

2013-15 Biennial Implementation Plan July 2013 Addendum

Community Needs Assessment

As described in our original Biennial Implementation Plan submission, the Washington County Behavioral Health Council (BHC) is an advisory committee to the Department of Health and Human Services and the Washington County Board of Commissioners and has as one of its core responsibilities, the design and implementation of our biennial behavioral health needs assessment process. Every two years, the BHC engages in a process of identifying needs, analyzing gaps and setting priorities for system improvement including the resource advocacy necessary to build a high quality, comprehensive system of care. Members of the Council live or work in Washington County and include behavioral healthcare providers, consumers and other individuals in recovery, family members, representatives of child-serving agencies, school representatives, a member of the Commission on Children and Families, advocates, professionals in the field, and lay citizens. 71% of the BHC's current members identify themselves as either a family member of someone in recovery or in recovery from a mental illness or addiction themselves.

The Community Needs Assessment process being undertaken by the two CCO's operating in Washington County in collaboration with each other continues to unfold. The Washington County Needs Assessment has been shared with the Health Share Community Advisory Council's Health Improvement and Mental Health and Addictions subcommittees. We will be continuing discussions with these groups as well as Healthy Columbia Willamette to incorporate our recommendations into the final Regional Health Improvement Plan.

The needs assessment process typically includes reflection upon priorities set, progress made, and notable accomplishments of the previous two years. Here is a summary of priorities and progress made for the last three biennia:

2007-2009		2009-2011		2011-2013	
Priorities	Progress	Priorities	Progress	Priorities	Progress
Increase/Stabilize Supported Employment funding	√	Continue Supported Employment Expansion	No new resources	Continue Supported Employment Expansion	No new resources
Increase resources for A&D Treatment (residential, Detox, youth, older adults)	√	Improve housing options for mentally ill adults	√	Increase subsidized housing options for the mentally ill	√
Increase Evidence-Based Practice Workforce Development activities	√	Improve workforce training recruitment and retention	√	Improve workforce training recruitment and retention	No new resources
Increase Intensive Community-Based services for uninsured Children	√	Increase and enhance Detox services	No new resources	Increase and enhance detox services	√
		Achieve equitable funding for acute care services	√	Create person-centered health homes within MH treatment settings	Planning stages

		Restore access to adult outpatient mental health services	No new resources	Restore access to adult outpatient mental health services	√
		Improve Integrated Treatment of Co-occurring Disorders	√	Improve integrated treatment of co-occurring disorders	√
		Participate in health care reform advocacy to emphasize needs of severely mentally ill	√	Participate in health care reform advocacy to emphasize needs of severely mentally ill	√
				Create collaborative strategies with first responders	√

In early 2013, the Behavioral Health Council considered the means to determine new priorities for the next biennium. The Council reviewed available epidemiologic data on Alcohol, Drugs and Mental Health closely comparing Washington County data to state and federal benchmark data where available. The Council also reviewed access to care data which is regularly collected by Washington County from Network Provider agencies. Additionally, the Council assisted the development of a System Array Assessment Survey tool and decided to engage “Key Informants” to participate in the System Array Assessment. The Council felt that a survey approach to access key informants’ perspective, rather than staging a community meeting or focus group as we had in the past, might be a faster and more efficient method to get input. Key informants to be included in the survey:

- Behavioral Health Council members
- Washington County Behavioral Health Staff
- Provider Network Clinical Lead Staff
- Child Welfare District Office Supervisors
- Juvenile Justice Supervisors
- Adult Community Corrections Supervisors
- Consumers in Recovery from Mental Illness and Addictions
- Family Members of both Adults in Recovery and Children with Mental Illness
- Washington County Sheriff Commanders
- Commission on Children and Families

Our Key Informants were asked to first review our submitted 2013-15 Biennial Implementation Plan which contains a detailed description of the system of care in Washington County.

Secondly they were asked to review Washington County alcohol, drug and mental health epidemiologic and access data to give perspective on the mental health and addictions issues prevalent in our population and the accessibility of the services we provide.

Finally, key informants completed the System Array Assessment Tool, a comprehensive list of services within a mental health and addiction system of care. While most of the services in the list are available in Washington County, some are not. A glossary was included to provide definitions so that the audience might better understand what each service is. Informants indicated for each service whether they believed the service has adequate capacity or whether capacity should be increased or decreased. Informants were asked to prioritize the

recommended action from 1 to 5 with 5 being the highest priority and were advised that increasing capacity in one area will likely mean decreasing capacity in another.

62 Key Informants were sent these participation tools.

42% responded with completed System Array Assessments.

The following were notable participants:

23% subcontracted behavioral health providers

19% consumers/family members

12% school staff

8% law enforcement/community corrections

4% hospitals

4% Commission on Children and Families

The results of the survey are located in Appendix A.

Strengths and Areas for Improvement

Strengths:

Areas of strength were indicated in the survey by citing adequate capacity, high priority ranking and narrative comments.

The following areas were notable system strengths:

- Alcohol, drug and gambling outreach and prevention community education activities
- Suicide Prevention Activities
- 24/7 Crisis Line
- Mobile Crisis Response
- Intensive Transition Team
- Mental Health/Law Enforcement Collaborative Response (MHRT) program
- Availability of outpatient mental health treatment for OHP insured adults and children
- Availability of outpatient alcohol and drug services for insured adults and kids
- ACT/Intensive Case Management services for severely mentally ill adults
- Availability of peer support services/drop-in centers
- Wraparound intensive care coordination and home-based supports for high needs youth and families

We plan to maintain or enhance funding in each of these program areas. Areas which we intend to increase capacity and investment include Suicide Prevention, Mobile Crisis Response, and MHRT. The balance of programs will be maintained at current funding levels.

Areas for Improvement:

To identify areas for improvement the survey responses were analyzed and the following criteria were applied:

- A majority of respondents cite insufficient capacity in the identified area
- Greater than 66% recommended an increase in capacity in the identified area
- The area received a greater than average priority rating (>3.82)

1. Increase capacity for outpatient mental health services for uninsured adults.

Washington County will begin immediately to direct increased funding to adult outpatient services to facilitate a “ramp up” to getting services to that population who will be increasingly insured with the implementation of the health insurance mandate and expanded Medicaid eligibility components of the Affordable Care Act due to be implemented in 2014. This effort will help to insure provider capacity is developed in advance of expansion.

2. Increase capacity for outpatient alcohol and drug treatment for uninsured adults.

As with mental health services to uninsured, Washington County expects this population will be increasingly insured with the implementation of the health insurance mandate and expanded Medicaid eligibility components of the Affordable Care Act due to be implemented in 2014. We will create a plan to provide support to addiction providers in transitioning to Medicaid while insuring that adequate capacity is maintained or increased for those ineligible for Medicaid.

In collaboration with addiction treatment providers, we will determine specific steps and a timeline to establish a smooth and effective transition to include:

- *Expectations for assisting eligible uninsured clients presenting for addictions treatment in applying for Medicaid*
- *Process to determine those ineligible for Medicaid continue to have access to care*
- *Assist with achieving a seamless financial transition from General Funds to CCO Medicaid reimbursement.*
- *Shift from indigent block grant/slot funding to an appropriate payment methodology that insures the maintenance of or increase in treatment capacity for those ineligible for Medicaid and an equitable distribution of funding across providers.*

We will develop these plans with providers utilizing a collaborative process that is transparent and effective.

3. Increase capacity for Co-existing Disorder Treatment (Mental Health/Addictions) for OHP insured and uninsured adults.

Addressing this need will require focus on workforce development, coordination of funding streams and program development activities. Washington County will be working on achieving this system improvement by working regionally through Health Share of Oregon to effect new payment strategies, and will work locally with our providers to provide technical assistance, training and startup funding.

4. Increase the availability of health services in mental health settings

Washington County will be working on achieving this system improvement by working regionally through Health Share of Oregon to effect new payment strategies, and will work locally with our providers to provide technical assistance, training and startup funding.

5. Increase the availability of affordable independent living options for mentally ill adults.

This is an area that requires a broad community-wide strategy, the development of new community partnerships and the identification of financial resources and support options. Washington County will join, support and encourage community partnerships including the Luke Dorf Housing TEAM Project, the Mental Health and Special Needs Community Consortium, and work closely with the Washington County Housing Services Department to address this need.

6. Increase the number of family/youth partners available within the Wraparound program.

Washington County will continue to provide support for Oregon Family Support Network and Youth Move Oregon to ensure that we have a minimum of two family partners and two youth partners working with Washington County Wraparound youth and families during the next biennium. This constitutes a 40% increase of capacity over the previous biennium. Washington County will also work to connect families with peer support (family/youth partners) offered through our mental health providers that educate and support families of youth with mental health needs as well as continuing financial support for Washington County NAMI and the Washington County Consumer Council Comfort Zone program. Washington County will make it a priority to work with our provider agencies to ensure that they are able to be develop and sustain peer support for their clients in order to make family and youth partners more widely available to the our members, including families and youth participating in the Wraparound program.

**Planned Expenditures 2013 – 2015
(Updated)**

	State Flexible Funding*	Local Beer and Wine Tax	County GF	Other	Total	Prior Period Carry-over Amount
<i>Mental Health Promotion and Mental Illness, Substance Abuse and Problem Gambling Prevention</i>						
Alcohol and Drug Prevention for Children	376,250	200,000			576,250	
Alcohol, Drug and Gambling Outreach and Prevention	56,000				56,000	
<i>Early Intervention</i>					0	
Suicide Prevention/Early Intervention	43,000				43,000	
EASA	1,367,142				1,367,142	
Washington County NAMI	172,000				172,000	
Support to the PATH Program					0	
Mental Health Promotoras Program	175,000			75,000	250,000	
<i>Treatment and Recovery</i>					0	
Child and Family Outpatient Services	300,000				300,000	
Transition Age Youth Intensive Services (TAYIS)	240,000				240,000	
Integrated Services Array/ Wraparound	10,000				10,000	
Home Based Stabilization	120,000				120,000	
Adult Outpatient Services	112,250			500,000	612,250	
Adult Brief Stabilization	144,500				144,500	
Rehabilitation	2,796,895				2,796,895	
Older Adult Services	30,400				30,400	
Culturally Specific Services:	53,200				53,200	
Assertive Community Treatment (ACT)	50,000				50,000	
Adult Mental Health Initiative (AMHI)				1,293,082	1,293,082	329,340
Licensed Residential Services				3,364,582	3,364,582	
Supported Housing	373,666				373,666	
Supported Employment	150,520				150,520	19480
Acute Care	1,846,448				1,846,448	
Jail Liaison Services			264,326		264,326	
Peer Supports			220,000		220,000	
DDA			30,000		30,000	
Outpatient Alcohol and Drug Services for Adults	1,418,354	144,060			1,562,414	
Residential Alcohol and Drug Services for Adults	867,200			1,202,130	2,069,330	
Detoxification Services	705,928				705,928	
DUII Services	364,316				364,316	
ITRS	908,228				908,228	
Drug Court:		140,000		888,188	1,028,188	
Adult Hispanic Alcohol and Drug Services	361,800				361,800	
Housing Subsidies for Adults and Children:	387,000				387,000	
Outpatient Drug and Alcohol Treatment for Youth	674,704	49,460			724,164	
Gambling Treatment	302,706				302,706	

<i>Crisis and Respite Services</i>						0
Crisis Line	473,348			46,652	520,000	
Mobile Capable Crisis Team	1,542,340			117,660	1,660,000	
ITT	452,000			144,000	596,000	
MHRT	678,240			71,760	750,000	128,240
Flexible Respite (Adults)	374,920				374,920	
Crisis and Planned Respite (Children and Adolescents)	135,000				135,000	
Involuntary Commitment Services			2,337,736		2,337,736	
<i>Other</i>						
Data, TPA Services	78,496				78,496	
PSRB	171,323				171,323	
State Hospital Co-Management	100,000				100,000	
LMHA Personnel	1,224,114				1,224,114	

Appendix A: Key Informants Survey Results

Appendix A

System Component	Adequate capacity?		Recommendation?				Rank Priority 1 to 5 5=Highest Priority
	Yes	No	Maintain	Increase	Decrease	N	
<i>Crisis/Acute Care</i>							
24/7 Crisis Line	95%	5%	100%	0%	0%	13	4.47
Peer Supported Warm Line	80%	20%	56%	22%	22%	10	2.78
Mobile Crisis Response	77%	23%	60%	40%	0%	15	4.54
Hospital/ER to Outpatient Transition Services (ITT)	65%	35%	50%	44%	6%	16	4.27
Urgent Care (Same Day/Next Day Access)	67%	33%	69%	31%	0%	13	3.83
Respite Care Adult	38%	63%	50%	50%	0%	6	2.38
Respite Care Kids	69%	31%	75%	25%	0%	8	4.00
Subacute Care Adults	50%	50%	20%	80%	0%	6	3.00
Subacute Care Kids	93%	7%	88%	13%	0%	10	3.44
Partial Hospitalization	91%	9%	100%	0%	0%	8	3.13
Social Detox/Sobering	47%	53%	62%	38%	0%	13	3.27
Medically Supervised Detox	43%	57%	57%	43%	0%	14	3.36
Mental Health/Law Enforcement Collaborative Response (MHRT)	69%	31%	50%	50%	0%	16	4.23
<i>Outpatient Services</i>							
Outpatient MH Treatment - OHP Insured Adults	70%	30%	81%	19%	0%	16	4.47
Outpatient MH Treatment - Uninsured Adults	31%	69%	27%	73%	0%	11	4.18
Child, Youth and Family Outpatient MH Treatment - OHP Insured	71%	29%	71%	29%	0%	14	4.07
Child, Youth and Family Outpatient MH Treatment - Uninsured	53%	47%	57%	36%	7%	14	3.69
Outpatient MH Treatment Older Adults	77%	23%	82%	18%	0%	11	3.90
Culturally-Specific MH Outpatient Services	44%	56%	38%	62%	0%	13	3.43
Outpatient A&D Treatment – OHP Insured Adults	73%	27%	80%	20%	0%	10	4.33
Outpatient A&D Treatment - Uninsured Adults	30%	70%	33%	67%	0%	9	4.25
Outpatient A&D Treatment - OHP Insured Youth	70%	30%	88%	13%	0%	9	4.00

Outpatient A&D Treatment - Uninsured Youth	42%	58%	56%	33%	11%	8	3.78
Intensive Outpatient A&D Treatment –OHP Insured Adults	100%	0%	100%	0%	0%	5	4.67
Intensive Outpatient A&D Treatment – Uninsured Adults	57%	43%	50%	50%	0%	6	4.00
Intensive Outpatient A&D Treatment – OHP Insured Youth	80%	20%	89%	11%	0%	9	4.14
Intensive Outpatient A&D Treatment – Uninsured Youth	40%	60%	33%	56%	11%	9	3.73
DUII Treatment	100%	0%	71%	0%	29%	7	2.83
Gambling Treatment	100%	0%	88%	0%	13%	8	3.00
Outpatient Co-existing Disorder Treatment – OHP Insured Adults	10%	90%	11%	89%	0%	9	4.25
Outpatient Co-existing Disorder Treatment – Uninsured Adults	0%	100%	0%	100%	0%	9	4.43
Outpatient Co-existing Disorder Treatment – OHP Insured Youth	69%	31%	90%	10%	0%	10	4.29
Outpatient Co-existing Disorder Treatment – Uninsured Youth	40%	60%	67%	22%	11%	9	4.00
Culturally-Specific A&D Services	67%	33%	80%	20%	0%	5	4.00
A&D Peer Mentoring	63%	38%	67%	33%	0%	6	3.75
MH Services in Primary Care Settings	35%	65%	56%	44%	0%	16	3.94
Health Services in MH Settings	11%	89%	27%	73%	0%	15	3.86
<i>Early Adult Transition-Aged Services</i>							
Early Psychosis Program (EASA)	76%	24%	60%	33%	7%	15	3.77
Transition-Aged Youth Intensive Services (TAYIS)	74%	26%	64%	29%	7%	14	3.92
<i>Rehabilitative Services for Adults with Severe Mental Illness</i>							
Service Coordination/Case Management	67%	33%	50%	50%	0%	10	4.11
Assertive Community Treatment/Intensive, Community-Based Case Management	70%	30%	63%	38%	0%	8	4.40
Adult Day Treatment	67%	33%	40%	60%	0%	5	2.14
Peer Support Services/Drop-In Centers	70%	30%	56%	33%	11%	9	4.29
Supported Employment	40%	60%	63%	38%	0%	8	3.38
Supported Education	63%	38%	67%	17%	17%	6	3.50
Psychiatric Consultation/Prescribing	29%	71%	45%	55%	0%	11	4.36
Family Support Services	64%	36%	89%	11%	0%	9	3.67
Supported Housing Services	23%	77%	33%	67%	0%	12	3.75
<i>Housing/Residential Treatment</i>							
Room and Board Housing Options	22%	78%	17%	83%	0%	6	2.71
Site-Specific Supported Housing Apartment Complexes	33%	67%	40%	60%	0%	10	3.67

Alcohol and Drug Free Housing	40%	60%	50%	50%	0%	8	4.00
Affordable Independent Living Options	9%	91%	11%	89%	0%	9	4.22
Rent assistance	54%	46%	45%	55%	0%	11	4.00
Adult Foster Care - MH	55%	45%	50%	50%	0%	9	3.11
Adult Treatment Homes - MH	78%	22%	71%	29%	0%	7	3.43
Adult Care Facilities - MH	83%	17%	80%	20%	0%	5	3.00
Adult Treatment Homes – Co-Existing Disorders	0%	100%	33%	67%	0%	6	3.50
Recovery Homes/Oxford House	67%	33%	60%	20%	20%	5	3.40
Treatment Foster Care	56%	44%	33%	50%	17%	6	4.50
Residential Treatment Children and Youth	79%	21%	55%	18%	27%	12	3.44
Alcohol and Drug Residential Treatment - Youth	67%	33%	60%	20%	20%	9	3.56
Alcohol and Drug Residential Treatment - Adults	45%	55%	40%	50%	10%	10	3.56
<i>Intensive Services for Children, Youth and Families</i>							
Intensive Care Coordination (Wraparound)	76%	24%	77%	23%	0%	13	4.00
Home-based supports	69%	31%	55%	45%	0%	11	4.22
Day Treatment – Child/Youth	69%	31%	50%	30%	20%	10	3.75
School based MH services	40%	60%	50%	42%	8%	12	4.27
After-School Structured Services	30%	70%	0%	100%	0%	7	3.50
Family/Youth Partners	45%	55%	33%	67%	0%	9	4.63
<i>Services to Special Populations</i>							
Services Located in the Jail	64%	36%	17%	83%	0%	6	4.38
Mental Health Court	56%	44%	17%	67%	17%	6	3.50
Drug Court	89%	11%	83%	17%	0%	6	3.43
<i>Outreach, Prevention and Early Intervention</i>							
School-Based Alcohol and Prevention Activities	57%	43%	50%	50%	0%	12	4.00
Community Alcohol and Drug Prevention Coalitions	64%	36%	67%	33%	0%	9	4.50
Suicide Prevention	72%	28%	47%	53%	0%	15	4.38
A&D Prevention Community Education	80%	20%	100%	0%	0%	8	4.14
Gambling Outreach and Prevention/Community Education	100%	0%	83%	0%	17%	6	4.00
Homeless Outreach and Engagement	60%	40%	67%	33%	0%	12	3.92
Latino Outreach and Engagement	44%	56%	43%	57%	0%	7	4.00
						Avg	3.82

Criteria for Selection of Priority Recommendations:

- A majority site insufficient capacity
- Greater than 66% recommend an increase in capacity
- Greater than average priority rating (>3.82)

Appendix B: Key Informants Survey Comments

System Component	Comments	Comments	Comments	Comments	Comments	Comments	Comments
<i>Crisis/Acute Care</i>							
24/7 Crisis Line	This LOCAL resource is an essential component to Washington County's mental health system	Very satisfied with current provider and service availability	Offer more opportunities for staff training in other community supports that may not be mainstream mental health services but impact mental health (out of the box options for people who do not qualify for traditional supports)				
Peer Supported Warm Line	There is a well used peer support warmline for this state, it would be nice if we had one for our own county.	Has been available but not widely used.	It is proven that peer delivered services such as this are more effective than the traditional services provided by non-peers.				
Mobile Crisis Response	We need to do a better job at the communications of resources which can be deployed in support of our schools. We work well with all our community partners, but need to always be aware of all the options they have to call upon. Not sure it is clear the best way to employ or request to be deployed the MCR Team.	Could possibly be increased in terms of capacity.	It is so important to have trained people responding to mental health crisis. When the responders are not trained, people get killed.	I initially recommended that the funding for the Mobile Crisis Team be increased, as I think it is an excellent service. However, I see an increased need for Crisis services as a barometer for the effectiveness of the "regular" rehab and outpatient services--the answer to which is NOT to increase Crisis Services, but to increase case management and outpatient therapy services.	The Mobile Crisis Response Team is only available in certain areas of Washington County and the area served should be increased.		

Hospital/ER to Outpatient Transition Services (ITT)	add more capacity for connected clts and kids	The purpose and function of this service is vital and meaningful. It needs more manpower. There is still a noticeable gap for patients who are discharged from the hospital and need to connect with ongoing outpatient mental health services. Complex insurance issues, the nature of the mental health system, anxiety, fear, cultural issues and other variables can often be barriers for people to connect with ongoing mental health services. Whether that assistance/advocacy is through the ITT team or through the hospital Social Worker who discharges the patient--it is a necessity.	Highly effective program.	This team is great, and some increase in capacity could help provide a longer bridge until other supports were in place.	There should be more resources for preventing the hospital/ER visit from happening in the first place.	ITT is the most effective, responsive, resilient, client-centered program we utilize. We were sorry to see that it is now limited primarily to HealthShare clients, and wish that it were once again available to any indigent or underfunded clients.	This service saves the system money and reduces trauma to individuals/families impact my mental illness who are frequent users of the ER
Urgent Care (Same Day/Next Day Access)	use existing resources more efficiently	This would impact the bed days in ED's and acute care	Available through crisis team and ITT.	I have heard of and experienced difficulties in accessing these services if the guardian does not do a considerable amount of pushing			
Respite Care Adult	This would impact the bed days in ED's and acute care	We have the capacity to access respite resources in other counties if needed but I don't think the demand would warrant development of a local program.	The adult team has discussed accessing Respite in Clackamas County, and it could be helpful to have this available in our county to support our members.	I consider the lack of respite services in Washington County to be one of the primary holes in the continuum of care. It directly contributes to longer length of stay on inpatient units, and to unnecessary admissions (patients who are seen in the ED who could be diverted, were respite available), end up being admitted.	Unsure of the impact this would make due to focus on supporting individuals being as independent as possible. The individual is less likely to need respite so this does not support individual independence.		

Respite Care Kids	Respite care is an extremely important tool that can sometimes prevent children from going into the hospital or to residential and/or foster care.	This service is desperately needed by families to increase children being able to remain in their homes and avoid caregiver burnout.	A respite program would benefit the community by reducing frequent use of ER for some individuals.				
Subacute Care Adults	This would impact the bed days in ED's and acute care	Washington Co. could probably access CAT-C if necessary however the need hasn't come up.	See comments above re: respite	A respite program would benefit the community by reducing frequent use of ER for some individuals.			
Subacute Care Kids	Feels like alternatives are often effectively employed...but I'd have to dig in deeper to state for sure.	There are no subacute programs available in Washington County					
Partial Hospitalization	Can be helpful at times, but only in certain circumstances. It's good to have, but not a critical part of the system.						
Social Detox/Sobering	We do not have detox option for OHP/General Fund youth.	This would impact the bed days in ED's and acute care	would be ideal to have options in the county (only aware of Hooper)	Seems like detox can be difficult to access when needed at the moment.	I am not aware of a sobering service for Washington County residents. I only know about Hooper...		
Medically Supervised Detox	We do not have detox option for OHP/General Fund youth.	This would impact the bed days in ED's and acute care	Not adequate for youth	Same as above.	Need for detox for youth	Need more providers and bed availability	Often difficult to access due to capacity limitations.
Mental Health/Law Enforcement Collaborative Response (MHRT)	This service is well used and it would benefit the community to have more coverage of the MHRT.	Great purpose, heading in a positive direction. Hopefully, there will be more funding in the future for increased mental health workers to assist law enforcement.	This would divert some clients who otherwise would go to ED	Again, this is something that we have not talked about this in detail, what the expectations or on request for service. Is the resource allocated at WCCCA based upon the call for service or is it something that should be requested. Not clear that all the SROs which support BSD are fully aware of this nor are the staff.	Proving to be highly effective at a relatively low cost compared to other interventions. Strong recommendation to expand. And it's been highly effective as a venue to improve relationships between MH and Law Enforcement.	Educating law enforcement about mental health is essential to keep people living with mental illness safe. When law enforcement is not working with mental health, people living with mental illness who are in crisis can easily be killed.	This is a great asset to our community and would be good to have an increased capacity through expanding hours of availability
Outpatient Services							
Outpatient MH Treatment - OHP Insured Adults	Parents I work with sometimes find it hard to access treatment for their own mental health needs.	Many of the insured adults are not receiving adequate care because of insurance guidelines and payment schedules.					

Outpatient MH Treatment - Uninsured Adults	Not enough low cost, sliding fee scale counseling options for uninsured adults and undocumented adult residents. Also, not enough Spanish speaking providers who provide low cost, sliding fee scale options for this population.	ideally could be available to wider range, slightly lower risk population, to prevent escalation of symptoms.	It IS available, just in a prioritized manner.	There may be a need for this.	Just look on any city street and you will see the results of not having mental health services available for uninsured adults. Where do they go?	
Child, Youth and Family Outpatient MH Treatment - OHP Insured	Good capacity in most areas with the exception of Tigard-Tualatin/Sherwood and Gaston/Banks. We also lack other language capacity, specifically in Spanish.	Western Psychological and Counseling Services needs to increase its bilingual capacity, especially for Spanish speaking youth and families. They need Spanish speaking front office staff for communication purposes and to help facilitate new referrals. Western Psych. also needs a higher volume of Spanish speaking therapists to better meet community demands.	Insurance requirements make it difficult for anyone to get the care they need in order to thrive.			
Child, Youth and Family Outpatient MH Treatment - Uninsured	Good capacity in most areas with the exception of Tigard-Tualatin/Sherwood and Gaston/Banks. We also lack other language capacity, specifically in Spanish.	Appreciate the Washington County General Fund, especially for uninsured youth who are undocumented and do not qualify for OHP insurance.	there are many children whose families have only what is considered "catastrophic coverage " with deductibles of 3 or 5,000 dollars and many times the family has no ability to pay for any of this deductible . It would help for the county to consider extending coverage via general fund dollars for these children at least until it is clear whether or not Cover Oregon addresses this problem adequately .	Due to the healthy kids initiative we appear to have fewer uninsured youth that we are working with	Children should never go without the medical or mental health care they need. When they do they grow up to be adults who are unable to contribute to our society.	
Outpatient MH Treatment Older Adults	Shoul include heavy outreach to ED's and acute care	Would like to see more prevention and targeted engagement with primary care.				

Culturally-Specific MH Outpatient Services	something for hispanic residents?	We need more clinicians who are linguistically and culturally specific, particularly for the Spanish speaking population.	LifeWorks Northwest, Youth Contact and Morrison Child and Family Services are great models for other agencies with regard to providing culturally specific mh outpatient services. To continue meeting the culturally specific mental health demands of the Washington County community, other agencies such as Western Psychological and Counseling Services need to offer culturally sensitive outpatient services reflective of the growing diversity within Washington County.	difficult to find bilingual providers (e.g. spanish speaking out pt therapist or service coordinator)	Not all cultures are easily served and most of the services are located outside of the county.	Increase access of culturally specific services to include lgbt, african,deaf community, etc
Outpatient A&D Treatment - Uninsured Adults	difficult to access an intake in a timely way (when someone is "ready")					
Outpatient A&D Treatment - OHP Insured Youth	Over reliance on group interventions					
Outpatient A&D Treatment - Uninsured Youth	too much funding available for dwindling group of youth	see comments in section above ranked #1	It's so difficult to get even insured youth the treatment they need. We need to make these services easier to access for youth and adults.			
Intensive Outpatient A&D Treatment –OHP Insured Adults	Advocate for improved IOP rates					
Intensive Outpatient A&D Treatment – Uninsured Adults	difficult to access an intake in a timely way (when someone is "ready")	Seems like providers are having a hard time meeting their targets indicating the availability is adequate at this time.				

Intensive Outpatient A&D Treatment – OHP Insured Youth	Over reliance on group interventions	We need to provide these individuals with mental health treatment otherwise they keep coming back to the system and never become truly clean & sober.				
Intensive Outpatient A&D Treatment – Uninsured Youth	too much funding available for dwindling group of youth	see comments in above section ranked no 1	Seems like providers are having a hard time meeting their targets indicating the availability is adequate at this time.	See above with the Youth and Family outpatient comments.	Not insuring and treating every youth who needs it is setting them up for future failure and having no chance of becoming a contributing member of society.	
Outpatient Co-existing Disorder Treatment – OHP Insured Adults	reallocate funds from regular a&d outpatient	It SHOULD be available as our providers are dually credentialled.	Seeing more and more individuals dually diagnosed.	Dual Diagnosis Annonymous is a wonderful program that should be added to this treatment program.	Co-existing disorders lead to increase cost to the system. An intergrated approach would produce better outcomes and therefore a reduction in cost to the system.	
Outpatient Co-existing Disorder Treatment – Uninsured Adults	ditto	DDA is a good program but cannot be the only option to people with severe problems.	Advocate and support integration of billing to reduce administrative and clinical confusion with billing.	Co-existing disorders lead to increase cost to the system. An intergrated approach would produce better outcomes and therefore a reduction in cost to the system.		
Outpatient Co-existing Disorder Treatment – OHP Insured Youth	Antequated system that separates MH and A&D services	encourage all programs to become able to provide dual diagnosis TX	It is hard to discern whether utilization of this service is a capacity or an engagement issue (often times these youth do not want to engage in the substance abuse component unless there is a formal requirement to do so)			
Outpatient Co-existing Disorder Treatment – Uninsured Youth	Antequated system that separates MH and A&D services	see above				
Culturally-Specific A&D Services	Need for more clinicians in this area.					
A&D Peer Mentoring	Peer Mentoring is a proven winner and there needs to be a larger investment made in this area. Much more effective than traditional services and can is much less expensive.	Advocate for inclusion as a medically necessary service if to be provided by healthcare provider; otherwise funnel funds to peer managed organizations/agencies.				

MH Services in Primary Care Settings	encourage primary care to include more providers on site and offer a range of options via increase coordination	I think we'd serve a lot more folks if it was embedded in most larger clinics.	This could be a great preventative support to help treat MH needs without members needing to go to multiple clinics	Increase partnerships between mental and physical health is needed. Co-locating services benefits both services and should be occurring more often.		
Health Services in MH Settings	county might facilitate conversations between providers of MH and primary care to develop this capacity	Really important.	I am now seeing many older adults with health care needs and that do not qualify for APD services staying longer in residential.	See above.	Support behavioral health providers capacity to bill for behavioral health (mental health and addiction) service array.	Increase partnerships between mental and physical health is needed. Co-locating services benefits both services and should be occurring more often.
Early Adult Transition-Aged Services						
Early Psychosis Program (EASA)	It would be helpful if this program was longer than 2 years and/or had better transition planning for youth exiting the program.	Great program. Very professional and families are generally pleased with the services they receive.	It could be helpful to allow longer than a 2 year treatment period to bridge youth to Adult Rehab supports if they require this team at age 15 or 16	This is such a tremendous program and can help prevent young people from becoming life-long consumers of the mental health system. We need to fund it better.	criteria sometimes exclusionary	
Transition-Aged Youth Intensive Services (TAYIS)	Many early aged TAYIS and EASA adults do not have the same diagnosis as our older adults and have different service needs.	See above.	Ditto from above.			
Rehabilitative Services for Adults with Severe Mental Illness						
Service Coordination/Case Management	Capacity is adequate however the overall turnover of staff in provider agencies impacts the quality of the service provided.	Lowering caseloads of case managers could be effective prevention, so that higher level rehab services are not needed.	I think the mental health system makes people living with mental health to dependent on case managers. I would like to see the system set up to empower folks with mental illness to think for themselves and be proud of being self-sufficient.	Rather than only increasing crisis services, the funding for case management should be increased to allow for smaller caseloads, closer monitoring (of ALL rehab clients, not just ICS/ACT clients), with an eye to reducing the need for hospitalization or other higher levels of care.		
Assertive Community Treatment/Intensive, Community-Based Case Management	Similar to the comment above.					

Adult Day Treatment	I don't believe day treatment is necessarily consistent with individualized support toward recovery. Partial hospitalization can be used for stabilization, but long term daily structure should emphasize integration in community, not clinical programs. Just my opinion.	May be a good opportunity to expand as individual sits at AFH all day without options.	Adult Day Treatment centers with on-site staff are an essential part of the continuum of care for SPMI clients. Clients get lonely, and this can lead to increased depression..and to the ED.			
Peer Support Services/Drop-In Centers	It would be nice to have greater access county-wide. I'd like to see more emphasis on embedding peer services within mental health providers rather than stand alone centers.	The current drop-in centers (Comfort Zone) is funded far to sparsley despite the wonderful, proven system it provides. We should be encouraging peer-to-peer drop-in centers instead of putting more money into the traditional system.	Need to support peer leadership organizations to champion peer mentored services	NAMI and Comfort Zone offer a range of services and opportunities for peers. If expansion is needed to meet community need, it should occur within these well-established programs.		
Supported Employment	It would be nice to have greater access county-wide, but challenging to have fidelity programs embedded within multiple providers.	Few opportunities and only one agency provides, LifeWorks.	Many people living with mental illness don't want to work or are unable to work but feel pushed into it by case managers or the inability to live on their meager disability incomes.			
Supported Education	This program can be self-supportive without much additional cost other than start up.	I think again, only one agency provides	I was recently told by Voc. Rehab that they didn't do supported education any more. I wanted to go back to school but felt I couldn't because there was no assistance available to me.			
Psychiatric Consultation/Prescribing	access is not always consistent across agencies	Need more LMPs in the system!	This is always a challenge. There are not enough prescribers to adequately meet the need of individuals in a timely manner.			

Family Support Services	This could always be expanded, but I think we have a good program in place.	I think that this is an engagement issue, and that adult providers could have a better focus on connecting families with these supports	While these are incredibly valuable, given the limited resources current levels are supporting the community and available funding needs to increase for the availability of services to underserved members of our community.			
Supported Housing Services	Isn't this captured below?	More funding in this area could lead to less utilization of Residential and Foster Care for adults	Support as alternative to more expensive residential treatment	Increased opportunities for individuals to live successful in our community both our community as a whole and the quality of life for individuals.		
<i>Housing/Residential Treatment</i>						
Room and Board Housing Options	need to leverage other sources of funding as well	would impact unnecessary bed days in RTF's and RTH's (and hospital)	I think it would be helpful to have, but not sure I'd want to use county money to develop it.			
Site-Specific Supported Housing Apartment Complexes	would impact unnecessary bed days in RTF's and RTH's (and hospital)	I suspect we could reduce the need for higher levels of care if the support was adequate.	Need to look at next steps from RTH/F to SH vs. AFH LOC.	See above with Supportive Housing comments	I think it is so important for people living with mental illness to be integrated into the community instead of living in isolated apartment complexes where they only live with their peers.	
Alcohol and Drug Free Housing	How about wet housing?					
Affordable Independent Living Options	would impact unnecessary bed days in RTF's and RTH's (and hospital)	Need landlords willing to work with mentally ill folks and folks with criminal histories.	This is a significant barrier due to the limited section 8 funding.			
Rent assistance	would impact unnecessary bed days in RTF's and RTH's (and hospital)	This could be an endless need.				
Adult Foster Care - MH	would impact unnecessary bed days in RTF's and RTH's (and hospital)	diffcult to know how to access	Lots of AFH availability, but funding is dependent on the State.	Using many APD homes for capacity.		
Adult Treatment Homes - MH	Not funded by County--state funded and service is considered a state-wide resource as opposed to local.					
Adult Care Facilities - MH	Same as above.	All RTFs in WashCo are 7 bed homes. Good size.				

Adult Treatment Homes – Co-Existing Disorders	Would need state development as licensed residential is a state resource, not local.	Should look to bringing in this skill set to the community as many folks are dual diagnosis A&D and MH.	Appropriate housing is more difficult for individuals with co-existing disorders.			
Treatment Foster Care	I believe that we are only using DHS funding for this at this time	Treatment Foster Care is difficult to access and homes are not always available close to the family of origin.	Current services do not seem very effective			
Residential Treatment Children and Youth	proper utilization is required to improve more than increase funding	Currently one Home for MH. Yet to be determined the need vs. referrals.	I think that we are using less PRTS dollars than are allocated	There are no residential care facilities in Washington County. Families must travel to Portland, sometimes several times a week, which can be a daunting task for working families or families that have more than one child.		
Alcohol and Drug Residential Treatment - Youth	proper utilization is required to improve more than increase funding - for example better aftercare planning	Need for Dual Dx res. For youth				
Alcohol and Drug Residential Treatment - Adults	Ideally we'd be able to access residential treatment the same day as the request.					
<i>Intensive Services for Children, Youth and Families</i>						
Intensive Care Coordination (Wraparound)	Great work, excellent evidence based model for at risk youth and families.	Do not have a rank order. Know that the resources may be there, problem with the youth intervention is how to get the parent to use the services and insure there is follow up.	I think it's an important service. I do wonder about MH picking up the full cost as it seems to benefit other systems greatly.			
Home-based supports	Allocating money here rather than PRTS or PDTS might be better used.					
Day Treatment – Child/Youth	I believe we have been under our allocation here as well as PRTS	Increase the education systems share in offering the service.				

School based MH services	School Districts have difficulty maintaining funding for these programs. Need to continue to find creative ways to support school based mental health services.	Care Coordinator program and Youth Contact are doing great work in the Hillsboro School District. Due to budget cuts, Beaverton School District is eliminating their version of Care Coordinators. Tigard-Tualatin School District may be losing their Care Coordinators. Mental health advocacy in schools is vital.				
After-School Structured Services	Continues to be a need for more affordable, structured and supervised prosocial services for youth after school. Gang prevention activities/organizations needed, similar to what Sky's the Limit program through Washington County Juvenile Dept. used to offer.	For families that have children w/severe behavioral issues there is little to no after school services. This is detrimental to working families.	This would dramatically increase the quality of lives for youth and families by providing a normal activity that youth with SPMI often do not have			
Family/Youth Partners	It'd be nice to have access to family partners for adults. Not frequently, just on occasion for particular situations.	Additional family partners would help connect families to natural supports	There are only 2 family partners available for all cases. Neither of them are culturally competent.	Look for non-fee-for-service models for more cost effect and quality services		
Services to Special Populations						
Services Located in the Jail	Increased focus on housing coordination	Very important service.	There should be a better plan for release to decrease recitivism			
Mental Health Court	Functionally not helpful as a service in the overall continuum of care as the folks who would benefit are unable to get in. I'd like to see these issues addressed but not sure there is adequate time/system will to address them.	Great program. It should be more available to people who need it.	This is an extremely valuable service that helps many and needs to help many more.			
Drug Court	Needs a stable source of funding rather than relying on grants.	Ditto from above.				
Outreach, Prevention and Early Intervention						

School-Based Alcohol and Prevention Activities	Not universal, wide diversity of programs across the school districts in the county.	School-based Youth Contact reaches many students in Hillsboro's secondary schools. But there needs to be more, especially with regard to education and prevention activities in elementary and secondary schools. We need to reach students sooner, preferably in elementary school.	We have reduced staff in this area. The county is okay, but as we reduce we rely more heavily upon community partners.			
Community Alcohol and Drug Prevention Coalitions	Only aware of Beaverton Together.					
Suicide Prevention	Not all school districts have best practices in place. We are in the beginning stages of creating a strategy for suicide prevention across the lifespan county-wide.	Proud of the Hillsboro School District and Washington County Mental Health leading the Suicide Prevention initiative through ASIST and the RESPONSE curriculum funded by the Garret Lee Smith Grant. Proud to be a facilitator of ongoing suicide awareness and intervention trainings at schools within HSD. Proud of the Washington County community coming together around this sensitive issue. The foundation has been established--keep the momentum alive. Amy Baker is doing a great job!	Know that there is a great level of support from the county and Amy Baker is doing great job. We within our sphere need to focus more and require additional county support to move forward.	New efforts are just underway, would like to see where it goes before increasing investment.	There is a Council forming called the Washington County Suicide Prevention Council that has a vision of zero suicides in Washington County. I believe this is going to be great work, and needs support of the community.	
A&D Prevention Community Education	Very important and there is a need for more A/D prevention and education in schools.					
Homeless Outreach and Engagement	it would be ideal to have some type of transitional shelter	Direct contract with the state, WaCo no longer funding this service.				
Latino Outreach and Engagement			We need more Latino outreach and engagement throughout Washington County.			

Addictions and Mental Health Division

January 21, 2014

Biennial Implementation Plan Amendment Template

CMHP: Washington County

Program: Crisis Team Expansion

Budget Item	Jan. 1, 2014 – Jun. 30, 2014	July 1, 2014 – Jun. 30, 2015
Personnel <i>(including FTEs, Classification of staff and associated costs)</i>	Services Director, .04 FTE (\$1,293) Program Director, .12 FTE (\$2,853) Clinical Supervisor, 2.0 FTE (\$34,320) Peer Specialists, 1.0 (\$7,020) Admin Asst, .07 FTE (\$1,225) LMP, .2 FTE (\$22,880) MH Therapist, 3.0 FTE (\$65,398) MH Therapist (coverage), .4 FTE (\$8,911) Benefits: \$34,536	Services Director, .04 FTE (\$3,517) Program Director, .12 FTE (\$7,762) Clinical Supervisor, 2.0 FTE (\$93,350) Peer Specialists, 1.0 (\$28,642) Admin Asst, .07 FTE (\$2,916) LMP, .2 FTE (\$46,675) MH Therapist, 3.0 FTE (\$113,413) MH Therapist (coverage), .4 FTE (\$18,178) Benefits: \$79,846
Travel	\$156	\$312
Equipment	\$50,780	\$5,880
Supplies	\$216	\$511
Consultants/Contracts	\$4,950	\$4,383
Other Costs: (please list)	\$71,685 Includes: -flex funds -client transportation -cell phones -wireless access -insurance -meeting material -printing -hiring expenses -software licensing -occupancy -quality assurance -front desk staff -indirect admin	\$159,689 Includes: -flex funds -client transportation -cell phones -wireless access -insurance -meeting material -printing -hiring expenses -software licensing -occupancy -quality assurance -front desk staff -indirect admin

Totals	\$311,770	\$583,314
Overall Project Cost	\$311,770	\$583,314
Revenue Identify expected revenues; i.e., Medicaid billing/encounters)	\$36,440	\$108,644
Number of individuals Intended to be Served	84	336

Budget Narrative:

- Please provide a description of the program and any unusual expenditures

Washington County is planning to expand the existing Crisis Services Program operated by Lifeworks NW by increasing the scope of services provided by existing teams and adding a fourth service, the Peer Crisis Support Program. Washington County will develop the existing Crisis Program into a comprehensive crisis support service program with multiple sub-teams available to provide a wide array of services designed to provide crisis intervention at the earliest possible intervention point, preferably prior to an ED or inpatient admission, through the mobilization of community based supports and preventative activities. In order to accomplish this, Washington County and Lifeworks NW is proposing a two strategy approach:

- **Strategy 1:** Add a peer crisis support team to the existing Crisis Services Program.
- **Strategy 2:** Expand the Mobile Crisis Team with an emphasis on development of specific support to emergency departments dedicated to working with EDs to provide inpatient diversion plans and supports.

Both of the expansion strategies include some initial start up expenses for office furniture, computers and a vehicle. Ongoing expenses are estimated using our experience with the other teams of the Crisis Program.

- Please provide an implementation timeline for this program.

Task	Completion Date	Person Responsible
Advertise for mobile crisis services position and peer services supervisor position	Upon contract execution	Kris Miller
Immediately expand Mobile Crisis Team by adding weekend hours	February 28, 2014	Kris Miller
Hire peer services supervisor and Mobile Crisis Team positions	March 1, 2014	Kris Miller

Outreach to local ED supervisors to develop ED support roles	March 31, 2014	New supervisor for ED specialist / Kris Miller
Develop program description for the Peer Crisis Support Program	March 1, 2014	Phyllis Maynard
Training for 6 crisis team & ITT staff regarding peer support model (and training for supervisors/management)	March 31, 2014	Phyllis Maynard
Advertise for peer staff	Upon contract execution	Kris Miller
Hire and train peer staff	March 31, 2014	Peer Support Services Supervisor
Begin Peer Crisis Support Program	June 1, 2014	Peer Support Services Supervisor
Create venue to work with EDs on addressing ongoing implementation issues	May 1, 2014	New supervisor for ED staff, Rich Roell and Kris Miller

Budget—REVISED 1/9/2014

RFP# 3693

Proposer Name: Washington County Health and Human Services, Mental Health Program

Project Term: Jan. 1, 2014 – Jun. 30, 2015

Budget Item:

Total:

Personnel: \$205,293

Travel: \$871

Equipment: \$2,000

Supplies: \$200

Consultants/Subcontracts: _____

Other Costs: (please list):

Flexible Funds: \$6,000

Overall Project Cost: \$214,364

Budget Narrative: (Use this space to further clarify items.)

The primary expense associated with this project is personnel costs. Washington County is requesting funding for two positions, a project manager and a service coordinator. The project manager will be a temporary position of limited duration. This position will be .4 FTE for 9 months with a fully loaded cost of \$46,000. As a .4 FTE, it will be a non-benefitted position. The other position will be a full time Mental Health Services Coordinator, a classification that is similar to other care coordination positions at the County. This position will be benefitted and will be ongoing after the initial 18 months. The fully loaded annual cost at the beginning of the pay scale, is \$111,050. The total cost of this position has been reduced from 18 months to 15.5 months as the position will be vacant during the recruiting process. We anticipate the position will be filled by 3/15/2014. The 15.5 month cost for this position with a 5% increase and 2% COLA for the second 6 months will be \$137,973. We've included .05 CMHP director time and .05 FTE Adult MH Supervisor time at a cost of \$21,320 for the 18 month period. This amount was reduced slightly to account for a decrease in CMHP director time after the project manager's task is complete in the final 6 months of the project.

We are requesting a laptop to support the work activities of this individual. The supplies primarily consist of meeting materials needed to facilitate discussion and light refreshments to facilitate engagement by the partners. In addition, we have included flexible expenses of

approximately \$100 per individual client served per year. The purpose of this funding is for engagement activities and supports. This funding will be available to both the coordinator and MHRT. Finally, we estimate 100 miles per month for the care coordinator to engage in outreach activities at \$.56/mile. This amount is reduced slightly from the original proposal as the reimbursement rate from the County was reduced effective 1/1/2014 and the coordinator will not begin accruing mileage expenses immediately.

Addictions and Mental Health Division

January 21, 2014

Biennial Implementation Plan Amendment Template

CMHP: Washington County

Program: Jail Diversion

Budget Item	Jan. 1, 2014 – Jun. 30, 2014	July 1, 2014 – Jun. 30, 2015
Personnel <i>(including FTEs, Classification of staff and associated costs)</i>	.4 FTE Sr. Program Coordinator (\$23,000) 1.0 FTE MH Services Coordinator (\$41,166.67) .05 MH Services Supervisor (\$3,525.00) .05 CMHP Director (\$4,250.00)	.4 FTE Sr. Program Coordinator (\$23,000) 1.0 FTE MH Services Coordinator (\$96,806.67) .05 MH Services Supervisor (\$7,050.00) .0375 CMHP Director (\$6,494.67)
Travel	\$266.00	\$605.00
Equipment	\$2,000.00	None
Supplies	\$100	\$100
Consultants/Contracts	None	None
Other Costs: (please list)	\$2,000 Flexible funding for client engagement and supports	\$4,000 Flexible funding for client engagement and supports
Totals	\$76,307.67	\$138,056.34
Overall Project Cost	\$214,364.00	

Revenue Identify expected revenues; i.e., Medicaid billing/encounters)	None. This program will not employ treatment interventions.	
Number of individuals Intended to be Served	20	40

Budget Narrative:

- Please provide a description of the program and any unusual expenditures

Washington County is proposing a strategy to achieve the following goals: decrease the number of jail days used by individuals with a severe mental illness (SMI) and increase the percentage of individuals connected to mental health treatment who has repeated contact with law enforcement and corrections. In order to accomplish this, we plan to utilize two concurrent strategies to align existing collaborative efforts between mental health and system partners to divert severely mentally ill individuals from jail:

- Strategy 1: Complete a systematic evaluation of the current system and identify intercept points for engaging individuals into mental health treatment. Develop shared understanding of goals and strategies by all system partners.
- Strategy 2: Implement a care coordination approach to focus on high jail utilizing SMI individuals. Coordinate client-specific strategies to meet that person's needs and reduce jail bed days.

The primary expense associated with this project is personnel costs. Washington County is requesting funding for two positions, a project manager and a service coordinator. The project manager will be a temporary position of limited duration. This position will be .4 FTE for 9 months. As a .4 FTE, it will be a non-benefitted position. The other position will be a full time Mental Health Services Coordinator, a classification that is similar to other care coordination positions at the County. This position will be benefitted and will be ongoing after the initial 18 months.

Other expenditures include a laptop and supplies, primarily meeting materials needed to facilitate discussion and light refreshments to facilitate engagement by the partners. In addition, we have included flexible expenses of approximately \$100 per individual client served per year. The purpose of this funding is for engagement activities and supports. This funding will be available to both the coordinator and MHRT. Finally, we estimate 100 miles per month for the care coordinator to engage in outreach activities at \$.56/mile.

- Please provide an implementation timeline for this program.

Strategy	Task	Timeline
Strategy 1: Complete a systematic evaluation of the current system and identify intercept points for engaging individuals into mental health treatment.	Staff hired and trained	5/1/2014
	Triage matrix for each intercept point developed	12/31/2014
	Triage matrix for each intercept point implemented on client specific basis	6/31/2015
STRATEGY 2: Implement a care coordination approach to focus on high jail utilizing SMI individuals.	Staff hired and trained	3/15/2014
	Care coordination provided to incarcerated severely mentally ill individuals	6/30/2014
	Data analysis of inmate data to identify individuals for outreach	6/30/2014
	Data analysis of outcome measure to determine jail bed day reduction	6/30/2015

Budget: Applicants must provide a budget including:

a. Proposed operating budget (18 months) and budget narrative

b. Existing budget reflecting current crisis services and budget narrative

Please see Attachment B for budget detail. The budget is broken out by strategy and includes the required current operating budget for the LifeWorks' Crisis Program for fiscal year 13-14 as it exists without the expansion. Both of the expansion strategies include some initial start up expenses for office furniture, computers and a vehicle. Ongoing expenses are estimated using our experience with the other teams of the Crisis Program. Additional detail can be provided upon request. We included additional training for all the crisis team clinicians around incorporating peer supports into the crisis interventions provided. We felt this would be important to establish the role of the peers into the Crisis Program and ensure there was clarity among all team members of how the peers may be utilized. This is included as a one time expense.

The two strategies have a combined cost of \$583,314 per year or \$895,084 for the 18 month period between January 1, 2014 and December 31, 2015 including start up. This reflects a slight FTE reduction in both programs to account for a reduced award. In addition, Health Share of Oregon, Washington County, will contribute 16% of the funding which is consistent with their member's utilization and the funding provided to other crisis services in Washington County. In doing so, the expanded program can be developed very close to the original model with minimal changes. The implementation of the Peer component will be delayed slightly for a cost savings as well. This is also necessitated by the need to replace the Peer Services Director at Lifeworks who recently resigned.

By leveraging existing expertise and resources, we believe we can employ a rapid start up that will ensure the funding is quickly utilized for clinical interventions with minimal start up costs. Each of the two strategies includes funding for a vehicle. We have found that it is critical for staff to have access to an agency car to facilitate transportation and rapid response. Below is a summary of the proposed budget:

	Start up	Year 1 (6 Months)	Year 2 (12 Months)	Total
Strategy 1, Peer Crisis Support Team	\$31,203	\$39,698	\$153,539	\$188,000*
Strategy 2, Crisis Team ED Expansion	\$26,445	\$214,424	\$429,775	\$562,000*
Total:	\$57,648	\$254,122	\$583,314	\$750,000*

*Reflects a 16% contribution to program cost by Health Share of Oregon (\$145,084). Actual program cost is \$895,084.