
Oregon Health Authority – Addictions and Mental Health Division (AMH)

Biennial Implementation Plan Guidelines

2013-2015

AMH developed the following guidelines in consultation with key county representatives and stakeholder advisory groups. The guidelines are designed to keep counties and AMH in compliance with statutes, block grants and other federal requirements. While flexible funding gives each county the freedom to spend local resources in the way that will best achieve health outcomes in its community, the biennial implementation plans will show how counties will meet those outcomes. To support success, AMH will provide resources and technical assistance to help develop plans that will meet each community's needs.

General Guidelines:

- Local Mental Health Authorities (LMHAs) will use information from their community needs assessment (Section 2) to describe the overall system, strengths and areas for improvement in the system, and a budget plan for the biennium.
- This information will be submitted in the form of a Biennial Implementation Plan (BIP) to AMH by March 1, 2013.
- AMH is available to provide technical assistance in the development of the BIP.
- AMH will conduct a review and approval process upon receipt of the plans.
- General review criteria can be found following each section, to help clarify the required information.
- AMH will notify each LMHA of any areas needing additional information, and when plans have been approved.
- Plans requiring additional information must be completed and approved prior to the effective date of the contract for the 2013-2015 biennium.

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
<p>a) Provide an overview of the County’s current addictions and mental health services and supports system, including:</p> <ul style="list-style-type: none">• Mental Health Promotion• Mental Illness, Substance Abuse and Problem Gambling Prevention• Early intervention• Treatment and recovery• Crisis and respite services• Services available to required populations and specialty populations• Activities that support individuals in directing their treatment services and supports
<p>Review Criteria:</p> <ul style="list-style-type: none">• Plan addresses each area.• Specific services and supports are described.• Plan prioritizes populations and addresses specialty populations, giving specific examples.• Plan incorporates the Strategic Prevention Framework to guide local prevention planning and program

implementation.

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

There are no subcontractors in Tillamook County in the delivery of addictions and mental health services.

Review Criteria:

- **List includes all services provided by the LMHA and all sub-contractors of the LMHA.**

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

The Executive Director of Tillamook Family Counseling Center is a Board Member of the Columbia Pacific CCO. The plan is to have the CCO Community Needs Assessment merge somewhat with the needs assessment process required for the Biennial Implementation Plan. The LMHA is very invested in working closely with the CPCCO and is very supportive of the current collaboration between the Health Department and Tillamook Family Counseling Center (Behavioral Health Consultant within Primary Care). An emerging collaboration should continue with the ramping up of the CPCCO's Consumer Advisory Council and the Clinical Advisory Panel.

Review Criteria:

- **Description includes current collaboration and plans for future collaboration as the new system is developed.**
- **Collaboration efforts include the community needs assessment.**

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

Review Criteria:

- **Complete list included with stakeholder representation.**
- **Representation required by statute is met, or plan included addressing any gaps in representation.**

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.

July 2013- A copy of a document describing the community needs assessment and the process is included with the submission to AMH on July 29th

Review Criteria:

- **Process is clear.**
- **The role of peers and family is described and is meaningful.**
- **Reference to supporting documents is included where applicable.**

- b) Describe how data from the community needs assessment is used to evaluate prevalence, needs and strengths in the local service system. **(Note information submitted under 2a)**

Review Criteria:

- **Data used is relevant and includes priority and specialty populations**

- **Evaluation is informed by and shows connection of data to other community service systems**
- **Prevalence, needs and strengths are all addressed and the use of data in each area is described.**

c) How does the community needs assessment process include feedback from advisory and quality improvement groups? Please identify the specific groups. (Note information submitted under 2a)

Review Criteria:

- **What groups did feedback come from?**
- **How is the feedback obtained?**
- **How is the feedback used?**

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. (see comments in 2a)

Review Criteria:

- **Reflects Community Needs Assessment.**
- **Identified strengths and areas for improvement match data and other information referenced in the community needs assessment.**
- **Plans to maintain and develop strengths are addressed in each area.**
- **Strategies to make improvements are described and match performance goal strategies where applicable.**

Area	Strength or Area for Improvement	Plan to Maintain Strength or Address Areas Needing Improvement
a) Mental Health Promotion	<ul style="list-style-type: none"> - mental health education and consultation for stakeholder agencies -current collaboration with schools related to at-risk youth -promotion of health and wellness with primary care integration pilot 	<ul style="list-style-type: none"> -maintain strength of community collaborations -continue collaborations/training with child serving providers -Consider initiating outreach to Senior Services Sites in Tillamook County
b) Mental Illness Prevention	(note areas indicated above)	(note areas indicated above)
c) Substance Abuse Prevention	<ul style="list-style-type: none"> -continue school-based prevention groups and emerging County Prevention Coalition -continue grant-funded young adult and underage drinking initiative 	<ul style="list-style-type: none"> -develop and build on the South Tillamook County Prevention Coalition as a component of the grant-funded initiative
d) Problem Gambling Prevention	<ul style="list-style-type: none"> -maintain focus on youth prevention through annual Middle School Art Contest -continue access to training for Financial Institutions via website 	<ul style="list-style-type: none"> -continue community presentations and contacts via PSA's and written media -explore collaboration with young adults thru Community College partnership -develop a presentation targeting Certified Public Accountants in Tillamook County to enhance awareness
e) Suicide Prevention	<ul style="list-style-type: none"> -community training has reached more than 75 stakeholders, advocates and professionals (Assist and QPR) 	<ul style="list-style-type: none"> -continue community outreach, training and collaborations

<p>f) Treatment:</p> <ul style="list-style-type: none"> • Mental Health • Addictions • Problem Gambling 	<p>(please note areas of strength and areas for improvement are noted in the bulleted points submitted with the review of the community needs assessment)</p>	
<p>g) Maintenance/Recovery Support (Include specifics pertaining to mental health, addictions and problem gambling treatment)</p>	<p>-continue maintenance treatment groups (addictions) and collaborations with self-help recovery resources within the community -continue to co-sponsor Family Support Group (MH) -Recovery Housing</p>	<p>-maintain continued support for recovery resources within the community; connect clients routinely to natural community recovery resources, 12 Step, Celebrate Recovery, GA, Alanon, etc. -reinitiate opportunities to consider Oxford Housing in Tillamook County</p>
<p>h) The LMHA's Quality Improvement process and procedure</p>	<p>-QI Plan includes areas of assurance and target improvement areas -Agency maintains a robust client satisfaction component -QI Committee includes significant advocate involvement</p>	<p>-improvement includes outcome measurement related to the top 3 diagnostic categories with agency consumers -reorganization with Clinical Supervision to maintain and improve overall documentation within agency EMR</p>
<p>i) Service coordination and collaboration with corrections, social services, housing, education, employment and other community service agencies</p>	<p>-maintain ongoing forums with key community partners to facilitate case coordination (Child Welfare, Juvenile Court, Corrections) -maintain primary care/behavioral health integration pilot with Community Health Centers</p>	<p>-continue to build on collaborations related to primary care and school in Tillamook County -establish a satellite office site in South Tillamook County -work with MH Advisory Committee to expand on a conversation related to the feasibility of a Mental Health Court -maintain current outreach/liaison partnership with Tillamook County Jail -continue to build on opportunities to serve Tillamook County Veterans and their families -Continued need for supported housing in the community -develop supported employment services prior to January 2014</p>
	<p>-maintain BH visibility within</p>	

j) Behavioral health equity in service delivery	primary care integration pilot	
k) Meaningful peer and family involvement in service delivery and system development	-maintain partnership with CCO re: consumer and advocate participation on Consumer Advocate Committee -Peer and advocate participation with agency QI Committee and process	-maintain and encourage peer/advocate and family involvement -maintain level of peer and advocate input from MH/CD/DD Advisory Committee
l) Trauma-informed service delivery	-Mental health consultations to child serving agency staff, including Tillamook Head Start -agency staff are trained in Trauma Informed CBT -Seeking Safety is an ongoing service provided	Training of clinicians with trauma informed treatment strategies will continue during the next biennium Ongoing group services (Seeking Safety)
m) Stigma reduction	-Maintain consultative relationships with community agencies and stakeholders -Promote services as part of an overall approach to health and wellness	Engage in targeted behavioral health promotion and education Utilize print media, radio and information forums that encourage the appropriate use of agency services as options for health and wellness
n) Peer-delivered services, drop-in centers and paid peer support	-Currently, paid Peer Support (.8fte)	-Maintain current paid peer support -Explore the option of having paid peer support as a service for addictions consumers (Recovery Coaches)
o) Crisis and Respite Services	-Currently, services of Peer Mentor are available and established -Recent option of Respite for youth and adolescents has just	-Assess crisis respite needs beyond the resource of the Peer Mentor

	been established	
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Part II: Performance Measures

AMH will identify performance measures and provide baseline data for several of the measures as it becomes available. LMHAs are required to describe findings from any current data they have available in applicable areas, as well as describe a plan for addressing the performance measures in planning, development and delivery of services and supports.

1) Current Data Available		
Performance Measure	Data Currently Available	Current Measures (If available)
a) Access/Number of individuals served	Number of individuals served January thru December 2012=3198 100% of individuals covered by OHP were scheduled/seen within the 14	CPMS data and Monthly Access report

	calendar threshold	
b) Initiation of treatment services – Timely follow up after assessments	95% of individuals seen for Behavioral Health Assessments were scheduled with a follow-up appointment	Based on Individual Service Records
c) Treatment service engagement – Minimum frequency of contact within 30 days of initiation	Within 30 days of initiation of contact, minimum frequency of contact is typically the scheduling of a BHA and at least one follow up episode. (2.0 episodes)	Based on Individual Service Records
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	100% of individuals were scheduled for follow-up visits within 10 days following hospitalization or any facility based service defined as residential during the current biennium to date	Based on Individual Service Record
e) Readmission rates 30 and 180 day: (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential	Data currently not available	

f) Percent of participants in ITRS reunited with child in DHS custody	60% of participants in ITRS were reunited with children in DHS custody	Current Agency CPMS data on ITRS enrollees
a) Percent of individuals who report the same or better housing status than 1 year ago.	Currently no mechanism for gathering data for this category	
b) Percent of individuals who report the same or better employment status than 1 year ago.	Currently no mechanism for gathering data for this category	
c) Percent of individuals who report the same or better school performance status than 1 year ago.	Currently no mechanism for gathering data for this category	
d) Percent of individuals who report decrease in criminal justice involvement.	Currently no mechanism for gathering data for this category	
e) Stay at or below a target ADP of individuals for which	Current Civil Commitment ADP is 0.9 days for the period Jan-Dec 2012	Per discussion with AMH, ADP targets that include state hospital stays are

the county is responsible in the state hospital psychiatric recovery program.		being re-evaluated (2/20/13)
f) Maintain an average length of stay on the OSH ready to transition list at or below a pre-determined target	ALOS on the ready to transition list is 14 days for the Jan-Dec 2012 time frame	Current AMH data re: Ready to Transition list
g) Each LMHA will complete a minimum of 80% of approved prevention goals and objectives.	Currently on task. Completion of goals for this area exceeds the expected 80% for the 2012-13 program year	Agency review of Prevention Plan goals and objectives for 2012-13
2) Plans to Incorporate Performance Measures		
<p>a) Describe the LMHA plan to actively incorporate the performance measures into planning, development and administration of services and supports:</p> <p>TFCC will fold key performance measures into the agency Quality Plan during the 2013-15 program years. Plan is to have the agency measures align as much as possible with the key performance measures outlined with the current CCO development and the performance measures related to the Mid-Willamette Acute Care Council. We plan to engage in this process once the Community Needs Assessment is completed for the Columbia Pacific CCO. The Community Needs Assessment for the BIP identified the need for performance measures within the Quality Plan that will highlight the areas of depression, anxiety, and alcohol abuse as being the top 3 diagnostic categories served within the agency. The Quality Plan has identified the PHQ-9, the GAD-7 and a tool not yet identified (alcohol abuse) to measure agency performance and client outcomes</p>		

for these areas.

Part III: Budget Information

Budget information includes planned use of all flexible funding included in the contract and planned use of beer and wine tax funds and funds specifically allocated for problem gambling services and prevention and substance abuse prevention.

1) General Budget Information

a) Planned expenditures for services subject to the contract:

(Budget information is include on a separate form with the submission due July 31, 2013)

Review Criteria:

- **Allocation matches goals for increased performance in areas needing improvement.**
- **Allocation reflects community needs assessment.**

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.	2145 Funds: \$16,000 Allocation directed primarily for addictions treatment services.		
b) Use of lottery funds allocated for Problem Gambling prevention and treatment.	Total allocation is \$33,986 Allocation for Problem Gambling treatment and prevention for 2012-13		
c) Use of funds allocated for alcohol and other drug use prevention.	SE 70 Prevention Funds for 12/13 is \$70,000 SPF-SIG Underage Drinking Initiative is \$100,000		

Additional Information (Optional)
<p>a) What are the current/upcoming training and technical assistance needs of the LMHA related to system changes and future development?</p> <ul style="list-style-type: none">• Flexible Funding Formats• Integration of Physical Health and Behavioral Health• The Role of Housing within System Change (mental health and addictions)
<p>*No review criteria</p>

Definitions:

“Early Intervention” means clinical or preventive services for a person of any age that begin prior to or in the early stages of a mental health problem. Intervening with young children is included in this definition.

“Family” means a support person of any age identified as important to the person receiving services.

“Health Equity” means the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to rectify historical and contemporary socially patterned injustices and the elimination of health disparities.

“Mental Health Promotion” means efforts to enhance individuals’ ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity. There can be overlap between promotion and prevention efforts, depending on the population served and the target of the prevention activity.

“Mental Illness prevention” means intervening to minimize mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus, with the ultimate goal of reducing the number of future mental health problems in the population.

“Peer” means an individual who self-identifies as a consumer, survivor, ex-patient, recipient of services or person in recovery.

“Required Populations,” as defined in the Federal Block Grant, means:

- Children with Serious Emotional Disorders (SED)
- Adults with Serious Mental Illness (SMI)
- Persons who are intravenous drug users
- Women who are pregnant and have substance use and/or mental health disorders
- Parents with substance use and/or mental health disorders who have dependent children
- Persons with tuberculosis

- Persons with or at risk for HIV/AIDS and who are in addiction treatment

“Specialty Populations,” as defined in the Federal Block Grant, means:

- Adolescents with substance use and/or mental health disorders
- Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not limited to addiction, conduct disorder and depression
- Military personnel (active, guard, reserve and veteran) and their families
- American Indians/Alaskan Natives
- Persons with mental health and/or substance use disorders who are homeless or involved in the criminal or juvenile justice system
- Persons with mental health and/or substance use disorders who live in rural areas
- Underserved racial and ethnic minority and Lesbian, Gay, Bi-sexual Transgender or Questioning (LGBTQ) populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines for enforcement
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies

“Trauma-informed Services” means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of

trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.