participants in ITRS reunited with child in DHS custody
This information is tracked – 75% of participants are reunified with child
- g. Percent of individuals who report the same or better housing status than 1 year ago
- CCMH has no current data available

- Only available quantitative measurement relates to CPMS enrollment and termination data; annual assessments do contain narrative description of housing status.
- h. Percent of individuals who report the same or better employment status than 1 year ago
- CCMH has no current data available except as submitted for individuals in Supported Employment
 - Employment status is tracked for individuals engaged in supported employment though it is not tracked year by year but rather employed/not employed per quarter; also tracked as CPMS item upon opening and termination
- i. Percent of individuals who report the same or better school performance status than 1 year ago
- CCMH has no current data available
 - School performance is tracked as a CPMS element but otherwise is not quantitatively tracked. It is an narrative element within the annual assessment
- j. Percent of individuals who report decrease in criminal justice involvement
- CCMH has no current data available outside of individuals involved in Mental Health Court
 - Again this is an element on the CPMS forms though as a Y/N response. We do track % of successful completion of MH Court
- k. Stay at or below a target ADP of individuals for which the county is responsible in the state hospital psychiatric recovery program
- CCMH has typically not tracked data regarding state hospital census since Coos routinely runs ADP of less than 1 and often zero
- l. Maintain an average length of stay on the OSH ready to transition list at or below a pre-determined target
- CCMH has not routinely tracked this since it has not occurred
- m. Each LMHA will complete a minimum of 80% of approved prevention goals and objectives

Currently prevention goals/objectives are not tracked in this manner. If done this way prevention goals would have to be significantly reworked as they are not measurable in this manner. E.g. reduce underage drug use, increase community engagement. Instead goals would need to relate to number of individuals receiving prevention message, number able to identify certain facts related to message etc.

2a) Describe the LMHA plan to actively incorporate the performance measures into planning, development and administration of services and supports:

CCMH already has an ability to report on a number of the performance measures with our current data systems with some clarity by AMH around the operational definitions of some of the items.

Access/number of individuals served data is available for many of the specific populations addressed in the plan. This data can be broken out in a number of ways eg by current enrollment, across a specified time period, by type of service, by type of program. Initiation and engagement treatment information can also be pulled as well with the proviso that the meaning of the data may not be easily discerned. Information regarding hospital readmissions and follow care is also available through our current systems. Residential data around the same measures is not currently available and might necessitate working with AMH around integrating this claims data within our own system or otherwise duplicating the AMH data within our own (this would not be our first choice).

Many of the new data items including housing status, employment status, school performance, criminal justice involvement are all new elements within the proposed COMPASS project and CCMH is working with AMH around these data elements.

Data regarding OSH admissions is of low concern to CCMH since these occurrences are of very low frequency and are handled individually rather than as a set of data. CCMH should be able to report information outside of formal data systems. Prevention goals follow a similar process and would be reports outside of our formal systems.

Part III: Budget Information

1) General budget: 2013-15 per biennium

- a. Planned expenditures PER BIENNIUM from General Fund dollars

SEE ALSO BUDGET TEMPLATE WORKSHEET

Assumed funding for 2013-15 Biennium SE 37 (estimate from 2011-13) **2,056,892**

Promotion/Prevention:

Comm. on Child & Family/Prev Specialist	187,000
Adapt- A&D	25,160
Adapt- Problem Gambling	3,113
TOTAL	215,273

Outreach:

THE house – beds for homeless mentally ill individuals	50,040	
Initial MH OP visits/screening/brief interv	160,000	
Adapt- A&D	50,322	
Adapt- Problem Gambling	6,227	
TOTAL		266,589

Initiation and Engagement:

Mental Health Court	54,800	
Zero to Three Court	20,000	
OP MH assessments, treatment planning	74,000	
Adapt – A&D	50,322	
Adapt –Problem Gambling	3,113	
TOTAL		202,235

Therapeutic Interventions for non-OHP:

MH OP Medication/psychiatric care	200,000	
MH OP Therapy Services- Individual/Family/Group	110,000	
MH OP Case Management	180,000	
MH OP Skills Training	96,000	
Civil Commitment activities	150,000	
Protective Service Activities	20,000	
MH Foster home/ residential licensing/monitoring/supervision	10,000	
Bay Apts – MH supportive housing unit subsidies	83,352	
Belloni Ranch – MH shelter bed for children	81,768	
PSRB Monitoring and supervision	100,000	
Crisis availability – 1 FTE, on call + backup+superv/training	100,000	
Protocall – after hours crisis call center	20,000	

Adapt – A&D treatment	327,097	
Adapt- Problem Gambling Treatment	48,567	
TOTAL		1,526,784

Continuity of Care/Recovery Management: (some of these activities may be listed/combined under Treatment Interventions)**

BayBridge Apartments – Mental health live in apt manager	24,000	
Representative payee program	40,000	
Adapt- A&D	50,323	
Adapt- Problem Gambling	1,245	
TOTAL		115,568

Peer Delivered Services:

SHAMA house- consumer clubhouse	48,000	
David Romprey Warmline	4,000	
TOTAL		52,000

TOTAL Flex Funding SE 37 2013-15 Projected Expenditures **2,378,449**

SE 1 Local Admin MH 90,095

Other Non- Flex funding Elements:

SE 35 Residential costs for MH consumers in specialized SPD settings	125,388
SE38 Supported Employment	94,662
SE201 Designated treatment services	16,872

2) Special Funding Allocation

a) Maintenance of Effort attestation

As required by ORS 430.359. (4), I certify that the amount of county funds allocated to alcohol and drug treatment and rehabilitation programs for 2013 – 2015 is not lower than the amount of county funds expended during 2011 – 2013.

Coos County has provided no funds for addictions prevention or treatment services in 2011-13 and will not in 2013-15.

b) Use of lottery funds for Problem Gambling

see Budget template – Lottery funds are not included in Flex funding but are contracted by AMH directly to Adapt Inc.

c) Use of funds allocated for alcohol and other drug use prevention

Beer and Wine tax	\$8044	Comm. on Children&Families –Prevention Activities
Beer and Wine tax	\$94,656	Bay Area First Step for transitional A&D housing
Beer and Wine tax	\$5,300	Administrative Costs

Local Mental Health Authority
 Biennial Implementation Plan (BIP)
 Planned Expenditures 2013 - 2015 (Based on historical allocation)

Budget Period:
 Date Submitted:

Category (as defined in the CFAA)	Sub-Category	Population	AMH Flex Funding*	Local Beer and Wine Tax	County GF	Other - Lottery Funds**	Total	Carry-over Amount
Behavioral Health Promotion and	Mental Health	Adults	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
		Children	\$187,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Alcohol and Other Drug	Adults	\$23,148.40	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
		Children	\$2,012.90	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Problem Gambling		\$0.00	\$0.00	\$0.00	\$3,113.30	\$0.00	\$0.00
	Outreach (Early Identification and Screening, Assessment and Diagnosis)	Mental Health	Adults	\$180,040.00	\$0.00	\$0.00	\$0.00	\$0.00
Children			\$30,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Alcohol and Other Drug		Adults	\$46,296.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
		Children	\$4,025.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Problem Gambling			\$0.00	\$0.00	\$0.00	\$6,226.60	\$0.00	\$0.00
Initiation and Engagement		Mental Health	Adults	\$123,800.00	\$0.00	\$0.00	\$0.00	\$0.00
	Children		\$25,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Alcohol and Other Drug	Adults	\$46,296.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
		Children	\$4,025.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Problem Gambling		\$0.00	\$0.00	\$0.00	\$3,113.30	\$0.00	\$0.00
	Therapeutic Interventions (Community-based Outpatient, Crisis, Pre-Commitment, Acute Care, PSRB and JPSRB)	Mental Health	Adults	\$1,029,352.00	\$0.00	\$0.00	\$0.00	\$0.00
Children			\$121,768.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Alcohol and Other Drug		Adults	\$300,929.20	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
		Children	\$26,167.70	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Problem Gambling			\$0.00	\$0.00	\$0.00	\$48,567.48	\$0.00	\$0.00
Continuity of Care and Recovery Management		Mental Health		\$64,000.00	\$0.00	\$0.00	\$0.00	\$0.00
	Alcohol and Other Drug		\$50,322.60	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Problem Gambling		\$0.00	\$0.00	\$0.00	\$1,245.32	\$0.00	\$0.00
Peer-Delivered Services		\$52,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Administration		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Other		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Total			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

*AMH Flex Funding includes State General Fund, State Beer and Wine Tax, Lottery Funds, SAPT Block Grant and Mental Health Block Grant

\$2,316,186.00

**Note: Lottery funds for Gambling Tx/prevention for Coos are not incl in Flex funds

\$62,266.00