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3/1/13

The Lincoln County Biennial Plan for 2013 – 2015 has been emailed along with this cover letter.

The Community Assessment section is not included as several community advisory boards wish to actively participate in creating and conducting the assessment and have requested that Lincoln County choose the option to defer submission of the assessment until later in the year.

Please contact me with any questions, concerns and/or feedback.

Sincerely,

Barbara L. Turrill, LPC, CADCIH, RDMT
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Lincoln County Biennial Implementation Plan 2013 - 2015

Part I: System Narrative:

This includes an overview of the current system; description of the community needs assessment process; and an analysis of the LMHAs strengths and areas for improvement.

1. System Overview

a) Overview of the County's current addictions and mental health services and supports system

Mental Health Promotion

Overall, the concept of recovery is the philosophical and real world paradigm that underlies Lincoln County's clinical services. Both the Adult and Child & Family programs include peer supported services, wrap-around models, collaborative documentation, an initial focus on strengths and client-centered goals/objectives, as well as an acknowledgement that recovery is possible. The County has a drop-in Intake process, called Open Access, that allows individuals to be screened quickly, usually the same day that they come to the clinic. Outreach to other agencies is done through community meetings, through mutual clients/individuals, responding to referrals, crisis episodes, and includes DHS/Child Welfare, DHS/Self Sufficiency, Confederated Tribes of Siletz, My Sister's Place, the school district, local law enforcement, juvenile justice, and the court system.

In the Adult Mental Health Clinic in South Beach, a Registered Nurse and a Case Manager provide "Wellness Groups" for the Serious Mentally Ill (SMI) population, addressing diet/nutrition, exercise, and stress reduction. An Occupational Therapist works with Individuals to increase ability to manage Activities of Daily Living (ADLs). The psychiatric team provides individual education on medication management, including how to choose a medication and work with possible side effects, as well as how to include therapy as a critical aspect of treatment. Case Managers and Peer Support Specialists are able to meet with Individuals in their homes, providing connections to needed resources (transportation, medications, tents, clothing, etc.) or, at times, a person to

simply talk with. Along those lines, there is a Warm Line office in the South Beach Clinic, staffed twice a week by a peer trained to provide non-judgmental support to anyone who calls.

In the Child & Family Program, a group called “Hand In Hand” encourages parents to develop additional parenting skills and to work with peers on problem-solving mutual challenges. “Collaborative Problem Solving” is an Evidence-Based Practice (EBP) that Child & Family therapists are trained in, which promotes mental health by mentoring the entire family to work through difficult episodes in life. Dialectical/Behavioral Therapy (DBT) groups and individual therapy are available for both adolescents and adults, with concurrent support for family and friends. This treatment is grounded in skills training so that Individuals learn how to better manage emotions, reduce self-harm behaviors, and interact more effectively with others. Child & Family clinicians provide individual, family and group therapy in all 4 School-Based Health Clinics (SBHCs), allowing youth to meet confidentially with a counselor as needed. Counselors also provide various services in the community, including facilitating multi-agency meetings, holding a parenting group for adults referred from Child Welfare, and responding to other agencies to support counseling services (Early Intervention, CASA, Children’s Advocacy Center, Confederated Tribes of Siletz).

In the Addictions Program, Motivational Interviewing and Motivational Enhancement are offered to all Individuals seeking treatment, with the added flexibility of referral to in-house psychiatric services or mental health treatment, as appropriate. The majority of the clinicians are able to provide treatment for co-occurring disorders, if an Individual cannot realistically meet with more than one counselor due to other commitments. Co-occurring group counseling is offered to adults through the South Beach Clinic, as well as at the County Parole and Probation office in Newport. An Addictions counselor provides services to the SBHC in Newport routinely and meets with youth in outlying SBHCs in Toledo and Waldport as needed. Through ITRS funding, the County is able to offer treatment to parents who are not on the Oregon Health Plan, with children in DHS custody. All of the services provided in the mental health and the addictions program are on a sliding fee scale (the Addictions Recovery Program slides to zero), based on income. The County has a relatively new Problem Gambling counseling program, with services provided in Lincoln City and Newport/South Beach.

Mental Illness, Substance Abuse and Problem Gambling Prevention

The Lincoln County Prevention Department A/D 70 & 80 is housed under the Lincoln Commission of Children & Families (LCCF). The Lincoln Commission on Children & Families, located at 351 SE Harney, Newport, was reviewed on August 18, 2012 to determine whether the program is delivering services in compliance with the administrative rule standards. The review was conducted by

Wendy Hausotter, Prevention Specialist with the Addictions and Mental Health Division of the Oregon Health Authority. The review found the program to be operating in substantial compliance with the relevant administrative rules and the program was granted a renewal of the Letter of Approval, expiring on August 15, 2015.

This partnership between Lincoln County Prevention and LCCF has been beneficial as the LCCF also provides fiscal management and program oversight for a federal Drug Free Communities grant which funds Partnership Against Alcohol & Drug Abuse (PAADA) a local A/D abuse prevention coalition.

PAADA's primary focus is to serve the Newport Community, allowing the Prevention Coordinator to duplicate services in the North, South, and East areas. The Prevention Coordinator offers support and participates in Community Efforts Demonstrating the Ability to Rebuild & Restore (CEDAAR), and East County Community Partnership (ECCP) coalitions.

Current identified priorities are:

- Continued support to community coalitions
- Opiates & Rx Drug Abuse
- Enforcement of Underage Drinking
- Youth Leadership Coalitions

Prevention Coordinator is a Certified Prevention Specialist, allowing her to offer support to tribal SPIF/SIG Coordinator, and Tribal Prevention Coordinator both of whom are new to the field of A/D Prevention, strengthening the partnership between the County and the Confederated Tribe of the Siletz Indians (CTSI). In the past the county and tribe have struggled to bridge the cultural gap in order to form collaborative partnerships.

This renewed partnership has been essential in the planning of the Hands Across the Bridge Recovery/Welbriety celebration, Rx Take Back, Lincoln County Youth Film Project, and the first annual Rx Drug Abuse Summit. Current projects include Enforcement of Underage Drinking Laws (EUDL) efforts in Siletz and Toledo, and bringing Community Norms training to our communities.

The first annual Rx Drug Abuse Summit was held at the Best Western Agate Beach on May 16, 2012. Over 175 were in attendance from around the state. The presenters were Lincoln County DA Rob Bovett, John Scherbenske, Deputy Assistant Administrator, FDA, Jay Wurscher, DHS, Kovi Ashley, Lines for Life, and Charles Dunn, Oregon Prescription Drug Monitoring Program. The 2012 Youth

Film Program premiered their PSA's during the lunch hour. Film topic for this year was Rx Drug Abuse. Andy Blubaugh from the Northwest Film Center introduced the youth from Newport, Toledo, and Siletz Valley High. Toledo High Film Program graduate Tyler Carey flew in from Los Angeles where he is currently working in film. At the close of the summit a panel with representatives from local pharmacies, law enforcement and treatment facilitated a discussion on local data and trends they are seeing. A group discussion led to many innovative ideas on how to combat the problem in Lincoln County.

As a follow up, staff partnered with CEDARR, ECCP, and PAADA to host premieres of the 2012 youth films in their prospective communities.

An Opiates Task Force has been formed in Siletz to address the growing number of Rx Drug and Heroin abuse in the community. County Prevention staff along with CTSI Prevention staff was recently invited to tribal Council to begin discussion about solutions. Lincoln County DA Rob Bovett and County Commissioner Bill Hall were also in attendance.

One result of this initial meeting is that a Youth Challenge Day has been scheduled for Siletz charter school.

Problem Gambling Prevention

Primarily focuses on information dissemination through distribution of problem gambling brochures and information. Coordinator also submits news PSA's and articles about problem gambling awareness on a regular basis. Lincoln County Schools are encouraged to participate in annual Problem Gambling Awareness Art Search. Prevention Coordinator has added a problem gambling component to community presentations including localized data from the Oregon Healthy Teen Survey and Oregon Student Wellness Survey.

Early Intervention

The Child & Family Team provide individual assessment, individual and family therapy, and group therapy to children from the ages of 5 through 17 (in some cases, services may be provided past 17). These services are offered in the Newport and Lincoln City Clinics, with additional services available through the School-Based Health Centers in Taft High School (Lincoln City), Newport High School, Toledo High School and Waldport High School. DHS/Child Welfare is the primary referral source for young children requiring treatment. Therapists are trained to assess very young children (0 – 5 y.o.) and use an Evidence Based screening tool called the "ECSI" to facilitate this. The Intensive Children's Treatment Services (ICTS) program addresses children who are referred to Lincoln

County Mental Health due to concerns about intensive treatment needs and are screened with a tool called the "CASII." Potential referrals may be made to Olalla Day Treatment or to a psychiatric residential setting, based on acuity.

Treatment and Recovery; Activities that Support Individuals in Directing their Treatment Services and Supports

Lincoln County's current mental health, addictions, and problem gambling services are centered on outpatient treatment, in 3 community clinics and 4 School-Based Health Centers. Youth are also seen at the Juvenile Shelter and Detention Center. Additional services are provided through home visits, as well as crisis services to local hospital settings and in the Lincoln County Jail. Contacts with indigent/homeless individuals may occur in local cafes, campsites, or at the Probation/Parole office, as well as in the clinical settings. Treatment services are all on an outpatient basis.

The fundamental service array across all programs includes individual, family and group treatment, provided by masters-level clinicians. Licensure and certifications include Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Certified Alcohol and Drug Counselors (CADC), a Dance/Movement Therapist (RDMT), an Occupational Therapist (OT) and a Problem Gambling Counseling Intern. The Psychiatric Team consists of a psychiatrist and 2 psychiatric nurse providers (PNP). The clinical staff also includes Case Managers, a Registered Nurse, Care Coordinators, Community Support Workers and Peer Support Specialists.

Access to treatment is done through a drop-in intake process called "Open Access." Individuals are directed to come in to the clinic at specific times/days, based on ease of access and age of the individual. If screened in to services, the clinician and the individual collaboratively complete an assessment and an Individual Services and Support Plan (ISSP), which then directs treatment. Working with a "Level of Care" tool, the therapist and the individual address goals and measureable objectives, discussing how to know when treatment is completed. Individuals may be asked to give their idea of what recovery means to them. With children and families, strengths and needs are assessed, as well as goals and objectives for treatment. Assessment for younger individuals also may occur over an extended period of time as the clinician focuses on building trust and avoiding re-traumatizing the child.

Referrals to additional services are made after some initial treatment occurs, with some exceptions (crisis referrals, hospital discharges). Group services range from 60 to 120 minutes, based on the EBP that the individual is involved with, and include Cognitive Behavioral Therapies, Parenting Education, Skills Training, Wellness, Relapse Prevention, Co-Occurring Disorders, and Motivational Enhancement. A developing Peer Clubhouse for the population identified with a Serious Mental Illness (SMI), called "Safe Harbor," runs Monday through Thursday in the South Beach Clinic, providing Peer Support, social interaction, a lunch program,

and other group activities. The Addictions Recovery Program offers services in all 3 clinics, as well as counseling services in the Newport High School. Problem Gambling treatment, reinstated in November of 2012 with one counselor, provides treatment to individuals and family members in Lincoln City and Newport/South Beach.

Crisis and Respite Services

Lincoln County provides 24/7 face-to-face crisis coverage for children and adults, with a Qualified Mental Health Provider (QMHP) or Masters level clinical team. Currently, the initial crisis phone screenings are completed through ProtoCall Services in Portland. All calls requiring a face-to-face assessment by a crisis worker are routed to either the counselor covering the daytime crisis shift, or the after-hours crisis worker. There are 2 hospitals in our County, one in Newport and one in Lincoln City. Neither hospital has a psychiatric unit nor has a "Hold" room, so any individual needing to be placed in a more intensive psychiatric setting to be assessed and then transported to a psychiatric bed outside of Lincoln County. This places a high burden on staff, both our clinical staff as well as the hospital ER or ICU medical staff, as it is fairly common for the regional psychiatric units (Good Samaritan/Corvallis and Salem Hospital) to be full. The crisis staff is trained in Acceptance/Commitment Therapy as a way to work with suicidal individual and hospitalization is not the initial crisis response in most cases. Last Spring, the mental health respite facility was closed (Trueman Recovery Program), representing quite a loss for both the mental health as well as the addictions treatment service array in the County. Currently, respite needs have to be met with motel stays and, occasionally, by Springer House in Albany. This is an on-going concern that a community group continues to organize around. Typical follow-up to a crisis contact is either a scheduled appointment the next working day or a referral to the next Open Access session.

Services Available to Required Populations and Specialty Populations

The Child & Family Program provides treatment for all children referred to the County and identified as having a Serious Emotional Disorder (SED). Based on the referral, a child with SED is assessed and screened with an ECSII (0 to 5 y.o) or a CASII (5 – 17), with appropriate treatment either provided in the clinics or referred to other providers, as appropriate. These other providers may include Olalla Day Treatment Program (in Toledo), a therapeutic foster home with services provided either through the County or at Olalla, or to a more acute care setting, such as Albertina Kerr or Jasper Mountain. In some very acute cases, children are hospitalized in a psychiatric setting although every effort is made to keep children within the community. Routine outpatient services are provided at the Nye St. and Lincoln City locations. Adolescents are seen at the SBHCs and receive counseling onsite. They may also be seen at either the Lincoln City or the Nye St. Clinic after school. Some referrals into the addictions program occur when an addictions provider is not available at the SBHC routinely.

Adults with a Serious Mental Illness (SMI) are treated in both the South Beach and Lincoln City locations, with some adults receiving medication management at the Nye St. location. The Safe Harbor Program, which was originally a Day Treatment service, is now being developed as a peer supported clubhouse, serving primarily SMI adults. This program is located at the South Beach Clinic and is currently open 8:30 – 2pm, Monday through Thursday, with a lunch program, individualized peer support, and group services. South Beach also provides a washer/dryer and a shower for indigent individuals to use as needed. Two Peer Support Specialists work within this program. Referrals for this population come from several sources: hospital discharges, crisis contacts, family, law enforcement, and the individuals themselves. Clinical services available include individual/group counseling, skills training, occupational therapy, case management and psychiatry. The challenges in Lincoln County are in the area of respite, as well as longer term housing. A high number of the SMI individuals are homeless and camp in the surrounding woods or on the beach. Some individuals work with case managers to locate low cost housing (typically, trailers or 5th wheels). Crisis respite is done through the use of local motels, with some limited access to Springer House in Albany. SMI individuals who are seen in crisis and assessed as needing psychiatric hospitalization are usually transported to either Good Samaritan in Corvallis or Salem Hospital. There are no psychiatric “hold” rooms in either of the two local hospitals. Individuals who are discharged from a hospital stay are referred back into treatment, scheduled with a clinician and, if appropriate, a psychiatric provider, for continuity of care. This process is facilitated by the RN working with the Adult Mental Health Program, who also dispenses medications under the direction of the staff psychiatrist. Lincoln County also contracts with Accountable Behavioral Health Network in Corvallis for a clinician to monitor all individuals in a psychiatric setting, as well as to provide crisis training as needed to County clinical staff.

Individuals who have been in the military or who are active in the military are seen in both the mental health and addictions programs. The VA also has a clinic that is co-located in the County Primary Care Clinic in Newport, providing access to a psychiatrist. The VA also provides transport to the VA hospital in Portland. Services have included individual and family treatment, crisis services, referral to psychiatric hospitalization, and continuing care.

The Addictions Recovery Program provides treatment to all individuals referred for substance abuse services, including IV drug users, women who are pregnant, individuals with co-occurring disorders (mental health and addictions), and individuals with/at risk for HIV/AIDS. The treatment itself does not separate out these individuals, although the access into treatment will vary, as entry into services is determined by the specific identifier. All individuals receive a screening by an addictions counselor, typically within the same day. Pregnant women are scheduled with a counselor within 48 hours, IV drug users within 14 days (usually sooner). Individuals with a co-occurring disorder (if the person does not meet the criteria just listed) may receive same-day services, if they

enter through the mental health Open Access process, or they may be scheduled with the next available addictions counselor. Intake appointments for addictions counseling are scheduled based on the clinic closest to the individual. Addictions counselors in the Nye St. Clinic in Newport are co-located with the County Public Health Department, allowing timely communication between the addictions providers and the public health staff. This has been extremely helpful when individuals have presented as positive for tuberculosis, Hepatitis B/C, or HIV/AIDS. An Addictions counselor is out-stationed at the Newport High School SBHC one day a week and is able to meet with adolescent clients at other SBHCs when referred by school staff, a parent, or someone from the SBHC staff. Adolescent clients needing substance use counseling are also seen in the Newport and Lincoln City clinics, as scheduled.

The Confederated Tribes of Siletz have a mental health and addictions program for tribal members and their families. However, occasionally, tribal members choose not to receive services through the Siletz Clinic and have been seen through Lincoln County Mental Health. Services for these individuals include the same service array that all other individuals receive.

Individuals identified as Developmentally Disabled (DD) and needing mental health/addictions/problem gambling treatment are referred through Lincoln County's Developmental Disability Program, into either the children's or the adult mental health/addictions services. Some DD individuals receive medication management only, which is provided through the psychiatric team. DD case workers and service coordinators work closely with both programs to coordinate services.

The elderly are served by the Adult MH program, typically through the Open Access process and/or through referrals from private providers. Some services, including addictions counseling, have been provided onsite at local assisted living centers. Crisis contacts are challenging if the individual is presenting with a mental illness and dementia, as geriatric psych units are very limited: Tuality/Forest Grove and Good Samaritan/Corvallis. A third resource may have just become available in McMinnville (Willamette Valley Medical Center). Assisted living centers and memory care units are reluctant to re-admit individuals who become aggressive verbally/physically. This is an underserved population, from a lack of training offered, lack of mental health clinicians with expertise in geriatric mental health, and a lack of resources for crisis respite/stabilization. Lincoln County recognizes that there is a rising elderly demographic that will require additional mental health/addictions expertise and resources, with an emphasis on integration of physical health with behavioral health.

The Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) community also receives mental health and addictions services through Lincoln County. The County provides a meeting space for the GLBT Task Force, which meets monthly, and the Division Director or a designee attends these meetings. Clinicians are strongly encouraged to participate in trainings as available on

therapeutic issues specific to the LGBT community. Clinical staff has assisted with a GLBTQ support group that meets weekly at the Newport High School. Resources currently available to GLBTQ youth include referrals to local Gay-Straight Alliance (GSA) groups and to Parents and Friends of Lesbians and Gays (PFLAG) meetings. Counselors share resources such as newsletters, training information, and informal support networks for both youth and adults. The local LGBTQ community has been much more visible and active over the past 4 years, following a suicide of an LGBTQ youth, and has held the County, as well as the schools, responsible for providing active support and therapy groups, as well as an effective response system for at risk LGBTQ youth.

The Latino population continues to be underserved in Lincoln County as a whole, primarily due to the lack of bilingual/bicultural counselors. Currently, Lincoln County has one bilingual/bicultural mental health counselor, who will be increasing her availability in order to better serve the needs of the Latino community. Referrals are often made internally, from the "Healthy Start" program (a County public health program for new parents), which may include someone who is not a citizen of the United States. The Healthy Start staff have asked for help with several individuals struggling with depression, domestic violence, and anxiety. It is a prioritized goal for Lincoln County Behavioral Health to be able to provide culturally appropriate treatment to anyone who is seeking help and meets criteria for services.

b) List the roles of the LMHA and any sub-contractors in the delivery of addictions and mental health services.

Lincoln County as the Licensed Mental Health Authority provides the following services:

- Crisis coverage, 24/7, for all children and adults, with face-to-face contacts as appropriate based on initial crisis screening;
- Mental Health and Addictions treatment services (outpatient) for indigent populations and those on Medicaid/Oregon Health Plan.
- Mental Health and Addictions treatment services (outpatient) for individuals who present with specialty needs and/or who are identified as being in a population requiring services
- Mental Health and Addictions treatment services on a sliding fee scale, with no individual turned away due to an inability to pay for treatment.
- Treatment (length of stay, therapy, referral to a psychiatric provider) or Level of Care will be based on acuity and context of individual's presenting concerns.
- Referrals to other providers/agencies as appropriate (primary care, dental providers, private therapists, psychologists, psychiatry)

Lincoln County sub-contracts with the following provider:

- Olalla Day Treatment

c) Describe how the LMHA is collaborating with the CCOs serving the county.

Lincoln County has been collaborating with this region's CCO – Intercommunity Health Network (IHN) – for over a year by participating in several committees (Regional Planning, Steering Committee, Community Advisory Committee, Quality Assurance), by planning and participating in local community meetings as IHN-CCO formed and was rolled out, and by continuing to participate in the above committees over time. Many of these meetings take place through video and/or phone conferencing, some are face-to-face. A Lincoln County pilot project involving integration of behavioral health and primary care has been developed with guidance by the Steering Committee that will focus on unaddressed mental health and addictions concerns within the local primary care settings.

The Addictions Recovery Program has been working with IHN for several years, due to the fee-for-service approach that is used with addictions clients on OHP. Clinicians use an authorization form to request specific periods of treatment, documenting diagnosis, Level of Care, and summarized aspects of each ASAM dimension.

As the timeline to shift management of OHP funding for mental health from the current model to one fully managed by IHN-CCO is not clearly determined (or the extent of the details of the shift), it is somewhat difficult to predict the impact on current mental health services within Lincoln County. Lincoln County staff will continue to attend committee meetings as scheduled.

d) List the Mental Health Advisory Council and the Local Alcohol and Drug Planning Committee (LADPC) Members, including their stakeholder representation.

MHAC:

Gerald Stanley, Community Member

Gus Willemin, Community Member

Ray Burleigh, Professional Member, Olalla Treatment Center

Sheri Crew, Professional Member, Discovery Counseling

Chandler Davis, Community Member
Mark Freudenthal, LCSW, Professional Member, Counselor in Private Practice
Otilia Ham, Community Member
Jaz Jasmine, Professional Member, Benton Place Group Home, Shangri-La
Pat Neal, Community Member
Brianna Robertson, Professional Member, Discovery Counseling
Linda Wallace, Consumer Member
Mary Warren, Consumer Member

LADAPC dba APARC:

Chandler Davis, Community Member
Pam Knight, Community Member
Sheri Crew, Discovery Counseling, Professional Member
LaLori Lager, MS, CADC, Professional Member, ReConnections Counseling
Pat Neal, Community Member
Partnership Against Alcohol & Drug Abuse (PAADA), Professional Member
Gerald Stanley, Community Member

2. Community Needs Assessment

a) Describe the community needs assessment process, including the role of peers and family members in the design and implementation of the process.

b) Describe how data from the community needs assessment is used to evaluate prevalence, needs and strengths in the local service system.

c) How does the community needs assessment process include feedback from advisory and quality improvement

groups? Please identify the specific groups.

The Community Needs Assessment is a current work in progress and will be submitted later.

3. Strengths and Areas for Improvement:

Based on the Community Needs Assessment, please indicate where there are strengths or areas for improvement in each of the areas below.

Area	Strength or Area for Improvement	Plan to Maintain Strength or Address Areas Needing Improvement
a) Mental Health Promotion		
b) Mental Illness Prevention		
c) Substance Abuse Prevention		
d) Problem Gambling Prevention		
e) Suicide Prevention		
f) Treatment:		

<ul style="list-style-type: none"> • Mental Health • Addictions • Problem Gambling 		
g) Maintenance/Recovery Support (Include specifics pertaining to mental health, addictions and problem gambling treatment)		
h) The LMHA's Quality Improvement process and procedure		
i) Service coordination and collaboration with corrections, social services, housing, education, employment and other community service agencies		
j) Behavioral health equity in service delivery		
k) Meaningful peer and family		

involvement in service delivery and system development		
l) Trauma-informed service delivery		
m) Stigma reduction		
n) Peer-delivered services, drop-in centers and paid peer support		
o) Crisis and Respite Services		

Part II: Performance Measures

1) Current Data Available		
Performance Measure	Data Currently Available	Current Measures (If available)

a) Access/Number of individuals served	2011-2012 See Addendum	Urgent/Emergent – 98% of members receive contact (phone or face to face) within 15 minutes. Emergency – 100% of members receive contact receive timely & medically appropriate care based on assessment or within 6 hours, whichever is less. Urgent – 95% of members receive care based on assessment or within 24 hours, whichever is less. Routine Non-emergency – 85% of members wait no more than two calendar weeks to be seen for an intake assessment following a request for covered services. For Missed Appointments – 95% of members will be rescheduled or provided Outreach services as medically appropriate or as needed to prevent the serious deterioration of the OHP member’s mental health condition.
b) Initiation of treatment services – Timely follow up after assessments	2012 with item C)	3 appointments offered within 30 days of request for service
c) Treatment service engagement – Minimum frequency of contact within 30 days of initiation	2012- see addendum	3 appointments offered within 30 days of request for service
d) Facility-based care follow up - % of individuals with	N/A	

follow up visit within 7 days after (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential		
e) Readmission rates 30 and 180 day: (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential	<p>1/1/2009 through 6/30/2012</p> <p>Readmits: 37</p> <p>Distinct Admits: 67</p> <p>Readmission rate: 55%</p>	
f) Percent of participants in ITRS reunited with child in DHS custody	Waiting to hear from DHS about this data	
g) Percent of individuals who report the same or better housing status than 1 year ago.	N/A	
h) Percent of individuals who report the same or better employment status than 1 year ago.	N/A	

i) Percent of individuals who report the same or better school performance status than 1 year ago.	N/A	
j) Percent of individuals who report decrease in criminal justice involvement.	N/A	
k) Stay at or below a target ADP of individuals for which the county is responsible in the state hospital psychiatric recovery program.	2012	See addendum
l) Maintain an average length of stay on the OSH ready to transition list at or below a pre-determined target	Data indicates that Lincoln County met the target for this measurement	
m) Each LMHA will complete a minimum of 80% of approved prevention goals and objectives.		See Addendum

2) Plans to Incorporate Performance Measures

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

Lincoln County has been and is currently still in a very dynamic planning process. Almost all of the Behavioral Health programs (Adult Mental Health, Child & Family, Addictions Recovery Program, Problem Gambling) are under the umbrella of the Federally Qualified Health Center (FQHC). The one exception is Developmental Disabilities, which is independent of the FQHC. Several of the performance measures described above are addressed through the FQHC's Quality Management/Quality Improvement Plan (access, initiation and engagement). These 3 performance indicators are used to focus on how successful each clinic (and, in some cases, each clinician) is regarding that initial contact and ability to fully engage individuals in treatment. With data on no shows, cancellations and follow-through, we are able to set goals regarding the process of entering treatment, look at EBPs that support increased engagement, and work with the Behavioral Health Management Team to planfully transition from one way of providing treatment to another.

Data on hospitalization and response to discharges are used to focus on the effectiveness of current processes and to identify where improvement is needed. This data is used to plan for and support the development of an ACT Team, which the County now lacks. This data has also been used to plan how discharges are addressed, so that the Adult Mental Health Program does not end up in a chaotic, crisis-driven environment, but is able to provide both clinical staff and outside providers with a clear process for serving individuals who are discharged from a hospital setting.

Data on ITRS funding and the successful reunification of families is actively used, primarily in the moment, to provide effective treatment for parents and caretakers who are struggling with substance use. Success for these individuals is often based in the type of support they receive while in treatment, such as financial help with medications or transportation. The feedback we receive on these resources is immediate – the individual either follows through with treatment, maintains sobriety and is able to find work, allowing the individual to keep their housing and ties to family, or the individual is not able to stop using, does not engage well with treatment, and the family is at risk for being separated. A member of the DHS/Child Welfare Addictions Recovery Team attends the Addictions weekly staff meetings and current ITRS cases are discussed. Planning for how to best use ITRS funding is done during Addictions Team meetings and staff retreats, when the treatment team looks at what has worked/not worked and

uses that information to suggest different groups, hours of service, etc.

Housing status, employment, school performance and criminal justice involvement measures are used now as measurable objectives on both adult and child ISSPs, and will continue to be used in this way. Lincoln County has a Mental Health and a Drug Court, as well as "Accountability Court" for DD individuals. These legal systems are shown to reduce recidivism as well as increase participation in treatment. Community response has been very positive and as long as funding to support these systems exists, they will be an integral aspect of an overall plan for addressing mental health and addictions.

Prevention goals guide the approach that community groups and institutions take, both in planning meetings and resulting documents, as well as projects that are implemented. Prevention in general encompasses a broad range of community activities, from those that take place in the classroom to Red Ribbon Week. Feedback on these activities forms the basis of group discussions and planning in several community groups, including APARC, PAADA, the Gay/Lesbian Task Force, MHAC, and the CCO Local Community Advisory Committee, among others. Prevention goals and the ideas that are generated by the community are one of the main drivers behind innovation in Lincoln County Behavioral Health.

Part III: Budget Information

1) General Budget Information
a) Planned expenditures for services subject to the contract: \$552,303.16
2) Special Funding Allocation

Area	Allocation/Comments	Review	
		Yes	No
a) Maintenance of Effort attestation for Beer and Wine Tax funding of addictions prevention and treatment services.	\$16,724.68 Prevention & Treatment		
b) Use of lottery funds allocated for Problem Gambling prevention and treatment.	\$67,500 Treatment \$24,432 Prevention		
c) Use of funds allocated for alcohol and other drug use prevention.	\$115,956.51 Prevention		

Additional Information (Optional)
a) What are the current/upcoming training and technical assistance needs of the LMHA related to system changes and future development? <i>This piece will be added later.</i>

ADDENDUM: PART II-PERFORMANCE MEASURES, CURRENT DATA AVAILABLE

A-C) Access to Services: 2011-2012

Quarter of Report (from mm/dd/yy to mm/dd/yy)		1/1/11 through 1/31/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	0	0	0	0	0
Emergency	0	0	0	0	0
Urgent	6	3	3	0	0
Routine	128	70	31	1	26
Totals:	134	73	34	1	26
Comments/Action Plan					
26 routine calls were put aside as “unable to contact” during the required time period despite multiple attempts to do so.					
One routine item placed in the “Unsure” category for the following reason:					
1) Client was not clearly identified, unable to verify data in electronic medical records (multiple clients, same name, different DOB and addresses).					

Quarter of Report (from mm/dd/yy to mm/dd/yy)		2/1/11 through 2/28/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	0	0	0	0	0
Emergency	0	0	0	0	0
Urgent	0	0	0	0	0
Routine	68	32	19	0	17
Totals:	68	32	19	0	17
Comments/Action Plan					
17 routine calls were put aside as “unable to contact” during the required time period despite multiple attempts to do so.					
We expect to see significant improvement in “met expectation” rates beginning with the March data, as we began “Open Access” mid-March.					

Quarter of Report (from mm/dd/yy to mm/dd/yy)		3/1/11 through 3/31/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	0	0	0	0	0
Emergency	4	4	0	0	0
Urgent	1	1	0	0	0
Routine	126	107	9	2	8
Totals:	131	112	9	2	8

Comments/Action Plan					
Mid March we began our open access services. As expected it has resolved much of our access issues. We should see even better success for April since it will have the whole month under the open access model. This is exciting improvement.					

Quarter of Report (from mm/dd/yy to mm/dd/yy)		4/1/11 through 4/30/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	39	39	0	0	0
Emergency	10	10	0	0	0
Urgent	2	2	0	0	0
Routine	96	96	0	0	0
Totals:	147	147	0	0	0

Comments/Action Plan					
100% Met expectations!					
Mid-March HHS began open access services. As expected, it has resolved our access issues. This is exciting improvement.					

Quarter of Report (from mm/dd/yy to mm/dd/yy)		5/1/11 through 5/31/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	51				
Emergency	2				
Urgent	1				
Routine	39		0	0	0
Totals:	93				

Quarter of Report (from mm/dd/yy to mm/dd/yy)		6/1/11 through 6/30/11			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	Unsure	Unable to contact
Urgent-Emergency	34	34	0	0	0
Emergency	1	1	0	0	0
Urgent	1	1	0	0	0
Routine	75	81	0	0	0
Totals:	111	111	0	0	0

Quarter of Report (from mm/dd/yy to mm/dd/yy)		7/1/2011 through 7/31/2011			
Indicator:		Call Tracking/Access			
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations	

Urgent-Emergency	10	10	0	100%
Emergency	0	0	0	n/a
Urgent	1	1	1	100%
Routine	85	81	4	95.3%
Totals:	96	92	5	98.4%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		8/1/2011 through 8/31/2011		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	17	17	0	100%
Emergency	4	4	0	100%
Urgent	1	1	0	100%
Routine	82	80	2	99.97%
Totals:	104	102	2	99.99%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		9/1/2011 through 9/30/2011		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	10	10	0	100%
Emergency	3	10	0	100%
Urgent	3	2	1	66%
Routine	73	73	0	100%
Totals:	89	88	1	91.5%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		10/1/2011 – 10/31/2011		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	27	27	0	100%
Emergency	0	n/a	n/a	n/a
Urgent	0	n/a	n/a	n/a
Routine	69	69	0	100%
Totals:	96	96	0	100%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		11/1/2011-11/30/2011		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	7	7	0	100%
Emergency	0	0	0	n/a
Urgent	0	0	0	n/a
Routine	83	83	0	100%
Totals:	90	90	0	100%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		12/1/2011 through 12/31/2011		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	13	13	0	100
Emergency	0	0	0	n/a
Urgent	0	0	0	n/a
Routine	69	69	0	100
Totals:	82	82	0	100

Quarter of Report (from mm/dd/yy to mm/dd/yy)		1/1/2012 through 1/31/2012		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	56	56	0	100%
Emergency	3	3	0	100%
Urgent	0	n/a	n/a	n/a
Routine	80	80	0	100%
Totals:	139	139	0	100%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		2/1/12 through 2/29/12		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	0	n/a	n/a	n/a
Emergency	46	46	0	100%
Urgent	2	2	0	100%
Routine	90	90	0	100%
Totals:	138	138	0	100%

Quarter of Report (from mm/dd/yy to mm/dd/yy)		3/1/12 through 3/31/2012		
Indicator:		Call Tracking/Access		
	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	10	10	0	100%
Emergency	19	19	0	100%
Urgent	1	1	0	100%
Routine	81	81	0	100%
Totals:	111	111	0	100%

April 2012 Began Tracking C) Engagement to Services, 3 visits within 30 days

Quarter of Report (from mm/dd/yy to mm/dd/yy)		4/1/2012 through 4/30/2012		
Indicator:		Call Tracking/Access, Engagement		

Call Tracking/Access	Total Calls	Met Expectations	to Services	
			Failed Expectations	% Met Expectations
Urgent-Emergency	36	36	0	100
Emergency	10	10	0	100
Urgent	0	n/a	n/a	n/a
Routine	105	104	1	99
Totals:	151	150	1	99.66

Engagement to Services (3 visits within 30 days)

Routine Cases: 105

Of 105 Routine cases, 104 met criteria for being seen within 14 calendar days. Of those 104, 58 No-showed their given appointment times, 5 more left without being seen and 2 were unclear. Of the 58 who no-showed, 10 came back and received screenings. Of the 10 screened, 1 was referred to private provider, 5 did not qualify for additional service, and 4 were seen for additional appointments. Of the 4 seen additional times, 3 met criteria for engagement. Of the 5 who left without being seen, 2 returned and were seen for additional appointments. The 2 remaining did not return.

Of the 39 routine cases that kept their given appointment times, 23 were screened and determined to not meet criteria for additional services. The remaining 16 routine cases were screened, and of those:

one case had one additional appointment, 5 cases had two appointments and 8 cases had at least 3 appointments within 30 days. The final 2 cases had 3 or more appointments, but did not receive all three appointments within the 30 days timeline.

Emergency Cases: 10

Of the 10 Emergency cases, all met criteria for being seen. For engagement to service, 1 was referred to AOD, 2 were referred to private providers. 3 were screened but did not meet criteria for additional services. Of the remaining 4 cases, 3 met criteria for engagement to services, and the final case had three appointments or more, but not within the 30 day timeline.

Urgent/Emergency Cases: 36

Of 36 cases, all were seen in the required timeline. For engagement to services, 4 were existing clients. Of the remaining 32 cases, 8 received three or more visits within 30 days. 4 received 2 visits within 30 days, and 16 received one visit within 30 days. There was one case which received 3 visits, but not within the 30 day timeline.

Quarter of Report (from mm/dd/yy to mm/dd/yy)			5/1/2012 through 5/31/2012	
Indicator:			Call Tracking/Access, Engagement to Services	
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	39	34	5 (unsure)	87%
Emergency	1	1	0	100%
Urgent	0	n/a	n/a	n/a
Routine	105	105	0	100%
Totals:	145			95.67
Engagement to Services:				
Of 105 Routine cases , 43 individuals 'No Showed' their first offered appointment. 12				

cases were referred out [55], three cases left without being seen [58], and one case canceled appointment with offer of another appointment time [59]. The final case, the client was in jail. [60]

For Engagement to services of Routine Cases: of the 45 cases who **kept** their first offered appointment, 13 received screens and did not meet criteria for additional services[32]. 10 met engagement criteria for three visits in 30 days [22], nine cases had two appointments in 30 days [13], and eight cases had one appointment in 30 days [5]. Two cases had three appointments, but not within 30 days [3], and two cases had two appointments, but not within 30 days [1]. There was also one case referred to the Addictions program [0].

Of the 43 “**No show**” cases, 34 did not return for services [9]. Of the 9 that returned for services, 7 received one appointment in 30 days (there were multiple cancellations or no-shows to scheduled appointments in this group) [2]. One case received at least 4 appointments, but not within 30 days [1], and one case was referred to Addictions, and no-showed or canceled all remaining scheduled appointments [0].

Emergency cases: there was one. This case was accepted into Hand in Hand, but only showed up for one appointment in 30 days.

Of 38 **Urgent/Emergent cases**, 34 met criteria for access. Five were unsure as records in OCHIN are unclear.

Of the 34 that met access criteria, 4 did not meet criteria for additional services (30), One client met access criteria, however, died before engagement into service (29). 14 met criteria for engagement to services (3 appointments in 30 days) [15]. Three cases received 2 appointments in 30 days [12], eight cases received one appointment in 30 days[4]. Two cases were referred out for service [2], and two cases were given appointments (and would have met criteria for engagement) but the clients canceled or no-showed the given appointments [0].

Quarter of Report (from mm/dd/yy to mm/dd/yy)		6/1/2012 through 6/30/2012		
Indicator:		Call Tracking/Access, Engagement to Services		
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	37	37	0	100
Emergency	6	6	0	100
Urgent	5	5	0	100
Routine	66	66	0	100
Totals:	114	114	0	100%
Engagement to Services:				
Urgent Emergency: of 37 cases, 4 were existing clients (33). Of those, 13 met engagement criteria (20). Five more received 2 appointments within 30 days (15). The remaining 15 cases received one appointment within 30 days (0).				
Emergency: of 6 cases, one was an existing client (5). One case met engagement criteria (4) and four cases received 2 appointments within 30 days (0).				
Urgent: of 5 cases, one was an existing client. Of the remaining cases, two met criteria for engagement (2). The remaining two cases received two appointments within 30 days.				
Routine: Of the 66 routine cases, 24 ‘No-showed’ their given appointment times (42). Nine were referred out to private providers (33). Eight cases are “unknown” as there are				

no client records in OCHIN (25). Four cases were existing clients (21) and two cases the services offered were declined (19).

Of the 19 remaining cases: Six met criteria for engagement. Four cases received two appointments (10). Seven received one appointment (17), and two received 3 appointments, but not in 30 days (19).

Quarter of Report (from mm/dd/yy to mm/dd/yy)		7/1/12 through 7/31/12		
Indicator:		Call Tracking/Access, Engagement to Services		
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	53	53	0	100
Emergency	1	1	0	100
Urgent	5	5	0	100
Routine	73	73	0	100
Totals:	132	132	0	100

Engagement to Services: Clients who have received 3 or more visits in 30 days

Total crisis/protocall numbers = 73

Of those 53 were Urgent/Emergent. Of those:

28 were seen at least 1 time in 30 days

7 were seen at least 2 times in 30 days

18 were seen 3 or more times in 30 days

Of the 73 crisis, 1 was Emergent. That one was seen 3 or more times in one month.

Of the 73 crisis, 5 were Urgent. Of those:

1 was seen, then referred

1 was seen 1 time in 30 days

1 was seen 2 times in 30 days

2 were seen 3 or more times in 30 days.

Of the Protocall numbers = 14

5 were anonymous callers and disposition is unknown

3 were not seen within 30 days of call to Protocall

2 were seen 1 time within 30 days of call to Protocall

3 were seen 3 or more times within 30 days of call to Protocall

Total Routine numbers = 73

Of those, 43 were no show to the first offered appointment

Of those who no-showed, 37 did not returned for services

Of the 6 who returned for services, 2 were seen 2 times in 30 days and 4 were seen 1 time in 30 days.

Of the 30 who kept their initial appointment, 1 decided not to engage in services.

Of the remaining 29 who kept the initial appointment:

1 had zero appointments in 30 days

8 had 1 appointment in 30 days

8 had 2 appointments in 30 days

13 had 3 or more appointments in 30 days

Quarter of Report (from mm/dd/yy to mm/dd/yy)		8/1/12 through 8/31/12		
Indicator:		Call Tracking/Access, Engagement		

Call Tracking/Access	Total Calls	Met Expectations	to Services	
			Failed Expectations	% Met Expectations
Urgent-Emergency	54	54	0	100
Emergency	2	2	0	100
Urgent	6	6	0	100
Routine	74	74	0	100
Totals:	136	136	0	100

Engagement to Services:

Total Crisis/Protocall numbers: 62

Urgent/Emergent = 33, of which 2 were seen then referred out. Of the remaining 31 U/E:

12 were seen 1 time in 30 days

8 were seen 2 times in 30 days

11 were seen 3 or more times in 30 days

Emergency = 2. 1 was seen 1 time in 30 days; 1 was seen 2 times in 30 days.

Urgent = 6, of which 1 was seen then referred out. Of the remaining 5 U:

3 were seen 1 time within 30 days

1 was seen 2 times in 30 days

1 was seen 3 or more times in 30 days

Protocall: 21

Of the total, 7 were anonymous or not registered in OCHIN

Of the remaining 14:

4 were seen zero times

3 were seen 1 time in 30 days

1 was seen 2 times in 30 days

6 were seen 3 or more times in 30 days

Routine: 74

Of those, 39 no-showed the initial appointment

Of those, 32 did NOT return for services. Of the remaining 7 that returned for services:

2 were referred out

3 were seen 1 time in 30 days

2 were seen 3 or more times in 30 days

Of the 35 who KEPT the initial appointment, 7 were referred out

Of the remaining 28,

15 were seen 1 time in 30 days

4 were seen 2 times in 30 days

9 were seen 3 or more times in 30 days

Quarter of Report (from mm/dd/yy to mm/dd/yy)			9/1/2012 through 9/30/2012	
Indicator:			Call Tracking/Access, Engagement to Services	
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency				
Emergency				
Urgent				
Routine				

Totals:				
Engagement to Services:				
Total Crisis/ProtoCall: 62				
<u>Total Urgent/Emergent: 26</u>				
Of those, 4 were seen 1 time and then referred out. Of the remaining 22 U/E,				
12 were seen 1 time in 30 days				
8 were seen 2 times in 30 days				
2 were seen 3 or more times in 30 days				
<u>Total Emergency: 4</u>				
Of those, 1 was seen 1 time and then referred out. Of the remaining 3 Emergency,				
2 were seen 1 time in 30 days				
1 was seen 2 times in 30 days				
<u>Total Urgent: 1</u>				
The urgent contact was seen once and then referred out				
<u>Total ProtoCall: 31</u>				
7 were anonymous or not registered in OCHIN. Of the remaining 24,				
6 were seen zero times in 30 days				
7 were seen 1 time in 30 days				
1 was seen 2 times in 30 days				
10 were seen 3 or more times in 30 days.				
Total Routine: 88				
Of the 88, 51 failed to keep their first offered appointment. Of those,				
41 did NOT return to be seen. Of the remaining 10 who returned,				
6 were seen 1 time in 30 days				
2 were seen 2 times in 30 days				
2 were seen 3 or more times in 30 days				
Total Kept initial appointments: 37				
8 were seen 1 time and then referred out. Of the remaining 28,				
18 were seen 1 time in 30 days				
6 were seen 2 times in 30 days				
4 were seen 3 or more times in 30 days.				

Quarter of Report (from mm/dd/yy to mm/dd/yy)		10/1/2012 through 10/31/2012		
Indicator:		Call Tracking/Access, Engagement to Services		
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	28	28	0	100
Emergency	9	9	0	100
Urgent	23	23	0	100
Routine	94	94	0	100
Totals:	154	154	0	100
Engagement to Services: 3 visits in 30 days				
Routine Contacts: 94				
Of the 94, 49 no-showed their first offered appointment				
Of the 49 no-shows, 2 did not return to be seen. Of the remaining 47 "no shows,"				
16 returned to be seen. 4 of those were referred out to other services. Of the remaining				

12:

3 were offered 1 visit in 30 days

7 were offered 2 visits in 30 days

2 were offered 3 or more visits in 30 days

Of the remaining 45 Routine contacts who kept their first offered appointment,

11 were referred out to other services

13 were offered 1 visit in 30 days

4 were offered 2 visits in 30 days

9 were offered 3 or more visits in 30 days

Crisis Contacts: 60

3 were referred out to other services

4 were offered zero visits in 30 days

19 were offered 1 visit in 30 days

11 were offered 2 visits in 30 days

23 were offered 3 or more visits in 30 days

Quarter of Report (from mm/dd/yy to mm/dd/yy)		11/1/2012 through 11/30/2012		
Indicator:		Call Tracking/Access, Engagement to Services		
Call Tracking/Access	Total Calls	Met Expectations	Failed Expectations	% Met Expectations
Urgent-Emergency	27	27	0	100
Emergency	4	4	0	100
Urgent	25	25	0	100
Routine	60	60	0	100
Totals:	116	116	0	100
Engagement to Services: offered 3 or more visits in 30 days				
ROUTINE: 60				
31 No showed their first offered appointment. Of those no-shows, none returned for appointments				
29 kept their first offered visits, and of those:				
8 were referred out for other services				
3 were offered 1 visit in 30 days				
7 were offered 2 visits in 30 days				
11 were offered 3 or more visits in 30 days				
CRISIS: 56				
1 was anonymous (Protocall)				
5 were unknown (Protocall)				
Of the remaining 50 contacts,				
7 were referred out to other services				
3 were offered 0 visits in 30 days				
11 were offered 1 visit in 30 days				
11 were offered 2 visits in 30 days				
18 were offered 3 or more visits in 30 days				

Quarter of Report (from mm/dd/yy to mm/dd/yy)		12/1/2012 through 12/31/2012		
Indicator:		Call Tracking/Access, Engagement to Services		

Call Tracking/Access	Total Calls	Met Expectations	to Services	
			Failed Expectations	% Met Expectations
Urgent-Emergency	36	36	0	100
Emergency	5	5	0	100
Urgent	31	31	0	100
Routine	58	58	0	100
Totals:	130	130	130	100

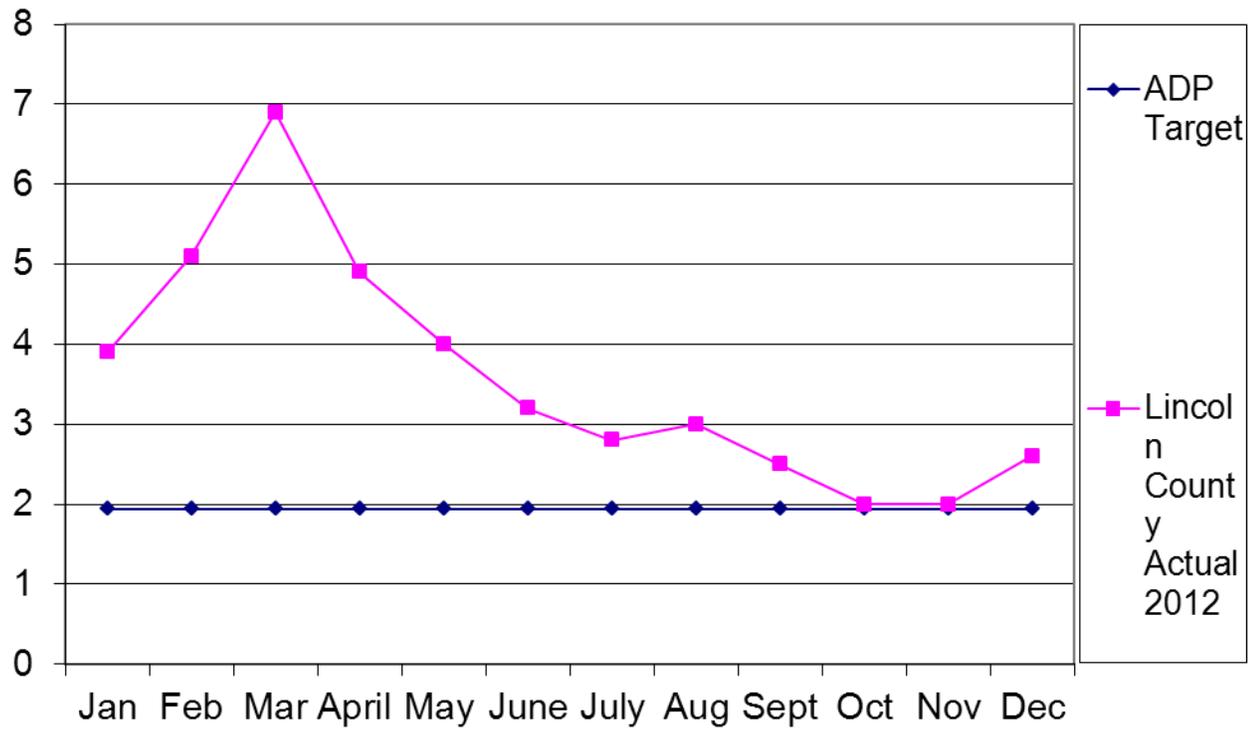
Engagement to Services:

ROUTINE: 58
21 "No Showed" the first offered appointment, none of those returned for appointments
Of the remaining 37,
8 were referred out for other services
10 were offered 1 visit in 30 days
11 were offered 2 visits in 30 days
8 were offered 3 or more visits in 30 days
CRISIS: 72
4 anonymous contacts (Protocall) [4 urgent contacts]
7 unknowns (Protocall) [7 urgent contacts]
4 were referred out for other services [4 urgent contacts]
Of the remaining 57,
17 were offered 1 visit in 30 days
15 were offered 2 visits in 30 days
25 were offered 3 or more visits in 30 days

ADDENDUM: PERFORMANCE MEASURES –

K) Stay at or below a target ADP of individuals for which the county is responsible in the state hospital psychiatric recovery program.

Lincoln County Actual ADP 2012



ADDENDUM: PERFORMANCE MEASURES –

M) Each LMHA will complete a minimum of 80% of approved prevention goals and objectives.

Lincoln County Biennial Plan Update (2011-2013)

29a.

Youth Strategies:

Alcohol/Drug and Gambling prevention presentations in classrooms/community, media, information dissemination, Annual Oregon Problem Gambling Art Search for grades 6-8 and promote Problem Gambling Helpline, 1-877-MY-LIMIT or 1877MYLIMIT.ORG, as well as, local resources. Strategy goals are to avoid or reduce teen alcohol/drug abuse, reduce risk of addiction and increase healthy decision making.

Older Adult Strategies:

Gambling prevention presentations at senior centers/retirement homes/community, media and information dissemination, including promoting Problem Gambling Helpline, as well as, local resources. Strategy goals are to avoid or reduce the risk of addiction and consequences to self, family and community.

33. Top Three Priorities

- Reduce teen alcohol use
- Reduce teen drug use
- Increase community engagement

34.

	Priorities	Evidence-based Practice	Projected funding	Outcomes
Priority 1	Reduce teen alcohol use	Support Pure Performance initiative.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Track fidelity of program. • Decrease MIP infractions at school from baseline by 10%.
		Identify and support the training of peer leaders in school.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • 50% of peer leaders will report an increase in leadership/motivation skills. • 50% of peer leaders will report increased knowledge regarding the negative impact of underage drinking/drug use.

				<ul style="list-style-type: none"> • 3% decrease in alcohol/drug use as reported by OHT.
		Support site councils in school district to increase mentoring/tutoring programs.	AD 70	<i>Measurement:</i> Youth will demonstrate: <ul style="list-style-type: none"> • Improvement in school performance. • 3% decrease in alcohol/drug use as reported by OHT. • 5% decrease in school drop out as reported by LCSD.
		Support School District in delivery of county-wide, evidence-based prevention curriculum.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • 50% of participating school staff will report students demonstrating knowledge, modified behaviors and improved conditions. • Decrease teen alcohol/drug use by 3% as reported by OHT.
Priority 2	Reduce teen drug use	Support youth driven PSAs and Drug Awareness Project/Youth Film Project.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • 50% of youth participants will report an increase in knowledge regarding the impact of underage drinking/drug use per youth survey. • Decrease alcohol/drug use by 3% as reported by OHT.
		Prevention staff to build/support "Parent Network"	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Increase parental involvement. • Two parent trainings. • 100 parents involved in Parent Network.

				<ul style="list-style-type: none"> • Decrease underage drinking/drug use by 3% as reported by OHT. • 5% decrease in school drop out as reported by LCSD.
		Support Prescription Drug Drop Box Program Countywide	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Quarterly media announcements regarding details of the program. • Decrease youth prescription drug use by 3% as reported by OHT.
Priority 3	Increase community engagement	Host four community forums/town halls throughout Lincoln County; review data and trends about underage drinking/drug abuse and provide community with reports & updates.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Community members will report an increase in knowledge/awareness regarding the negative impact underage of underage drinking/drug abuse per community survey.
		Prevention staff to participate/support Drug Free Workplace efforts in Lincoln County	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Increase number of Lincoln County employers to implement Drug Free Workplace policies to address substance abuse issues.
		Prevention staff to participate/support EUDL efforts, including recruiting EUDL volunteers.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Increase EUDL participation/volunteers by 10%. • Decrease underage drinking by 3% as reported by OHT.
		Prevention staff to organize and attend quarterly	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Increase effectiveness and

		Community Prevention Team meetings to develop, implement and support a variety of joint projects.		<p>efficiency of community prevention resources.</p> <ul style="list-style-type: none"> • Increase community participation in prevention strategies.
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35.

	Support/maintain local coalitions	Projected funding	Outcomes
Strategy 1	Prevention staff to participate in five existing community coalition meetings (Youth Development Coalition, Hispanic Cultural Coalition, Partnership Against Alcohol and Drug Abuse, East County Community Partnership and Community Efforts Demonstrating the Ability to Rebuild and Restore) and provide technical assistance for evidence-based prevention strategies and programmatic activities for local coalitions.	AD 70	<p><i>Measurement:</i> Increase coalition membership by 10%:</p> <ul style="list-style-type: none"> • Identify/invite new partners. • Encourage members to bring guests to meetings. • Disperse member packets/member ship applications. <p>80% of coalition prevention activities will be evidenced-based practices.</p>
Strategy 2	Prevention staff to collaborate efforts with coalitions to support Recovery Month activities.	AD 70	<p><i>Measurement:</i></p> <ul style="list-style-type: none"> • 15% increase in community participation. • Five media stories will be published (print and/or radio).
Strategy 3	Recognize community	AD 70	<p><i>Measurement:</i></p> <ul style="list-style-type: none"> • Increase number

	coalitions and other community volunteers by collaboration with the School District and APARC (Addiction Prevention and Recovery Committee) in the organization of community “Make a Difference” recognition week.		of schools, businesses, agencies and community members who participate in the annual event by 15%. <ul style="list-style-type: none"> • Five media stories will be published (print and/or radio).
Strategy 4	Build and enhance sustainability of community coalition by providing technical assistance in at least one grant application.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • At least one grant application completed.
Strategy 5	Prevention staff to assist with the structuring of a new Lincoln City Coalition.	AD 70	<i>Measurement:</i> <ul style="list-style-type: none"> • Create a Logic Model. • Formative and summative evaluations.

36. The Lincoln County Prevention Program will continue to collaborate with a group of local professionals to focus on working and connecting with the Latino community. The group, currently called, Almost A Coalition (AAC), began in September 2009. The group meets monthly to discuss numerous cultural considerations in order to better serve the Latino community in Lincoln County. Issues include; lack of access to mental health and addiction services, no bilingual providers, depression, lack of resource information in Spanish, etc. Almost A Coalition will continue to expand and be effective. The Lincoln County Prevention Program will also continue to collaborate efforts with the Siletz Tribal Community / Community Efforts Demonstrating the Ability to Rebuild and Restore (CEDARR.). CEDARR’s mission is to work to use resources to eradicate and prevent the use of all illegal drugs, underage drinking and abusive use of alcohol, delinquency and community violence. CEDARR will continue efforts to obtain a Drug Free Communities Grant.

The Lincoln County Prevention Program does not provide any evidence-based program or gender specific program. Universal efforts are used in regards to providing prevention education/awareness.

**2011-2012 Problem Gambling
Prevention/Awareness (AD 80) Plan**

Date: June 6, 2011

County: Lincoln

Agency Information

Name: Lincoln Commission on Children & Families

Agency Address: **351 SE Harney Street**

City, State, Zip: Newport, OR, 97365

Phone: 541-574-3305

Fax:

Agency Director: Barbara Dougherty

Problem Gambling Program Director: Barbara Dougherty

Problem Gambling Prevention/Awareness Program

Prev. Coordinator: Jennifer Versteeg

Phone: 541-574-3305

E-mail Address: Jversteeg@co.lincoln.or.us

check here if you are also the A/D prevention coordinator

check here if you are a Certified Prevention Specialist (CPS)

Fiscal Issues

Contact Person: Jennifer Versteeg

Phone: 541-574-3305

E-mail Address: Jversteeg@co.lincoln.or.us

2011-12 Problem Gambling Prevention/Awareness Plan

County: Lincoln

Prevention Coordinator: Jennifer Versteeg

See attached sample. Using the grid below, list all the proposed programs for which the County is requesting AD 80 funding in '11-12. All outcomes must be measurable. **Add extra sheets as needed.**

Proposed Programs/activities	Outcomes	Measures
<p>At least one activity must be based on 2010 Student Wellness Survey data: indicate that activity in this box and cite the SWS data point(s) upon which it is based:</p> <p>Target Age: 6th & 8th grade students.</p> <p>Activity: Based on Table 20, 2010 Student Wellness Survey, Communication about the risks of gambling 58% of grade 6 teachers and 47% of grade 8 teachers have talked to students about the risks of betting/ gambling</p> <p>Will Provide 6th and 8th grade health curriculum teachers with current information on adolescent brain development and gambling prevention materials.</p>	<ul style="list-style-type: none"> 75% of 6th teachers & 60% of 8th grade teachers will incorporate gambling prevention curriculum. 	<ul style="list-style-type: none"> Percentage of students reporting that teachers have talked to students about the risks of betting/ gambling will increase by 10%
<p>At least one activity must infuse problem gambling prevention into an existing prevention activity/program/initiative; indicate that activity here:</p> <p>Increase general awareness about problem gambling</p>	<ul style="list-style-type: none"> Improve agency/county web information on problem gambling Develop one new psa or media release for OPGAW 	<ul style="list-style-type: none"> Agency/county website will have current and accurate information on problem gambling PSA or media release will reach at least 10,000 local

	<ul style="list-style-type: none"> • Contact six schools and youth groups regarding participation in annual OPGAW art search • Provide a supply of helpline brochures and posters and information on how to order more to at least 20 sites 	<p>residents based on viewer or readership numbers</p> <ul style="list-style-type: none"> • 25% more students/youth group members will participate in art search compared to '11 • Helpline brochures and posters will be available to the public in at least locations
<p>Increase knowledge of Problem Gambling Coordinator</p>	<ul style="list-style-type: none"> • Review Oregon Problem Gambling Community Resource Guide and other gambling prevention materials • Complete Prevention Specialist co-hort training • Increase gambling prevention resource network 	<ul style="list-style-type: none"> • Identify two ways to raise gambling awareness in the community • Obtain CPS Certification • Attend 50% of OPG provider meetings and a minimum of 2 OPG webinars

Lincoln County Biennial Implementation Plan 2013 - 2015

2011-2012 Problem Gambling Prevention/Awareness Budget

County: Lincoln

Gambling Prevention/Outreach Contact Person: **Jennifer Versteeg**

Email: Jversteeg@co.lincoln.or.us

Fiscal Contact Person: **Jennifer Versteeg**

Email: Jversteeg@co.lincoln.or.us

Total projected funding available for 11-12: ___\$24,432___

Budget Category	AD 80 Funds 7/1/11-6/30/12	Comments (optional)
Personnel	\$21,602	Includes salary and benefits for Prevention Coordinator
Professional Development, Trainings, Conferences	\$200.00	
Program	\$1,315.00	Includes printing, office supplies, professional publications/texts/journals
Other (specify) Office, utilities	\$1,315.00	Includes travel, lodging, meals
TOTAL	\$24,432	

Required Signatures:

Program Manager:

Fiscal staff:

Prevention/awareness staff: