
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

a) Provide an overview of the County's current addictions and mental health services and supports system, including:

- **Mental Health Promotion**

WVCW promotes Mental Health care through outreach programs such as Living Well with Chronic Illness and Mental Health First Aid classes.

Living Well with Chronic Conditions (the Chronic Disease Self-Management Program or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. Through weekly sessions, the workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about.

Mental Health First Aid is an evidence-based program, which originated in Australia and involves 12 hours of training that has the goal of increasing mental health literacy. Like CPR training helps a non-medical professional assist an individual following a heart attack, Mental Health First Aid training helps an individual who doesn't have clinical training assist someone experiencing a mental health crisis. In both situations, the goal is to help support

an individual until appropriate professional help arrives, with the added underlying intention to promote health literacy. Mental Health First Aiders learn to apply a single strategy in helping someone through a panic attack, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an individual who has overdosed. In practicing the intervention strategy, Mental Health First Aiders learn the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis and addiction; engage in experiential activities that build understanding of the impact of illness; and learn information about evidence-based treatment and support - ultimately building participants' mental health 'literacy'.

- **Mental Illness, Substance Abuse and Problem Gambling Prevention**

WVCW meets monthly with a wide variety of service providers in order to address determinants of health problems. This group is called the Wallowa County Network of Care and consists of traditional medical providers, non-traditional medical providers, social service providers etc. WVCW also employs three Behavior Health Consultants to work within the primary care setting to provide prevention services. The primary prevention programs are run by Building Healthy Families (BHF) and include the following..

Substance Abuse Prevention: In the 2013-2015 biennium, our focus is going to be on using our recently completed Community Readiness Assessment (CRA) to guide our work. Along with the results of the assessment and the support from the state SPF-SIG trainings, we will be working to move our community forward from a “Preplanning” level 4 stage of readiness. To do this, we will utilize the tools in the CRA manual, the SPF-SIG model, and input from our community partners and Wallowa County Prevention Coalition.

We are currently implementing and supporting programs such as Natural Helpers (peer to peer program), After School Programming in each school district in our County, mentoring, a partnership with one of our local school districts to offer a class in the High School twice per week where we bring in community agencies for presentations, we utilize life skills lessons, and provide service learning opportunities in the

community. We are also working with our local Law Enforcement to increase community awareness around underage drinking as well as drinking and driving, build and train a Controlled Party Dispersal Team, and organize “party patrols”, minor decoy operations, and reward and reminder programs. Finally, we promote various awareness campaigns throughout the year including Prom Perfect, Red Ribbon Month, Family Meal Day, and several others. These campaigns are comprised of radio ads, news paper ads and articles, table tents in local restaurants, flyers, etc. We are also looking forward to utilizing the mORE positive community norms campaign being created by the state in the future. These activities are all planned to continue into the 2013-2015 biennium as well as other activities that may come up though work with our coalition, the SPF-SIG process, and CRA.

Problem Gambling Prevention: In the 2013-2015 biennium, we are focusing on more integration of Problem Gambling Prevention with our other Substance Abuse Prevention programs and services. This involves incorporating this topic as a risky behavior that we cover and discuss in presentations, media campaigns, etc.

Each year we participate in the state art search for the Problem Gambling Calendar. To generate interest in this contest, we use students from the high school Community Health Class to create a local art search. The students put together a presentation that they give to all the 6th graders in the County, they create the flyers, radio ads, and newspaper ads for the contest and they judge the entries. This is a project that has been very successful in previous years and will continue. We also make sure every year that the Elks Christmas Baskets include Problem Gambling Prevention Calendars every year (between 250-300 baskets go out each year), we promote Problem Gambling Awareness Week, and teach a two session curriculum in one of the high schools.

- 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

- **Early intervention**

WVCW has placed a counselor in the schools to ensure that children who are showing early signs of difficulty are screened for mental health and other issues. At times this child is seen and support in the school setting, and at times the child and the family are referred to other services. WVCW has regular representation at Early Childhood meetings facilitated by the Commission on Children and Families (CCF) and also participates in the Service Integration Team meetings run by CCF. Additional coordination and collaboration is facilitated by the Mental Health and Alcohol and Drug Advisory Committee (LADP/MHAC) as well as the newly form Community Advisory Council (CAC) which relates to Eastern Oregon Collaborative Care Organization (EOCCO) which is the CCO for the County. WVCW also meets regularly with the county's Multi-Disciplinary Task Force and with Juvenile Crime Prevention. Ongoing contact with Early Intervention/Early Childhood Special Education coordinator (EI/ECSE). Support of the Home Visit program through Building Healthy Families. Working on coordinating with Union County to enroll young adults into the EAST/EASA program.

- **Treatment and recovery**

Wallowa Valley Center for Wellness (WVCW) provides a broad range of services for people with the full spectrum of mental health issues. The outpatient program serves nearly 300 adults suffering such issues as depression, anxiety, bipolar disorder, Posttraumatic Stress Disorder (PTSD), and trauma. The program utilizes medication therapy, using psychiatric (MD) services, individual therapy, using master's level therapists, and group therapy. The program uses a broad range of evidence based individual and group approaches to help people move toward recovery. WVCW provides around 500 hours of individual therapy per month. Details of the program will follow in section b).

Wallowa Valley Center for Wellness also includes an Alcohol and Drug program that is led by a Certified Drug and Alcohol Counselor (CDAC II). In addition a number of Master's level counselor support the program at a .5 level to support the services of this program. This program provides individual therapy, a variety of group programs, dual diagnosis care, and some intensive services. Details follow in section b).

Many of the clients involved at WVCW are involved in individual therapy, but WVCW is using an increasing number of groups due to the fact that for many conditions group approaches are extremely effective and because groups are sometimes more cost effective. WVCW provides over 75 hours of groups per month.

Some of the evidence-based practices, which involve both individual therapy and group therapy include:

- **Assertive Community Treatment (ACT):** Assertive Community Treatment is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia.
- **Illness Management and Recovery (IMR):** The goal of IMR is to empower consumers with severe mental illness to manage their wellness, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills. The core components of this approach are psycho education, behavioral training for medication management, relapse prevention training, and coping skills training. This approach is time limited, lasting 3 to 6 months on average
- **Supported Employment:** Although we do not currently provide Supported Employment, we are committed to developing a Supported Employment program if it is feasible. We have entered into conversations with several employers and are currently exploring the possibilities.
- **Peer to Peer Programming:** Develop peer to peer programs such as peer counseling or a peer run drop-in center.
- **Motivational Interviewing:** An interactive technique that allows therapists to work with clients around issues such as addictions. Helps assess the client's status in terms of readiness to change, and then helps

move them through the recovery continuum.

- **Seeking Safety:** Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.
- **Eye Movement Desensitization and Reprocessing (EMDR):** A comprehensive, integrative psychotherapy approach. It contains elements of many proven psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies. EMDR is an information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health.
- **Cognitive Behavioral Therapy – Trauma focused (TF-CBT):** A psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma
- **Dialectical Behavioral Therapy (DBT):** A form of psychotherapy that combines standard CBT techniques for emotion regulation and reality testing with concepts of distress tolerance, acceptance, and mindful awareness.
- **Repeat After Me:** This is a program designed to take people through a process to recognize how their present life is influenced by their past. The program offers clients the opportunity to learn how to identify and express feelings, define successes, establish healthy boundaries, recognize intrusive behavior, create healthy rituals, identify needs, recognize strengths, develop realistic expectations and much more.

- **Crisis and respite services**

Crisis services are provided by Master's level counselors and are available 24/7 through a crisis number or through the Emergency Room at the local hospital. This program receives an average of 289 calls per month.

Crisis counseling is available 24x7x365 through a crisis phone answered by QMHP with access to the full complement of emergency services. Crisis workers provide support to individuals in crisis, Law enforcement, WM Hospital and the local primary care docs, residential programs, and family members of people in crisis. The goal is always to be as supportive and minimally intrusive as possible although for seriously ill individuals at risk for harming themselves or others, assessment and safety are initiated/provided by whatever means necessary and appropriate, including initiation of Civil Commitment proceedings.

Crisis resources include: local respite (residential beds, motel with PCA/ACT support, WM Hospital respite, regional respite (Pendleton, Hermiston, Boardman). WM Hospital has a state certified Hold room that is available for local crisis use although most individuals on Hold status are usually referred to other in-state psychiatric facilities (St Charles/Sageview, Bend; OHSU, Portland; Salem or Corvallis) for acute psychiatric care. Individuals seeking voluntary care can be referred to psychiatric facilities in Spokane, Tri-cities, Lewiston or Boise. More recently our region gained another facility for acute and respite care with the opening of Juniper Ridge in John Day, Oregon.

During any crisis, crisis workers are able to request consultation and support from a clinical supervisor, and can draw on the full complement of ACT team services including, Psychiatry, RN, and QMHA's. Crisis workers aid law enforcement such that individuals suspected of criminal behavior can be assessed for MH disorders and provided appropriate mental health treatment and if appropriate, diversion from jail and criminal prosecution.

- **Services available to required populations and specialty populations**

Required Populations:

- Children with Serious Emotional Disorders (SED) – School-based counseling, ICTS, outpatient child mental health
- Adults with Serious Mental Illness (SMI) – Three residential programs and ACT program
- Persons who are intravenous drug users – A&D therapist. No IV specific programs in our remote rural county.
- Women who are pregnant and have substance use and/or mental health disorders – A&D therapist and mental health outpatient program. Integrative care with local Primary Care Providers
- Parents with substance use and/or mental health disorders who have dependent children – Integration between A&D, outpatient, primary care and social services outpatient mental health programs. Continuation of the wrap-around program established by the Northeast Oregon Collaborative for Child Safety (NOCCS). Also, we will be participating in a Community Health Worker program funded by a grant from the Center for Disease Control (CDC) and run by Northeast Oregon Network (NEON).
- Persons with tuberculosis - Integrative care with Primary Care and Public Health
- Persons with or at risk for HIV/AIDS and who are in addiction treatment – Integrative care with Primary Care and Public Health.

Specialty Populations:

- Adolescents with substance use and/or mental health disorders – Juvenile Crime Prevention (JCP) dollars help us provide adequate care for youth with substance use or mental health disorders. Also the school counselor funded by our program is at work in the schools with the “Natural Helpers” program. This coming year our Mental Health First Aid (MHFA) trainer will be certified to train in the youth version of MHFA. Our goal is to train youth in all of the schools to provide MHFA to their peers.
- Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not

limited to addiction, conduct disorder and depression – School based therapist

- Military personnel (active, guard, reserve and veteran) and their families – Club Med, ACT, residential and outpatient services
- American Indians/Alaskan Natives – ACT, residential and outpatient services
- Persons with mental health and/or substance use disorders who are homeless or involved in the criminal or juvenile justice system – PSRB, ongoing collaboration w/law enforcement, Drug Court.
- Persons with mental health and/or substance use disorders who live in rural areas – ALL WVCW clients qualify
- Underserved racial and ethnic minority and Lesbian, Gay, Bi-sexual Transgender or Questioning (LGBTQ) populations – Less than 1% of the county’s population qualifies but more than 1% of clients are either an ethnic minority or LGBTQ
- Persons with disabilities – WVCW includes DD services
- 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 The Prevention Collaborative helps provide activities in this area.
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies. Building Health Families and the prevention collaborative provide interventions in community settings.

- **Activities that support individuals in directing their treatment services and supports**

Collaborative Documentation is utilized by clinicians in order to promote the individual’s involvement in their treatment.

Skills trainers that are part of the ACT program promote independence and help individual direct their treatment services and supports.

WVCW helps high-needs clients obtain Personal Care Assistants who help monitor status and assist with daily living tasks so that they can maintain their desired level of independence in the community.

Review Criteria:

- **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.

WVCW provides services through several distinct but integrated programs:

- **The mental health general outpatient program:** Provides care for people with a wide range of mental health issues. A team of Master's level clinicians provide services to people of all ages including adult outpatient, children's outpatient, and crisis services. The combined full-time equivalent of all clinicians providing mental health services equals approximately 4 FTE. There are 2 FTE focused primarily on children and 2 FTE focused on adults. Of the two counselors working with children one spends 3 days a week working in the three local school districts. A Psychiatrist is available to the program 1 day per week and spends about 50% of available time serving standard outpatient clients. This program serves an average of 285 clients at any one time.
- **Crisis services** are provided by Master's level counselors and are available 24/7 through a crisis number or through the Emergency Room at the local hospital. This program receives an average of 289 calls per month.

- **Assertive Community Treatment (ACT):** WVCW has a program specifically focused on people with severe, and in most cases chronic, mental illness. This team uses an evidence based approach called Assertive Community Treatment. The ACT team includes a Master's level supervisor, two Therapists/Case Managers/Skills Trainers (both of these positions are filled by Masters Level professionals), and a Skills Trainer/Work Crew Supervisor (Qualified Mental Health Associate, Bachelors Level). Approximately 50% of available Psychiatric time is focused on this population. This team works with 32 clients who are in local residential programs and around 35 additional clients who live in a variety of additional settings within the community. Services are provided not only at the clinic, but in the community and include therapy, psychiatric care, case management, medication management, social engagement, supported employment and psycho education. The ACT program also includes a number of other important programs.
 - 1) **Riverside Center, a peer-run drop in Center.** WVCW opened this program in 2007 after receiving a grant from the Collins Foundation. The Center is open 7 days a week. Clients gather at the center for social events, opportunities to talk with friends, and for various support services including a Dual Diagnosis program (AA for people with mental illness). WVCW also utilizes Peer Support Counselors. These people, who have mental illness, have been trained to support others with mental illness and help them deal with their issues effectively.
 - 2) The **Residential Programs** are overseen by the ACT Program manager. This program includes two homes that provide unique types of services. Joseph House (in Joseph, Oregon) is a residential treatment home (RTH) that serves people with both a physical health issue and a severe mental illness. This house provides oversight, room and board, and nursing care. In addition, WVCW operates Wallowa River House, an 11 bed residential treatment facility (RTF) for people with severe physical and mental issues. This facility is located in Wallowa, Oregon. This combination of facilities allows WVCW to serve people whose mental health issues make it difficult for them to live independently in the community. In many cases their physical health issues are the most significant factors making it difficult for them to live on their own. Providing these programs allows WVCW to keep people in the country and minimizes the number of people who must access sub-acute or acute care.

- Wallowa Valley Center for Wellness includes an **Alcohol and Drug program** that is led by a Certified Drug and Alcohol Counselor (CDAC II). In addition, a Master's level counselor is committed at a .5 level to support the services of this program. Additional time is available from other Master's Level counselors as necessary. This program provides individual therapy, a variety of group programs, dual diagnosis care, and some intensive services. There is no inpatient care available in the county, but this team refers clients to regional inpatient programs when appropriate. The program uses an evidence based approach (ASAM) to determine appropriate levels of care. This program serves an average of 25-35 clients ongoing, with an additional group of 15-20 clients who have been identified as having a "dual" diagnosis (both mental health and addiction issues). This program works in collaboration with the mental health program to provide additional therapy groups that focus on such skills such as DBT and such issues as childhood trauma. Normally, there are two such therapy groups in process at any time.
- **The Developmental Disabilities program** is run by a case manager who works exclusively with those people who have a developmental disability. The program includes a .75 FTE case manager/ program manager. This program currently serves 29 people.
- **Problem Gambling**
 - 1) Outreach - Community Education:
 - a) News Paper Ads for problem gambling prevention
 - b) Radio Ads approximately 10 spots/week for a year.
 - c) Brochures for use at various public sites including Primary Care offices, Hospital , Community Connections, Churches, Public Health, Banks, Lawyers, CPA's, and other places related to human services or fiscal services with contact information (including the state-wide Helpline) related to problem gambling. Brochures would provide information about problem gambling, including danger signs and treatment options.

d) Presentations to community groups such as Rotary, Lions, Soroptomists, and Faith Communities related to problem gambling (prevalence, warning signs, treatment options, and contact information).

2) Physician Education:

a) Education about problem gambling.

b) Establishment of Wallowa Valley Center for Wellness as the agency providing care.

c) Distribute information to all medical offices related to referral to WVCW.

3) Community Partner Education:

a) Provide various forums to educate community partners about problem gambling with an emphasis on problem identification, program contact information and referral procedures.

b) Review and adopt, as appropriate outreach strategies as recommended by state task group.

c) Ensure State-wide helpline has current and accessible phone number.

d) Ensure calls from potentials callers are returned timely, preferably same day.

e) Inclusion of PG Services on county websites

4) Case Finding -- Key elements will include:

- Development of a workshop that would train people in how to screen for problem gambling.

- Meetings with other agencies in Wallowa County, including the Courts, Probation, Department of Human Services, Health Care Providers, Mental Health Providers, and Community Partners in order to develop collaborative relationships related to problem gambling. These meetings would be opportunities to work on developing how these partners could work with WVCW on addressing problem gambling.

- Development of referral protocols related to problem gambling

5) Problem gambling treatment interventions

We will provide outpatient problem gambling treatment assessment, treatment and rehabilitation services delivered on an outpatient basis to individuals with gambling related problems who are not in need of 24-hour supervision for effective treatment. These services will include regularly scheduled face-to-face or non-face to face therapeutic sessions, or services in response to crisis for the individual

and may include individual, group, couple, and family counseling.

Note: WCVW is training an addictions specialist to be a certified problem gambling counseling on staff. Our goal is to have clinician certified within six months to one year. We will provide ongoing continuing education funding for clinicians involved in the problem gambling program to ensure that the level of care remains excellent and so that new evidence based practices may be incorporated into the program. We will ensure appropriate supervision by a certified specialist.

6) Quality control and improvement plan including incorporation of consumer feedback

The Problem Gambling Program will be incorporated into WVCW ongoing QA and QI program and the Quality Management Plan developed by WVCW for Mental Health, Alcohol and Drug Treatment and Developmental Disabilities will be applied to this program as well. One key element of the quality improvement program is to establish quality indicators for each program. For problem Gambling those indicators will include access, retention, successful completion, and client satisfaction.

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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.

Due to the development of the CCOs, the clinicians of WVCW felt that they were being given a tremendous opportunity to reform health services in accordance with the specific needs of their rural community. After a state-sponsored informational session in April 2012 providers started gathering for monthly meetings beginning in May 2012. These providers represented primary care, hospital care, behavioral health, holistic care and

community service organizations. They met to discuss questions, concerns and ideas around quality improvement and how to develop an evidence-based culture and the delivery of coordinated care in the primary care setting.

The Wallowa County Network of Care was developed in order to promote the formalization of an integrated healthcare network which seeks to:

- 1) Achieve efficiencies
- 2) Expand access to, coordinate, and improve the quality of essential health care services
- 3) Strengthen the rural health care system as a whole

Wallowa County Network of Care:

Our Vision: 100% ACCESS, 0% DISPARITY

Our Mission: Better Health and Better Living Through Community Collaboration and Education

Our Values: Communication, Collaboration, and Creativity

WVCW is working with EOCCO, County Government and local providers to ensure that the CCO concept works well within our county. We participate in the Wallowa County Network of Care and provider staff to facilitate the meetings of that group. We participate in the local Community Advisory Council and again, provide leadership to that group. One of the stakeholders in the CCO is Greater Oregon Behavioral Health. The Director of WVCW is on both the Board and the Executive Board of the group and thus is greatly involved in decisions made by the CCO. WVCW is actively working to implement program changes that support the efforts of the CCO transform healthcare in the County and move to radically integrated care.

For example, three **Behavioral Health Consultants** trained by WVCW and on the staff of WVCW provide consultation-liaison services to medical patients within a patient centered primary care home and also provide support for acute care, as well as rehabilitation services in Wallowa County. The objective of Behavioral Health Consultants is to provide quality, patient-centered behavioral health services to patients in the medical setting, by

overcoming behavioral obstacles that stand in the way of greater wellness. Treatment planning is based on effective, evidence-based interventions and tailored to the unique needs and circumstances of the patient. BHC's are skilled in coordinating services with physicians and multidisciplinary teams and optimizing patient outcomes. He/she promotes patient care consistent with the philosophy and objectives of the rural health clinics of Wallowa County.

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.

The county commissioner agreed to have one advisory board represent both areas. The CCO Advisory Board is also wrapped into this group. The board includes 51% consumers. Providing leadership for the CAC are Susan Roberts, County Commissioner, Chantay Jett, CAC/LADPC/MHAC facilitator, Stephen Kliewer, WVCW Director (MH, A&D,DD), and Billie-Jo Deal, Prevention Coordinator. Remaining members, currently, are

- Beverly Jacob, Consumer
- Darren Biggs, Consumer
- Diane Bingham, Consumer
- Jody Brown, Consumer
- Vicky Crane, Consumer
- Lori McNall, Consumer
- Jennifer Miller, Consumer

- Kathy Norman, Consumer
- Gretchen Piper, Consumer
- Lisa Roepke, Consumer
- Melinda Schlatter, Consumer
- Dody Yaccarino, Consumer
- Vivian Tillman, Consumer
- Tim Funk, Consumer
- Amy Busch, Consumer
- Ida Pacheco, Consumer
- Jeff Greene, Consumer
- Koreen Sanders - Pharmacy
- Michael Farley - Pharmacy
- Dodie Beck, WCVW, ACT Team
- Kari Haines, Domestic Violence Program
- Kay Garber, Minister
- Billie Jo Deal, Prevention Coordinator
- Beth Hulse, WCSO
- Julie Garland, School Counselor
- Amy Johnson, Building Health Families
- Pepper McCouglan, NEON
- Linda McIntyre, Veteran's Advocate
- Stephen Kliewer, WVCW
- John Lawrence, Juvenile Department
- Susan Roberts, BOCC
- Tammy Pierce, DHS

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.

Data Sources:

Wallowa County is using the following sources to assess community need:

- Wallowa County Health Department Annual Plan 2012-2013
- Northeast Oregon Network's Community Needs Assessment Final Results Report 2010-2011
- Wallowa County Commission on Children and Families Community Survey 2011-2012
- Prioritization of needs by the members of the Wallowa County Network of Care.
- Prioritization of needs by the members of the Mental Health Advisory Council, the Local Alcohol and Drug Planning Committee (LADPC) and the EOCCO Community Advisory Board
- Community meetings will be held in March and April to gather additional information.
- Substance Abuse Prevention Community Readiness Assessment: The results of the CRA have been shared with the Prevention Coalition at this current time. Our plan in this biennium is to continue to share results with other community groups via presentations, meetings, etc. We created an easy to read brochure highlighting the results. The process for this specific assessment was limited mainly because we made the

decision as a community to contract for Colorado State University to conduct the assessment. The Prevention Coalition worked together to provide the names of people to be interviewed but once the names were passed on to the University, all we had left to do is wait for our results. The next CRA that is conducted for our County will be conducted locally and will draw on support and feedback from the Prevention Coalition and various community partners.

- In addition Wallowa Valley Center for Wellness took the review grid from the BIP template and created a series of survey questions. These questions were asked of the Peer Leadership Group, who provided feedback from their perspective as people receiving services. This group is made of people with severe and chronic mental health and/or addictions issues. Forms were disseminated to all staff, to the Board of Directors of WVCW, the Rotary Club, local PCP providers, and other communities members (All staff were asked to interview 5 community members who are not part of the program).
- A “domain” assessment tool was used at a Community Advisory Council (CAC) meeting in order to look at the overall services that are “wrapped around” the people served by the mental health and addictions programs.

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.

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.

- The assessment process involved the leadership group from the drop-in center which is made up entirely of peers.
- The assessment process involved the Board of Directors of WVCW (all community members)
- The process involved the Community Advisory Council which is a combined council representing the Local Alcohol and Drug Advisory Group, the local Mental Health Advisory Council, and the CCO Local Advisory Council.
- The grid was reviewed by the QA and QI committee of WVCW

All of the feedback, which was gathered through returned forms and through notes taken using an interview process were put together into a master feedback form which then was used to create the bullet points in the grid. Many of the assessments involved physical health measures, and will be useful as we move forward with integration. Most of the feedback at this point has been qualitative, but we are hoping that we will have more qualitative measures in the future. We are currently looking at satisfaction survey options that will provide us with more quantitative information. The information in this report, combined with the information we will continue to gather as we do the community assessment for the CCO will be available to guide our program as we move forward into the future.

We are continuing, since returns continue to come in, update the results. We plan to use the feedback in the development of the strategic plan for WVCW.

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.

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 (WVCW)	<p>Strength</p> <ul style="list-style-type: none"> • Integration of Behavioral Health Consultants in the Primary Care Clinics • Counselor in three schools, providing counseling and support to children and youth • Counselor in three schools implementing a variety of programs to support student's ability to manage stress, supporting self-esteem, etc. • Mental Health First Aid classes (almost 200 trained so far) <p>Needing Improvement</p> <ul style="list-style-type: none"> • Need Behaviorists integrated in all clinics • Need a broader cross-section of the population to understand mental illness, or know what the mental health program offers. <p>Offer more classes to the community covering areas such as stress management</p>	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Partner with schools to secure funding • Undergo training to provide the “youth version” of Mental Health First Aid. <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Utilize the local newspaper (weekly) and radio station to education the community about mental health issues, as well as programs that will support mental well-being. • Develop courses that help promote mental well-being. • Collaborate with the various faith communities, leveraging what they can offer in mental health promotion efforts. • Collaborate with local charitable groups such as Rotary to promote well-being.
b) Mental Illness Prevention (WVCW)	<p>Strengths</p> <ul style="list-style-type: none"> • Behaviorists identify potential health issues earlier and are able to develop resources to prevent further health 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to offer MHFA • Offer youth version of MHFA

	<p>risks.</p> <ul style="list-style-type: none"> • Mental Health First Aid (MHFA) training. <p>Needs Improvement</p> <ul style="list-style-type: none"> • People do not know what our programs do. We do not have a broad enough spectrum of programs • Connection with faith community is weak. • Need to do more work with law enforcement, including cross training. 	<ul style="list-style-type: none"> • Foster good community partnerships that can help address other domains of health which, can contribute to ongoing issues such as the parenting program offered by Building Healthy Families. <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Routinely provide articles on mental health topics in local newspaper • Provide outreach groups on stress management, anger, grief, pain management, etc. for the entire community. • Collaborate with community partners to address the social determinants of health (and mental health). • Build better ties with law enforcement • Increase ties with faith community
<p>c) Substance Abuse Prevention (BHF)</p>	<p>Strengths</p> <ul style="list-style-type: none"> • One of the strengths highlighted in our assessment is the competency of our prevention professionals. Several of the interviewees were very supportive of staff • In order to continue to have highly trained and competent prevention professionals, we are utilizing and taking full advantage of state offered trainings. We have made this a priority. • To strengthen our working 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to work on the relationship with law enforcement by making them part of the Prevention Coalition <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Continue to work on the relationship with law enforcement by making them part of the Prevention Coalition (This is a strategy to both maintain and improve).

	<p>relationship with law enforcement, we have invited them to the table and they are now a part of the Prevention Coalition. We are also coordinating prevention/enforcement activities for the 2013-2015 biennium</p> <p>Needs Improvement</p> <ul style="list-style-type: none"> • One of the areas for improvement that was noted, is to strengthen our relationship with law enforcement` 	
d) Problem Gambling Prevention	<p>Strengths</p> <ul style="list-style-type: none"> • Our local Art Search Contest is our strongest program in the County. This is due to the fact that we are able to educate high school students in this area and then they present to the younger students. Students presenting to other students has been very effective in this project. <p>Needs Improvement</p>	<p>Maintain Strength</p> <ul style="list-style-type: none"> • As long as we are able to continue the Community Health Class at Joseph Charter High School, we will be able to continue this project. The school is very supportive of continuing this class and we don't foresee it going away. <p>Address Areas Needing Improvement</p>
e) Suicide Prevention	<p>Strengths</p> <ul style="list-style-type: none"> • We have several people trained in the County as gatekeepers and trainers. • Established QPR program • Established ASIST program <p>Needs Improvement</p> <ul style="list-style-type: none"> • We continue to have difficulties getting RESPONSE fully implemented but, we are working on 	<p>Maintain Strength</p> <p>Address Areas Needing Improvement</p>

	gaining more support from the schools. The interest is there.	
<p>f) Treatment:</p> <ul style="list-style-type: none"> • Mental Health • Addictions • Problem Gambling 	<p>Strengths - MH</p> <ul style="list-style-type: none"> • Good Crisis program that provides 24/7 coverage and support of the local ER • A wide spectrum of residential options for people in the county who may need additional support • A wide range of Evidence Based Practices in place • A strong Assertive Community Treatment Program (ACT). • A therapy team that is mostly licensed (creating access) or working toward licensure. • Staff trained to work as Behavioral Health Consultants in the Primary Care setting. • School counseling program (in each school every week with a licensed therapist). • Mental Health Court (new) • “Club Med” medication mgt program focused on helping people manage their own medications. <p>Needs Improvement - MH</p> <ul style="list-style-type: none"> • Therapeutic Care for people with issues that are not diagnosable. The “walking wounded”. 	<p>Maintain Strength - MH</p> <ul style="list-style-type: none"> • Continue to work at developing EBPs • Continue to support therapist /psychiatrist interface. • Continue to work at further development of Child Psychiatry using telemedicine. <p>Address Areas Needing Improvement - MH</p> <ul style="list-style-type: none"> • Working on enhancing training for therapists around identified issues (trauma, etc.) • Continue to work on therapist / psychiatrist interface. • Develop a “partner” (or client) advisory council for our program using a model developed in our primary care system. • Work with Union County to develop a supported employment program. <p>Maintain Strength - Addictions</p> <ul style="list-style-type: none"> • Continue to develop strong relationship with primary care. • Continue to use Evidence Based approaches to treatment, after-care, and education. <p>Address Areas Needing Improvement - Addictions</p> <ul style="list-style-type: none"> • Find additional support for the A&D

	<ul style="list-style-type: none"> • Services to families with marital or family systems issues. • Somewhat limited psychiatric availability both for adults and children. <p>Strengths - Addictions</p> <ul style="list-style-type: none"> • Good solid set of groups for education, relapse prevention, and treatment. • Experienced counselor • Integration into problem gambling program • Integration with mental health program • Drug Court <p>Needs Improvement - Addictions</p> <ul style="list-style-type: none"> • Would be nice to have programs specifically focused on young people. This is difficult due to the number referred for treatment. • Develop better screening for A&D issues in primary care • Develop quicker referral from PC to A&D • Increase ability to offer intensive outpatient services <p>Strengths – Problem Gambling</p> <ul style="list-style-type: none"> • Problem gambling services program 	<p>Specialists</p> <ul style="list-style-type: none"> • Improve relationship / communication with law enforcement and the criminal justice system • Try to develop a “small county” model for a sustainable intensive outpatient program <p>Maintain Strength – Problem Gambling</p> <ul style="list-style-type: none"> • Continued training of specialist • Effective supervision of specialist <p>Address Areas Needing Improvement – Problem Gambling</p> <ul style="list-style-type: none"> • Develop relationships with lawyers, financial planners, insurance agents, etc. for identification / referral of people with gambling issues. • Use of local media to advertise services • Use of local media to educate community about gambling (things to look for)
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	<p>now offered in Wallowa County.</p> <ul style="list-style-type: none"> • Addiction specialist is trained as a gambling specialist <p>Needs Improvement – Problem Gambling</p> <ul style="list-style-type: none"> • People don't know about program. We need educational outreach to the community to improve recruitment of people into the program. 	
<p>g) Maintenance/Recovery Support (Include specifics pertaining to mental health, addictions and problem gambling treatment)</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Peer support counselors (MH and A&D) • Peer run drop in Center (MH) • Local Dual Diagnosis Groups (A&D and MH) • Supported Housing available for some clients (A&D and MH) <p>Needs Improvement</p> <ul style="list-style-type: none"> • No aftercare for gambling at this point (PG) • Opportunities for people in recovery to have safe places to gather for socialization (MH, A&D) 	<p>Maintain Strengths</p> <ul style="list-style-type: none"> • Continue to support local AA groups (A&D) • Continue to support local DDA groups (MH A&D) • Provide opportunities for peers to be trained as peer counselors, and as leaders within the drop-in program (MH and A&D) • Continue to develop the drop-in Center (MH A&D) <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Develop peer leadership (MH A&D) • Develop resources within peer community (MH A&D) • Identify places people in recovery can meet safely (A&D and MH) • Help develop places for people in recovery to meet and socialize (MH and A&D)

<p>h) The LMHA's Quality Improvement process and procedure</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Active QA and QI Committee • Active participation at MHO/CCO level • Recent move to EMR • Ongoing monitoring / review of documentation to look for quality of care, etc. • Use of nationally proven strategies for improvement of access (same day access) • Development of collaborative documentation process. • Involvement of psychiatrist in QA and QI process • Newly reviewed and revised Policies and Procedures <p>Needs Improvement</p> <ul style="list-style-type: none"> • Working to “reboot” QA QI Committee • Continued peer involvement • Use of new EMR to look at outcomes • Ongoing chart reviews for QA and QI purposes 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Need to hear from consumers more effectively • Need better peer involvement in county advisory board <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • New peer advisory panel for clinic • Help enable participation of peers in County Advisory Council • Member satisfaction survey
<p>i) Service coordination and collaboration with corrections, social services, housing, education, employment and</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Strong relationships with community partners addressing all domains of health and mental health • Integrative approach and Behaviorists 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to keep liaison with Local Law Enforcement in place. • Continue to provide support for Mental Health Court and Drug Court

<p>other community service agencies</p>	<p>embedded in PC Clinics</p> <ul style="list-style-type: none"> • Drug Court • Participation in the Prevention Coalition • Ongoing participation in Juvenile Crime Prevention initiatives. • Presence in the schools • Work in area of housing (residential programs, supported housing, etc). • Ongoing relationship with law enforcement <p>Needs Improvement</p> <ul style="list-style-type: none"> • Could strengthen connection with law enforcement. • Need to develop Supported Employment at some level.al 	<ul style="list-style-type: none"> • Continue to place counselor in the schools • Continue to participate in local partnerships such as the Early Learning Council and the Aging and Disability Resource Connection. <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Develop a Supported Employment program, or develop program under the umbrella of an existing program. • Teach MHFA to law enforcement officers
<p>j) Behavioral health equity in service delivery</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Behaviorists in Primary Care • Licensed Therapists enable a wide range of payor sources. • No wait list <p>Needs Improvement</p> <ul style="list-style-type: none"> • Access to psychiatrist • Access for Veterans 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to create same day access. • Continue to use creativity to help clients be able to access and afford care. <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Honestly, we struggle with how we can meaningfully be in this area; many efforts go unrewarded. We will try to get a direct contract with the VA for care of local Veterans.
<p>k) Meaningful peer and family involvement in service</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Incorporation of people in development of their Individual 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Mental Health First Aid • Use of Collaborative Documentation

<p>delivery and system development</p>	<p>Support and Services Plan (ISSP)</p> <ul style="list-style-type: none"> • Inclusion of family in development of ISSP • Use of case manager and ACT approaches to include family, when possible, in ongoing support of clients. • Education of families in how they can help support their family member who is struggling with mental health issues. Mental Health First Aid is very helpful in this area. • Use of collaborative documentation. <p>Needs Improvement</p> <ul style="list-style-type: none"> • Helping families where mental illness may spread across generations to find stability and improve their family system. • Helping families who are not local be more involved in their family member's care. 	<ul style="list-style-type: none"> • Identification of natural support systems in the assessment process <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Develop approaches to work with families that have trans-generational issues
<p>l) Trauma-informed service delivery</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Organizationally we understand the dynamics of trauma and violence. • EMR assessment tool provides an opportunity to explore an individual's experiences with trauma and violence. • We incorporate ISSP planning that facilitates consumer choice, control, 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to provide targeted training around trauma focused interventions. • Inclusion of trauma focused care as part of the QA and QI process <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Additional trainings for all staff related to trauma focused care.

	<p>and participation in: treatment, program/policy development, and evaluation.</p> <ul style="list-style-type: none"> • Overall we provide a practice environment that is physically and practically designed to avoid re-traumatization; an environment that is safe and nurturing; an environment that is empowering and is culturally competent. • We provide some trauma focused therapies, include Trauma focused CBT and EMDR. <p>Needs Improvement</p> <ul style="list-style-type: none"> • Training and comprehension of <u>all staff</u> regarding trauma and violence issues, and how to provide treatment and care to individuals who have experienced trauma or violence. • Training of staff in trauma focused therapies. • More client input related to our practice environment • Organizational understanding about how we do in terms of trauma focused care. 	<ul style="list-style-type: none"> • Organizational self-assessment, and also a post-assessment after any changes are implemented. <p>Possible re-do of waiting area to provide a “safer” and more hospitable environment.</p>
m) Stigma reduction	<p>Strengths</p> <ul style="list-style-type: none"> • Mental Health First Aid • Facebook page that educates the community about mental illness and 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Continue to offer MHFA • Continue integration with primary care

	<p>overtly addresses stigma</p> <ul style="list-style-type: none"> • Use of local paper periodically to present information about mental health issues. • Presentations to local groups about mental illness • Having residential programs that create an ongoing interface between the community and people with mental illness. • Integration with Primary Care (the doctors involvement helps reduce stigma, as does integration itself) <p>Needs Improvement</p> <ul style="list-style-type: none"> • More exposure to information about mental illness and the fact that it is treatable in the local newspaper and radio (local media). • Greater ability to educate “on the run” as law enforcement, the ER, and community members have difficult encounters with people with mental illness. 	<p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Develop a speakers bureau, and promote it • Get the “youth version” of MHFA in place • Have staff write articles and get in newspaper regularly if possible • Update Facebook page more frequently, and “like”
<p>n) Peer-delivered services, drop-in centers and paid peer support</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Peer support counselors • Peer run drop in Center • Work Crew (providing meaningful work for peers through a team run by WVCW – Not supported employment) 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Ongoing training of peers • Support of the Frontier Leadership Network • Ongoing support of the drop in center (providing the building, maintenance, and support of leadership group).

	<ul style="list-style-type: none"> • Involvement of peers in the Frontier Leadership Network (FLN) • Peer “Board” or “Council” • Peers working as Personal Care Assistants <p>Needs Improvement</p> <ul style="list-style-type: none"> • More training for peer support counselors • Certification of peer counselors 	<p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Involve some peers in a certification process • Develop peer leader skills using training and mentoring/coaching
<p>o) Crisis and Respite Services</p>	<p>Strengths</p> <ul style="list-style-type: none"> • 24/7 access to a master’s level therapists • Experienced and skilled crisis coordinator • Good relationship with ER staff • Numerous residential and supported housing options within the county, and thus an ability, at times, to find appropriate respite care. • A hold room at the local hospital • Immediate access to ER by Crisis Staff • Participation in an ongoing group that includes the Hospital, Law Enforcement, Primary Care and Mental health discussing common issues related to people with mental health, addiction, or other issues. 	<p>Maintain Strength</p> <ul style="list-style-type: none"> • Keep communication healthy between crisis program, outpatient program, ACT program • Continue to develop relationship with ER • Continue to work on relationship with Local Law Enforcement. • Continued participation in collaboration. <p>Address Areas Needing Improvement</p> <ul style="list-style-type: none"> • Mental Health First Aid Class for Law Enforcement

	<p>Needs Improvement</p> <ul style="list-style-type: none"> • No acute care available nearby. Closest acute care program is around 4 hours away. • Better training of local first responders in how to deal with people with mental health issues • Transportation for people who need acute care 	
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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	EHR indicates 285 open clients	OWITS report

individuals served		
b) Initiation of treatment services – Timely follow up after assessments	EHR indicates initiation of treatment services averages 6 days from intake	OWITS report
c) Treatment service engagement – Minimum frequency of contact within 30 days of initiation	How many clients return more than once, ie: engage, within 30 days	OWITS report
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	This is a rare occurrence in our county. However the staff person responsible for transitions reports 100% received follow up care after hospitalization or other facility based care.	OWITS report
e) Readmission rates 30 and 180 day: (1) Hospitalization for mental illness; or (2) any facility-based service defined as residential	Data should be available from GOBHI and the AMI program but has not been gathered	Acute Care Council, GOBHI
f) Percent of participants in ITRS reunited with child in DHS custody	Data available from program director. Not currently applicable	
a) Percent of individuals who report the same or better housing status than 1 year	Data potentially available from OWITS Program not written to pull	OWITS WILL REPORT

ago.		
b) Percent of individuals who report the same or better employment status than 1 year ago.	Data potentially available from OWITS Program not written to pull	OWITS will report
c) Percent of individuals who report the same or better school performance status than 1 year ago.	Data unavailable	Unknown
d) Percent of individuals who report decrease in criminal justice involvement.	Data potentially available from OWITS Program not written to pull	OWITS will report
e) Stay at or below a target ADP of individuals for which the county is responsible in the state hospital psychiatric recovery program.	Data Available from Acute Care Council (ACC) and Adult Mental Health Initiative (AMHI)	ACC /GOBHI
f) Maintain an average length of stay on the OSH ready to transition list at or below a pre-determined target	Data Available from ACC and AMHI	State of Oregon
g) Each LMHA will complete a minimum of 80% of approved prevention goals and objectives.	Data Available from Building Health Families	

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:

OWITS needs modifications that allow for the capture of the performance measures OR the state needs to supply the necessary data. However it is our hope that between OWITS and the EMRs used by the primary care practices we will be able to capture a majority of the necessary data. It is probable that the COO itself will be able to provide some additional measures, and that the State of Oregon will be able to provide data related to such measures as hospitalization.

Wallowa Memorial Hospital will also gather some of the necessary information through its EMR

The Public Health Department will be able to provide additional information

Our goal is to use the information from all sources to continue to monitor outcomes. The local Network of Care described above will in an ongoing manner use the information to look at community outcomes and where problems are apparent plans will be made to address the issues.

We will also look at individual clients (hot-spotting) and use a team approach to develop plans of care that help the people with mental (or physical) issues achieve success in finding recovery.

The information gathered will be used to look at systems issues (such as access), issues related to a variety of domains (including the social indicators of health), and treatment issues (are EBPs being used).

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:

See attached Budget Template for the Prevention, Mental Health, and Addictions Programs.

BHF has provided additional detail related to the prevention budget which are included below. Additional breakdowns of the budget can be obtained from WVCW upon request.

Prevention Details.

Planned expenditures for services subject to the contract:

- Substance Abuse Prevention: We are anticipating a total of \$75,000.00 each year as was received in this current year. We also have \$10,000 of SPF/SIG funds to attend state trainings in the first year of this biennium.
- The anticipated \$75,000 each year will be spent on the following expenses:
 - Salary and other related expenses of the Prevention Coordinator
 - \$51,078
 - Projects within the schools. These projects will be determined in coordination with the

schools

- \$3,000 (\$1,000 per school district)
- “Special Projects” in the community or schools. These projects will be determined with the coalition and could include partnerships with the schools, law enforcement projects, etc.
 - \$3,000
- Programs including Natural Helpers, Community Health Class (collaboration with Joseph Charter High School), and Exploration (after school programming). A portion of these funds also supports our largest Problem Gambling Awareness Project
 - \$4,500 Natural Helpers
 - \$5,000 Community Health Class
 - \$3,400 Exploration
- Advertising and marketing for prevention campaigns
 - \$3,000
- Supplies, printing and copying
 - \$2,022
- SPF/SIG Funds:
 - State approved trainings
 - \$10,000

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.	At this time, the prevention coalition does not receive beer and wine tax funds for alcohol and other drug prevention.		
b) Use of lottery funds allocated for Problem Gambling prevention and treatment.	\$20,450		
c) Use of funds allocated for alcohol and other drug use prevention.	The remaining state SPF/SIG funds will be spent this biennium on SPF/SIG training as directed from the state.		

Additional Information (Optional)
a) What are the current/upcoming training and technical assistance needs of the LMHA related to system changes and future development?

WVCW receives excellent support from Greater Oregon Behavioral Health (GOBHI) and EOCCO. The Director of the program is working with The National Council of Community Mental Health Programs related to system change and future development with a focus on care integration.

Local partners, including the medical doctors, pharmacists, chiropractors, physical therapists, complimentary medicine providers (such as functional medicine), public health, and other service organizations have come together in a powerful way to create the Network of Care

NEON is helping provide training for community health workers (CHWs)

However:

- OWITS reports are not fully functional requiring manual manipulation of data
- As care is coordinated across providers various EHRs don't "talk" to each other
- There is no funding to help pay for program components such as CHWs and Care Coordination efforts in the integrated system to help cover start up costs and "fill the gap" until the savings become evident. This creates fiscal vulnerability for both primary care clinics and mental health and addictions programs.

***No review criteria**

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.

	room Wireless Hub 360 (60 per month) \$1186.88 (Misc. administrative and programmatic expenses. Phone book, advertising the service, secure transport (versus mileage above), crisis phone, etc) \$937 Office space next to hospital. .5 of total rent	Wireless Hub \$720 2373.76 (Misc. administrative and programmatic expenses. Phone book, advertising the service, secure transport (versus mileage above), crisis phone, etc) \$1,875 Office space next to hospital, .5 of total rent
Totals	56,617.04	61,174.08
Overall Project Cost	56,617.04	61,174.08
Revenue Identify expected revenues; i.e., Medicaid billing/encounters)	Grant 39,580.16 **Original State Funding \$17036.88	Grant 27101.32 **Original state funding 34073.76
Number of individuals Intended to be Served	60	120 (see table below)

*It should be noted that there is no way to know when in the 18 month period monies will be expended for respite care. Thus the entire amounts for the rooms and psych sitters was put in the first 6 months

** It should be noted that the \$34,073.76 does not cover the 25/7 services (including salaries, travel, phone, etc.). Total cost for that program has been around \$50,000 a year. Some of this can be capture by encountering, but the program is still marginally funded

PROGRAM DESCRIPTION

It is the goal of this crisis program to provide adequate 24/7 crisis services for Wallowa County. These services will be provided in collaboration and cooperation with community partners, most specifically local Law Enforcement (Enterprise Police Department and Wallowa County Sheriff's Office). However a close partnership with the local medical community and specifically the Emergency Room at Wallowa Memorial Hospital will also be critical. Through this program any person seeking emergency services related the mental health issues and/or addiction issues will have immediate access, through phone contact, with a master's level therapists, and if the

situation is urgent, will have face to face contact with a master's level therapists as soon as is possible. Services include:

- Crisis mental health assessment
- Brief crisis intervention
- Assist with placement in crisis respite or crisis residential services
- Initiation of civil commitment process
- Assistance with hospital placement
- Connect individual with ongoing services and supports

The ultimate goals of the program is to provide access to mobile crisis services and to reduce hospitalization of consumers utilizing mobile crisis serves and to reduce law enforcement involvement.

Timeline

January through March 2014

The program establish the crisis office.

The program will move the Crisis Manager into his new position

The program will purchase the Vehicle

The program will purchase the laptop

The program will identify core team members

The program will begin development of response protocols

The program will beginning training efforts, beginning with Mental Health First Aid

Agreements will be developed with local hotels and the hospital related to respite sites

Peer Counselors and other caregivers will be identified and trained to provider crisis

Observation.

WVCW will collect data related to crisis contacts and hospitalization

April through June 2014

The core team will continue to meet and develop protocols and other identified plans

Training of all providers involved in crisis response will continue (example: Crisis Triage)

Training of core team will continue

Crisis respite sites will be implemented

July through September 2014

Training of caregivers, crisis response workers, and Local Law Enforcement will continue

The protocols will be adapted as necessary

The core crisis team will continue to meet

We will begin to collect data related to Law Enforcement involvement

September 2014 through June 2015

Program will continue to function

Adjustments will be made as necessary

Budget Narrative

BASE CRISIS BUDGET

24/7 Crisis coverage, providing a "live" response to individuals needing help 24/7 (hotline)

24/7 Crisis coverage to the local Emergency Room
24/7 Crisis coverage/support to local law enforcement

A master's level clinician carries a phone and responds immediately if appropriate

Funding comes from the Flexible Budget, Service Element 25 at a rate of \$34,073.76

BUDGET ENHANCEMENT

The Enhanced Program will add the additional (grant funded) expenses

Crisis Manager .4 FTE

We have figured this cost at Mr. Spriggs-Flanders current rate. This amount includes all associated costs. Salary at \$1,613.36 per month, plus \$395.50 OPE per FTE = \$2,008.86 per month (\$36,159.48)

30 Nights of Crisis Respite equaling \$3600.00

We have figured a rate of \$90.00 per night for local hotels/ Motels (X 20 nights) \$1800.00

A rate of \$180.00 per night for hospital respite for more critical situations (X 10 nights)
\$1800.00

Observers/Psych sitters/Caregivers. \$4,680

We have figured a cost of \$15 per hour at 12 hours per crisis respite placement X 30 Nights

Satellite enable Laptop

Laptop (\$500) Toshiba Satellite enabled, Office Suite (2010) \$200, Hardware/software \$700,
Wireless Service/Hub 18 months \$1,080

Crisis Triage Training/Debriefing by Crisis Mgr. for Staff/Psych sitters/peers

10 hrs/yr for team members (x6) @ \$15/hr \$1350.00/18mos

Office Space/landline/supplies/administrative costs – we are only asking for office space which is leased

The average value of the office space that will be provided by WVCW will be \$2812/ 18 months based on the room being prorated at .5 of the time (312.44 per month for that office at the Medical Office Building next to the Hospital)

Transportation for acute situations

We anticipate 3 trips

Average mileage cost per trip @ 200 per trip \$600

Vehicle for program

We recently purchased a Subaru for the overall program at a cost of \$15,000 used.

We cannot anticipate a clean used vehicle, but will ask that the grant provide \$15,000

for the purchase of an appropriate vehicle \$15,000

TOTAL BUDGET FOR GRANT (not including GIK)

\$66,681.48