

**Oregon's
Community Mental
Health Services and
Substance Abuse
Prevention & Treatment
Block Grant Application**

2014-2015

**Written comment will be accepted
through 5:00 pm on May 31, 2013.**

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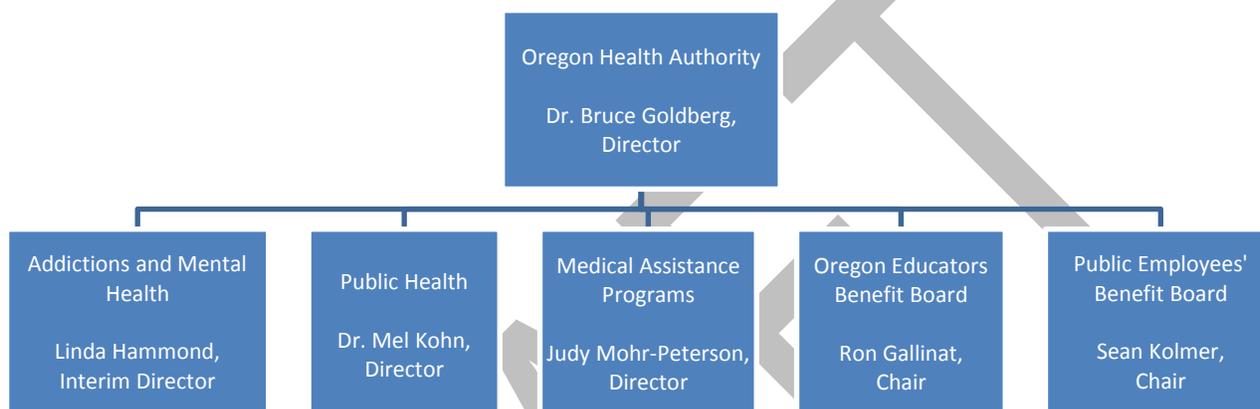
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STEP ONE

The Addictions and Mental Health Division (AMH), situated within the Oregon Health Authority (OHA), envisions a healthy Oregon in which mental health disorders and addiction to substances or gambling are prevented through education, early intervention and access to appropriate health care. Figure 1 depicts the organizational structure of OHA and identifies the Director of each Division.

Figure 1.



The mission of AMH is to assist Oregonians to achieve optimal physical, mental and social well-being by providing access to health, mental health and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities. This mission is accomplished by working in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to implement the services and supports described in this plan.

Per Oregon Revised Statute (ORS) AMH is responsible for:

- Planning, designing, and developing resources for behavioral health programs throughout the state;
- Ensuring the quality, effectiveness, and efficiency of those programs;
- Operation, control, and management of the state hospitals;
- Psychiatric residential and day treatment services for children with mental disorders;
- Managing contractual relationships with AMH providers of local behavioral health services;
- Legal and financial compliance audits; and
- Managing the budgeting and business operations of AMH to expedite the effective delivery of services.

The Addictions and Mental Health Division's Prevention Unit oversees the service delivery system at the state level, including the following major responsibilities:

- Determine provider eligibility and allocate funding for prevention services;

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- Monitor contract compliance;
- Provide training and technical assistance on evidence-based practices and tribal best practices, program planning, implementation and evaluation;
- Set policy and standards for prevention services;
- Provide prevention training for the prevention workforce;
- Collect and provide relevant data to local communities;
- Collaborate with key stakeholders; and
- Advocate for prevention.

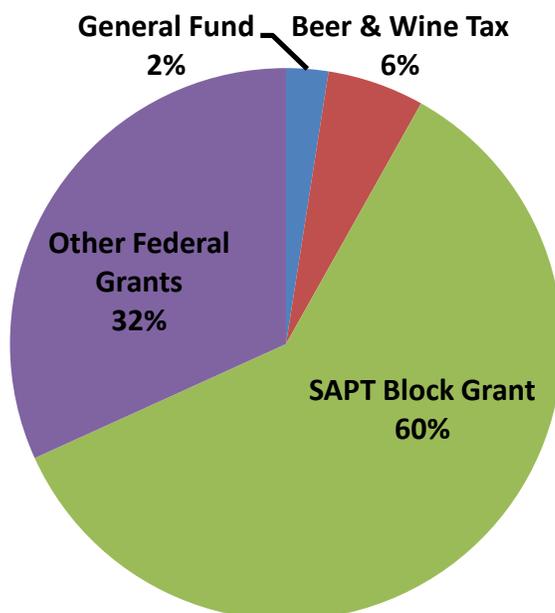
AMH is working to develop a greater focus on prevention activities that incorporate prevention of mental illness disorders and that reinforce the importance of behavioral health promotion.

AMH also serves as the State Mental Health Authority and the Single State Agency for purposes of the Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG) respectively.

Funding for Behavioral Health Services

Prevention Services

Substance abuse prevention funding comes from several sources, including General Fund, Beer and Wine Tax, SAPT Block Grant and other Federal Grants, (e.g. Enforcing Under-Age Drinking Laws and Strategic Prevention Framework Grant). Federal grants provide over 92 percent of alcohol and drug abuse prevention funding. Graph 1 represents the percentage of each in the total prevention budget. Lottery funds provide 100 percent of problem gambling prevention services. Graph 1.



County and tribal allocations are based primarily on population, but each is provided with sufficient base funding to employ a minimum half-time prevention coordinator. Base funding provides the capacity to meet a minimum level of prevention services at each county and tribe across the state.

Thirty-one Community Mental Health Programs (CMHPs), nine federally recognized Tribes and two statewide contractors receive funding to develop and provide prevention services at the local level. Their major responsibilities include:

- Implementation of effective prevention programs based on a community needs assessment and overall prevention standards;
- Submission of timely and accurate Minimum Data Set (MDS) data,
- Submission of biennial implementation plans and annual reports;
- Compliance with state statutes and administrative rules governing prevention;
- Promotion of sustainability through local funding development, grant-writing, and advocacy;
- Collection, analysis and utilization of current local data for trends in alcohol, tobacco and other drug use and gambling;
- Leading and participation in collaborative planning with partners and coalitions;
- Technical assistance to and collaboration with community agencies, law enforcement, schools and other key partners.

Approximately 20 percent of the funds OHA receives for mitigating harm from gambling are allocated to problem gambling prevention efforts. Problem gambling prevention programs are overseen at the state level (allocations, technical assistance, policy, performance monitoring, etc.) and administered locally by certified prevention specialists.

Mental Health Services

State funds for community mental health programs serving individuals with mental or emotional disorders or substance use disorders are allocated to counties through intergovernmental agreements called County Financial Assistance Agreements (CFAAs). In allocating these funds, the Oregon Health Authority observes the following priorities:

1. To ensure the establishment and operation of community mental health programs for persons with mental or emotional disorders in every geographic area of the state to provide some services in each category of services described in [ORS 430.630](#)
2. To ensure survival of services that address the needs of persons within the priority of services under [ORS 430.644](#) (Priorities for services provided by community mental health programs) and that meet authority standards;
3. To develop the interest and capacity of community mental health programs to provide new or expanded services to meet the needs for services under ORS 430.644 and to promote the equal availability of such services throughout the state; and
4. To encourage and assist in the development of model projects to test new services and innovative methods of service delivery.

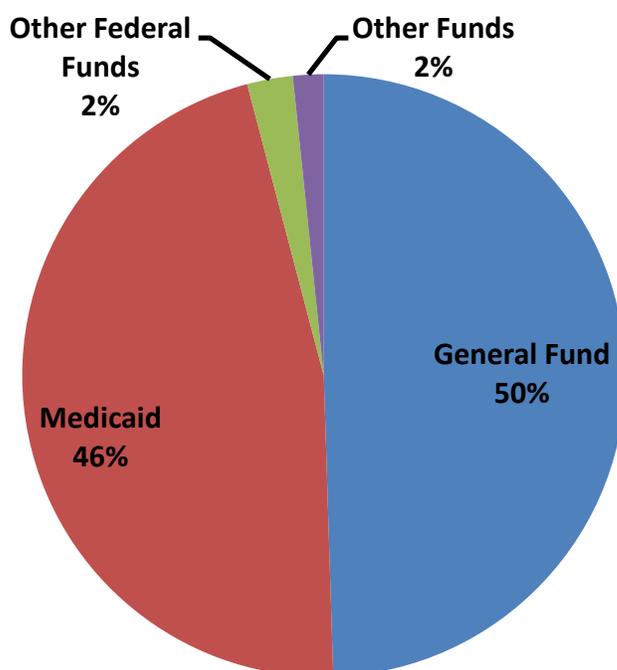
AMH assists Oregon counties¹ and groups of Oregon counties in the establishment and financing of community mental health programs (CMHPs) operated or contracted for by one or more counties. If a county declines to operate or contract for a CMHP, AMH may contract with another public agency or private corporation to provide the program. If a county agrees, AMH may contract with a public agency or private corporation for all services within one or more of the following program areas:

- Mental or emotional disorders,
- Drug abuse, or
- Alcohol abuse and alcoholism.

At the request of the tribal council of a federally recognized tribe of Native Americans, AMH may contract with the tribal council for the establishment and operation of a community mental health program in the same manner in which the Authority contracts with a county.

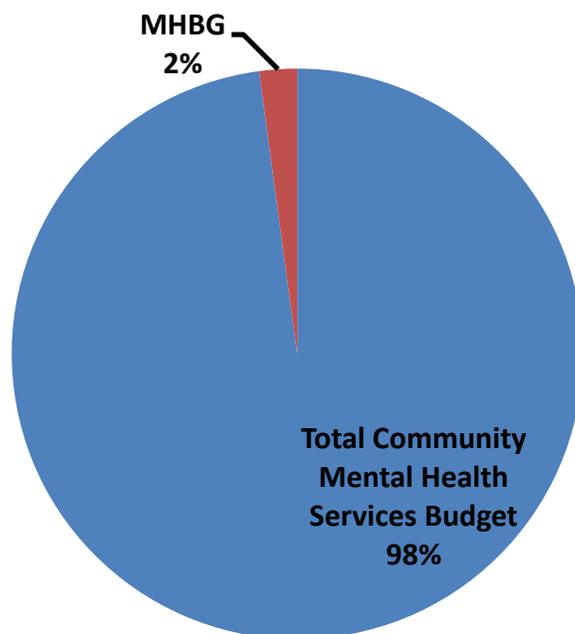
Publicly-funded community mental health services in Oregon are supported by four main sources: State General Fund dollars, Medicaid (federal and state match), other Federal funds (e.g. Block Grant, Projects for Assistance in Transition from Homelessness), and other funds. Graph 2 represents the percentage of each in the total budget while Graph 3 represents the percentage of the total community mental health services budget represented by the MHBG.

Graph 2.



¹ The county court or board of county commissioners of Oregon counties are designated as Local Mental Health Authorities (LMHAs).

Graph 3.



Addictions Services

County and tribal financial assistance agreements support a continuum of substance use disorder treatment and recovery services statewide. Block grant funds continue to support outpatient, intensive outpatient, case management, recovery support services, medication assisted treatment, social detoxification and residential treatment services across the state to support individuals and services not covered by a third-party benefit such as private or public health insurance. Children and adults of all ages who have a diagnosed substance use disorder are eligible for services.

Any person enrolled in the Oregon Health Plan (OHP) may access the OHP chemical dependency benefit when medically appropriate. There are specialized programs designed to meet the needs of women, parents with children, minorities and adolescents. For example, Oregon supports a number of residential treatment programs designed specifically to serve parents whereby dependent children accompany their parents. These programs focus on teaching parents with serious addiction issues how to effectively parent while engaging in early recovery.

Oregon supports one culturally-specific Hispanic residential treatment program and two culturally-specific Native American residential treatment programs; one for adults and one for youth. In addition, one residential treatment program in the Portland metro area is designed to serve African American women who are single, pregnant or parenting. Six programs throughout the state are designated to serve youth populations in a residential setting.

Priority populations to be served include but are not limited to intravenous drug users (IDU), pregnant women with substance use disorders and low-income youth and adults with substance use disorders.

AMH plans to continue promoting a recovery-oriented system of care through investments supporting a range of prevention, treatment, and recovery services and supports through a managed community-based system that is accountable and responsive to the needs of individuals and families. AMH plans to build upon contract language expanding on integration efforts across addictions, mental health and physical health care.

Medicaid-Funded Services

Oregon established a set of policy objectives to guide the development of a methodology for setting health care priorities to enable accountable and effective funding of health care. In 1989, the Oregon Legislature created the Health Services Commission and directed it to develop a prioritized list of health services ranked in order of importance to the entire covered population. The list rank-orders general categories of health services (e.g., Maternity and newborn care; Comfort care) based on relative importance gauged by public input and based on Commissioner judgment. Within these general categories, individual condition/treatment (CT) pairs are prioritized according to impact on health, effectiveness and cost. The prioritized list is used by the Legislature to allocate funding for Medicaid. The benefits based on the prioritized list are administered primarily through Coordinated Care Organizations (CCOs).

In 2002, the Commission developed a summary level prioritized list to be used in further expanding health coverage. This list prioritizes broad categories of service (e.g. hospital inpatient, physician, prescription drugs, and mental health) and identifies cost sharing levels for each category of service at each priority level. Its goal was to develop a public program benefit package that approximates the typical private insurance benefits purchased by Oregon businesses for employees.

The full prioritized list is available at:

<http://www.oregon.gov/oha/OHPR/HERC/docs/L/Oct2012/Oct12List.pdf>.

Mental health care and chemical dependency services extracted from the prioritized list of health services and their prioritized list line number are available at:

<http://www.oregon.gov/oha/OHPR/HERC/docs/L/Oct2012/Oct12MHCD.pdf>.

Over the last 18 months, significant changes have taken place in processes aimed at assisting Oregon to achieve the Triple Aim of better health, better care and lower cost. Oregon's Health System Transformation and the AMH System Change Initiative are described below.

Health System Transformation

Through a public process lead by Governor Kitzhaber and the Oregon Legislature, Health System Transformation was implemented to provide better care for people who rely on the Oregon Health Plan (Medicaid). The passage of House Bill 3650 and Senate Bill 1580 created a statewide system of Coordinated Care Organizations (CCOs).

A CCO is a network of all types of health care providers (physical health care, behavioral health care and, in 2014, dental health care providers) who have agreed to work together in their communities to serve people who receive health care coverage under the Oregon Health Plan.

Better care brings lower costs, and minimizes the likelihood of higher costs over time. CCOs have the flexibility to provide the services and supports that help people stay healthy or get healthier:

- Preventive care
- Coordination of care to limit unnecessary tests and medications
- Integration of physical and mental health and addictions services and supports
- Chronic disease management to help people avoid unnecessary hospitalization
- Person-centered care

CCOs are focused on prevention and helping people manage conditions like diabetes, asthma, mental illness and addictions. This helps reduce unnecessary emergency room visits and gives people support to be healthy. CCOs are replacing a fragmented system of care that relied on different groups to provide physical health, dental health, mental health and addictions care. CCOs are set up to put an emphasis on person-centered care, where all care providers are coordinating efforts to make sure service plans complement each other. CCOs strive to increase health equity, to ensure that everyone in Oregon has the care they need to stay healthy.

CCOs are locally governed by a partnership among health care providers, community members and stakeholders in the health systems that have financial responsibility and risk to address community needs. CCOs are required to complete a community health assessment and develop a community health improvement plan to address the needs and gaps identified in the assessment. CCOs are accountable for the health outcomes of the populations they serve. To provide the flexibility needed to support new models of care that are patient-centered and team-focused, and reduce health disparities, CCOs have a global budget that grows at a fixed rate. They have flexibility within their budget to provide services utilizing OHP benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the populations they serve.

A competitive application process was implemented in March, 2012, and resulted in fifteen² CCOs operating in communities around Oregon. The majority of OHP members now receive care through a CCO.

² See the complete list at www.health.oregon.gov.

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OHA has initiated a strategy to partner with CCOs that will identify dynamic Transformation Plan milestones, deliverables, and targets for becoming a fully integrated CCO in the communities they serve. The Transformation Plans address eight key components:

1. Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions. This plan must specifically address the needs of individuals with serious mental illness.
2. Continuing implementation and development of Patient-Centered Primary Care Homes (PCPCH) for eligible individuals.
3. Implementing consistent alternative payment methodologies that align payment with health outcomes.
4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with 2012 Oregon Laws.
5. Developing electronic health records; health information exchanges; and meaningful use.
6. Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs of populations served.
7. Assuring provider network and staff ability to meet culturally diverse needs of the community (cultural competence training, provider composition reflects Member diversity, nontraditional health care workers composition reflects Member diversity).
8. Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Each CCO has submitted a Transformation Plan to OHA for final approval. The Transformation Plans consist of two parts:

- A *detailed narrative* which describes the CCO's plan to transform the health care delivery system including a description of how the CCO will address the eight key components mentioned above; and
- *Contract deliverables* which are a standardized template that incorporates the key plan milestones with measurable targets from the plan's detailed narrative. This will result in a tool for monitoring progress and serves as the contract amendment.

To encourage continuous quality improvement, recognizing that transformation is an iterative process and that Transformation Plans will and should evolve over time, a process has been established for OHA to review draft Plans, provide feedback, and finalize the OHA/CCO contract amendment. Additionally, a process for ongoing review of CCO progress toward achieving the objectives and timelines identified in the Transformation Plans will be developed.

Senate Bill 1580, which implemented the CCOs, requires OHA to provide CCOs with Innovator Agents who will act as a single point of contact between the CCO and OHA and to help champion and share innovation ideas, either within the CCOs or the state agency, in support of the Triple Aim. The Innovator Agents are critical in linking the

needs of OHA, the community and the CCO, working closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of health resources in the CCO. The role of the Innovator Agent is to:

- Serve as the single point of contact between the CCO and OHA, providing an effective and immediate line of communication; allowing streamlined reporting and reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to system and process improvements through ad hoc phone and written communications and meetings, and summarizing these opportunities and obstacles in monthly reports.
- Assist the CCO in managing and using data to accelerate quality improvement.
- Work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The Innovator Agent will observe meetings of the CAC and keep OHA informed of the CAC's work.
- Assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care.
- Build and participate in a statewide learning collaborative with other Innovator Agents, CCOs, community stakeholders and/or OHA.

A critical role of the Innovator Agents is to share information with OHA, the CCO, other Innovator Agents and community stakeholders. Information will be shared through the following mechanisms:

- Weekly in-person meetings and/or phone conversations with OHA and other Innovator Agents;
- Daily contact with the CCO and/or community stakeholders;
- Community meetings and/or forums;
- Secure website with a database into which the Innovator Agent will log all CCO/ community stakeholder questions and answers; and
- Not less than once every calendar quarter, all of the Innovator Agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their assigned coordinated care organizations for the purposes of sharing information across CCOs and with OHA.

Focus on Children's Mental Health

Current health and education system transformation and agency reorganization will affect how the State's most vulnerable children receive services. The Department of Human Services (DHS) and OHA are responsible for services and programs that serve the state's most vulnerable children. Interagency coordination and a children's health policy strategy is necessary to ensure that the needs of these children and families are met.

The Children's Health Policy Team (CHPT) was created to ensure a coordinated, child- and family-focused health policy strategy for the children and their families served by both agencies. The Team meets monthly, and is comprised of representatives from Child Welfare, Self-Sufficiency (TANF), Developmental Disabilities, Addictions and Mental Health, Public Health, Office for Oregon Health Policy and Research, Office of

Equity and Inclusion, both DHS and OHA Health/Data Analytics Groups, and Vocational Rehabilitation. It is co-led by the Children's Medical Director for OHA and the DHS Medical Director.

Residential Addictions and Mental Health Services

In promotion of behavioral and physical health coordination, AMH is transitioning Medicaid funded addictions and mental health residential treatment for adults and youth to Oregon's CCOs. To aid in this transition, an advisory group comprised of consumers, CCOs, community mental health program representatives, alcohol and drug residential providers, and mental health residential providers was established to advise the Oregon Health Authority on the transition. Outreach efforts are underway to inform CCO's of the importance of behavioral health stabilization including detox and residential capacity within the continuum of care in Oregon communities.

AMH System Change

In addition to the work to develop CCOs, AMH has undertaken a parallel but separate system change effort with Oregon's county governments to restructure the publicly-funded addiction and mental health system for people who are not eligible for the Oregon Health Plan. The goals for this system change, similar to those of Coordinated Care Organizations, include:

- Emphasizing prevention and early intervention to promote independence, resilience, recovery and health and to avoid long term costs including loss of employment, damage to family stability, increased health care costs, and criminal justice involvement.
- Providing flexibility to local communities to enable them to better serve people with addictions and mental health needs.
- Improving accountability in the community-based addictions and mental health system.
- Ensuring consumer and family involvement in both the planning and on-going governance of the system.
- Reducing reliance on high-cost institutional care.
- Increasing the availability of high quality community-based addictions services and mental health care.

Integration of primary and behavioral health represents another major system change initiative for AMH and continues as a major focus during the next biennium. Coordinated Care Organizations and Local Mental Health Authorities have been tasked with collaborating to serve the residents of their communities. This collaboration will ensure those with Medicaid services and those without Medicaid services will receive coordinated care. As part of this system change, residential treatment services for Medicaid eligible individuals will transition to Coordinated Care Organizations by July 1, 2013. Providers will continue to serve those without Medicaid using SAPTBG funds. AMH will work with stakeholders to prepare for this transition and ensure SAPTBG funds continue to be used to serve priority populations.

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Primary to this integration is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

The SBIRT model holds promise in expanding the continuum of addiction services beyond specialty addiction services providers. AMH is exploring the SBIRT model with partners in primary care: CCOs, primary care providers, Oregon Health and Science University (OHSU) and others. AMH monitors the Substance Abuse and Mental Health Services Administration's (SAMHSA) discretionary grant programs web site for release of SBIRT funding announcements and maintains formal and informal contacts with stakeholders who have expressed an interest in partnering with AMH.

These improvements to the addictions and mental health system are driven by the discretion afforded by flexible funding; allowing counties to allocate resources where they are most needed to serve people in their communities. The budgeting flexibility is balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served. To protect the integrity of Block Grant funds, performance and utilization requirements aligned with block grant priority areas are included in the flexible funding agreements. AMH will continue to realign investments to support strategies and services that are not included in health benefit packages under OHP and for people not covered by Medicaid, including prevention, early intervention and recovery support services.

Oregon Revised Statute requires that Local Mental Health Authorities (LMHA) submit Biennial Implementation Plans for operation of each CMHP to AMH for approval. As CMHPs are receiving more flexibility in their use of addictions and mental health funding, it is important that there is a mechanism to inform AMH and the community about the plans to administer those funds. The new Biennial Implementation Plan process facilitates that accountability. Additionally the Biennial Implementation Plan is designed to ensure compliance with statutes, Block Grants, and other federal requirements. Information is required in three areas: system narrative, performance measures, and budget information.

To support success, AMH will provide further guidance and resources to develop plans that meet each community's needs. A designated AMH staff member is assigned to assist each LMHA/CMHP in answering questions, connecting with resources and providing technical assistance as needed. AMH and CMHP Directors will continue to meet to monitor the process and discuss opportunities to align Biennial Implementation Plan requirements with CCO operations.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

AMH supports a continuum of care that incorporates behavioral health promotion, prevention, treatment, recovery and maintenance. Behavioral health promotion is a broad concept with specific strategies, supporting wellness, early intervention and prevention of mental and substance use disorders.

As Oregon's Health System Transformation proceeds, behavioral health promotion emerges as a crucial missing component to keep costs down, to improve quality of care and increase satisfaction with care. Promoting healthy environments, norms and behaviors, rather than delaying intervention until there is development of full-blown disease states is the most cost-effective approach and constitutes an essential aim of health reform. Behavioral health promotion plays an important role in the prevention of both physical and mental disease and chronic disorders.

Health Promotion

Health care transformation provides an opportunity to examine how individuals are assisted in maintaining or regaining their health. Health, according to the World Health Organization, is defined as a state of complete physical, mental and social well-being. Mental health is an essential component of general health, inextricably linked with good physical health and balanced by social competence.

Health promotion provides a foundation to the concept of behavioral health promotion. There are two aspects of successful health promotion. *Universal* health promotion describes whole population activities that have a goal of optimizing positive mental health, such as promoting involvement in community activities to foster a greater sense of social well-being in the population. *Focused* promotion may reinforce already existing healthy adaptive behaviors within an at-risk group or may identify an at-risk group.

Behavioral Health Promotion

Mental health promotion is key to maintaining positive mental health and protective against the loss of mental health. The term *mental health* emphasizes wellness. Commonly, when the phrase mental health is used, *mental illness or mental disorder* may be what is actually meant, as in mental health treatment, mental health services, etc. Mental health is more than the absence of mental illness or a substance abuse disorder, and is not a synonym for mental illness. Good mental health is a necessary condition providing a foundation for health and wellness. Mental health is protective against the development of mental illness, pathological gambling and substance abuse disorders. It is also protective against the development of physical illness.

A continuum of care from mental health promotion, mental illness prevention and substance abuse prevention to treatment, recovery and maintenance needs to be built into existing health care systems. In 2009, SAMHSA recommended strongly that "public

education....promoting wellness and resilience” and prevention of risky and unhealthy behaviors be part of a National Health and Wellness Plan across the age span.

The report recommends early and *Universal* screening for mental and substance use disorders, as a means to save substantial amounts in health care costs and dramatically improve Americans' health³. It further recommends that “every medical practice should have a prevention specialist who focuses specifically on wellness and who is trained in mental health and addictions to support general practitioners in making appropriate referrals and coordinating care”.

The report suggests that trained peer counselors or certified or masters'-level mental health or addictions professionals [“recovery navigators”] provide follow-up services and encourage “positive lifestyle behaviors”. Personal health navigators named in the Coordinated Care Organization legislation would be ideally suited for this role. It further recommends that spouses, children and communities need support to cope with realities of living with those with diagnosed behavioral health disorders.

Importantly, mental health is an essential component of general health. Behavioral health promotion is integral to the promotion of health, which in turn is an important component in assurance of public health, or the health of the population.

Prevention and Early Intervention

Each community mental health program, subject to the availability of funds, is required to provide or ensure the provision of the following services to persons with mental disorders:

- Prevention of mental disorders and promotion of mental health;
- Preventive mental health services for children and adolescents, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional, behavioral and cognitive disorders, and suicide attempts in children.
- Preventive mental health services for older adults, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional and behavioral disorders and suicide attempts in older adults.

The six CSAP Strategies: Alternatives, Community-based Processes, Education, Environmental, Information Dissemination, and Problem Identification and Referral are used to categorize prevention planning. Oregon follows the Institute of Medicine model with Universal, Selective, and Indicated populations. Based on data-drive decisions, risk

³ Hutchings, Gail P., and King, Kristen, Ensuring U.S. Health Reform includes Prevention and Treatment of Mental and Substance Use Disorders—A Framework for Discussion: Core Consensus Principles for Reform from the Mental Health and Substance Abuse Community, Substance Abuse and Mental Health Services Administration, Rockville, MD. SMA 09-4433 2009.

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and protective factors are selected, including the factors that are shared between mental health promotion, and substance abuse prevention to target a variety of problems behaviors determined at the county and tribal level.

Oregon's prevention efforts are guided by the Strategic Prevention Framework. The Strategic Prevention Framework (SPF) is a five-step planning process known to support positive youth development, reduce risk-taking behaviors, build on assets and prevent problem behaviors.

- Step 1: Conduct a needs assessment
 - The project will build upon current needs assessment efforts in the state creating an integrated needs assessment process that will aid in identifying communities and at-risk populations to target with prevention efforts.
- Step 2: Build state and local capacity
 - The SPF Advisory Council will serve to mobilize state and local leaders and stakeholders to address and engage in coordinated substance abuse prevention efforts. Training and technical assistance will also be provided at the local level.
- Step 3: Develop a Comprehensive Strategic Plan
 - Development of a comprehensive and integrated strategic plan for substance abuse prevention priorities at the state and local levels.
- Step 4: Implement Evidence-Based Prevention Policies, Programs and Practices
 - State and local stakeholders will utilize proven prevention efforts to address targeted substance abuse issues within local communities.
- Step 5: Monitor and Evaluate Program Effectiveness through the State Epidemiological Outcomes Workgroup (SEOW)
 - The data infrastructure established via the grant and in collaboration with communities, the project will continually evaluate the process and monitor outcome data. Inherent in each step of the SPF process is cultural competency and sustainability.

Oregon was awarded the Strategic Prevention Framework State Incentive Grant (SPF SIG) in 2009. The Oregon SPF has three goals:

1. Prevent the onset and reduce the progression of substance abuse, including underage drinking;
2. Reduce substance abuse-related problems; and
3. Build prevention capacity and infrastructure at the State/Tribal and community levels.

The State Epidemiological Outcomes Workgroup (SEOW) began this work at the state level with a three step assessment process. The first step reviewed substance use trends and rates to identify areas where Oregon has been least and most successful at reducing substance use. The second step considered this narrowed set of data and examined the magnitude and severity of the consequences of substance use. This step showed that consequences associated with alcohol abuse had a greater impact than either tobacco use or drug use in Oregon. The third step identified patterns of alcohol

consumption that lead to the greatest consequences by focusing upon causality and changeability.

After the SEOW presented this assessment information to the Strategic Prevention Framework State Advisory Council (SPF SAC) and made its recommendations, Oregon prioritized alcohol dependence and abuse among 18 to 25 year olds as its SPF SIG priority.

More specifically, Oregon allocated its SPF SIG funds to decrease alcohol dependence and abuse for Oregonian's 18 to 25 years old while reducing associated consumption behaviors including:

- Binge Drinking – males that have five or more drinks and females that have four or more drinks on any one occasion or within a couple of hours;
- Heavy Drinking – males that exceed two drinks per day or females that exceed one per day; and
- Underage Drinking – Any use of alcohol by anyone 18 to 20 years old.

The allocation model chosen allows the Oregon SPF SIG to reach all corners of the state in order to catalyze change in the whole prevention system and assess the possible impact on different populations. Details of the model include:

- Ensuring set-aside funding for all nine Native American Tribes in Oregon who have disproportionately high rates of alcohol-related mortality, other alcohol-related consequences and alcohol consumption. These funds are being used by each Tribe to implement the first three steps of the SPF.
- Fund six urban counties to implement all five steps of the SPF. These sub-recipients will include the three urban counties with the largest population and the three urban counties that contribute the highest rates of alcohol consumption.
- Fund four rural counties to implement all five steps of the SPF. These sub-recipients will include the two rural counties with the largest population and the two rural counties that contribute the highest rates of alcohol consumption.
- Fund two frontier counties to implement all five steps of the SPF. These sub-recipients will include the one frontier county with the largest population and the one frontier county that contributes the highest rates of alcohol consumption.

Unfunded Oregon Counties benefit from the SPF SIG indirectly as the State has begun to build a bridge to incorporate the SPF process into Oregon's SAPT Block Grant and through capacity building activities. For example, SPF training and technical assistance has been introduced to the unfunded counties and each of the 24 counties have been given a small grant to participate in this on-going SPF training. Oregon also hopes that this work leads to greater State agency collaboration and communication, development of a common prevention language, increased utilization of evidence-based strategies, more use of data-driven decision making, and the general strengthening of Oregon's prevention system.

Across Oregon's prevention system a wide variety of programs and activities are conducted. Local prevention programs generally include a number of approaches used simultaneously, including:

- Coalition work;
- Multi-media campaigns;
- Awareness campaigns;
- Data collection;
- Multi-session prevention education programs such as parenting classes and evidence-based curricula;
- Policy work such as local ordinances, information and referral,
- Participation in community events;
- Promotion of alternative activities; and
- Ongoing collaboration with community partners and stakeholders.

The state prevention system has many strengths including: competent, well trained, prevention workforce; ongoing prevention training for the prevention workforce; required prevention certification; use of evidenced-based and tribal best practices; prevention funding for all 36 counties and nine federally-recognized Native American tribes, and openness to including new risk behaviors, such as problem gambling.

Oregon's prevention system also includes a focus on problem gambling prevention to address emerging and related risky behaviors among Oregon youth. Oregon's problem gambling prevention efforts use the same framework as the Center for Substance Abuse Prevention's (CSAP) six core prevention strategies. A review of research of several problem behaviors and problem gambling suggests that many risk and protective factors are shared. Further, Oregon Student Wellness Survey and Oregon Healthy Teens Survey data consistently show that over 30 percent of 6th - 11th graders gamble and those who do are much more likely (in some cohorts, twice as likely) to use alcohol, binge drink, skip school, get in fights, etc. Oregon's prevention Administrative Rule now includes problem gambling with substance abuse prevention.

Providers develop and implement locally specific prevention plans that include measurable goals and objectives aimed at prevention of problem gambling. Local prevention activities include infusing problem gambling prevention into existing substance abuse prevention efforts, working with schools on gambling prevention education, incorporating gambling prevention into activities aimed at other youth risk factors and working with senior citizen groups on gambling education.

Early Learning Council (ELC)

The Early Childhood and Family Investment Transition Report was presented to Governor Kitzhaber early in 2011. It included recommendations to integrate state funded services, agencies and structures to ensure that every child enters school ready and able to learn, enters first grade ready to read, and leaves first grade reading. The focus of change is on:

- Early identification and support;

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- Shared measurement and accountability through development of an early childhood data system, performance-based contracts and shared outcome measures; and
- Creation of an Early Childhood System Director position in the Governor's Office and an Early Learning Council replacing the former structure of the Early Childhood Matters Advisory Council (with Health Matters, Family Matters and Early Learning Matters committees) to consolidate multiple existing coordination efforts, funding streams and administrative structures.

As part of Governor Kitzhaber's overarching education initiative to create a world-class education system, the Early Learning Council guides efforts to integrate and streamline existing state programs for at-risk youth and ensure all children are ready to learn when they enter kindergarten. Progress to date includes:

- Appointment of the Early Learning Council
- Hiring an Early Learning Systems Director
- HB 4165 §11 Joint Workgroup Recommendations by the State Interagency Coordinating Council and the Early Learning Council⁴
- Data System Recommendations to the ELC⁵
- Report from Kindergarten Readiness Assessment Workgroup to the Early Learning Council
- Development of a charter for the Early Learning Council/Oregon Health Policy Board Joint Subcommittee⁶

Parent-Child Interaction Therapy (PCIT)

PCIT is an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In 2008, four counties were selected to develop the infrastructure for implementing Parent Child Interaction Therapy (PCIT). The goals of the project have been to:

- Implement the evidence-based practice PCIT with fidelity through provision of PCIT services to families;
- Demonstrate outreach to and access by identified ethnic, linguistic or cultural minorities;
- Demonstrate links and supports for family members receiving PCIT through referral to a family-run organization;
- Provide for certification of at least two clinicians in PCIT, including one from an ethnic, cultural or linguistic population or experience and links with the cultural/linguistic population; and
- Develop a local and statewide training program in PCIT.

Thirty-three therapists were trained in the 2011-2012 fiscal year. Seven of these therapists speak Spanish, and one is fluent in Vietnamese. Sites provide outreach to

⁴ <http://www.oregon.gov/gov/docs/OEIB/1aaSICCELCHB4165.pdf>

⁵ <http://www.oregon.gov/gov/oeib/docs/12datasystemrecommendations.pdf>

⁶ <http://www.oregon.gov/gov/docs/OEIB/1Charter.pdf>

multiple child and family serving agencies, including those that serve Hispanic/Latino(a) families. Each county with the PCIT program has one or more “promotores” – community health workers, linking with the Hispanic community.

Between April 1, 2011 and March 31, 2012 the overall number of children and families served was 373. Of those served, 60 percent were boys. The majority of referrals were for children from ages three through five, which reflects the age at which most children are in more formalized early care and education settings. The child welfare system provided 14 percent of the referrals. Three of the four sites met or exceeded their target proportion of children and families from the Hispanic/Latino(a) population.

Collaborative Problem Solving (CPS)

CPS is an approach which sets forth two major tenets

1. Social, emotional, and behavioral challenges in kids are best understood as the byproduct of lagging cognitive skills; and
2. These challenges are best addressed by resolving the problems that are setting the stage for challenging behavior in a collaborative manner.

Support funding for OHSU/Think:Kids Alliance in the state of Oregon focuses on advancing practitioner and family member skill development in the application of the Collaborative Problem Solving model, supports work in creating connectivity and coordination among systems and organizations utilizing CPS, and creates affordable CPS training opportunities for professionals and families throughout Oregon.

To achieve the outlined support goals above, the OHSU/Think:Kids CPS Alliance⁷ at OHSU is working with Eastern Oregon Coordinated Care Organization and other systems of care in Northeastern Oregon to host a Tier 1 training in the CPS model. Tier 1 is advanced intensive training in the CPS model consisting of 2 ½ days and inclusive of theory and practice. This partnership will ideally be replicated with other systems to ensure training access across Oregon. In addition, OHSU will continue to provide ongoing support to foster care parents in Oregon. OHSU/Think:Kids has partnered with a coalition of foster care providers and parent programs in the development of CPS supports and training for foster care families. Support funding ensures OHSU guidance in these discussions and helps guide growth and practice of CPS in foster care.

Support funding aids in the goal to provide a regular CPS Parent Training Group at OHSU. This group will provide support to parents who are struggling with children identified at high risk for social, emotional, and behavioral problems. The funding support will ensure the group is low cost and accessible to families.

Funding support will assist in training the next generation of health care providers in the CPS approach. OHSU is Oregon's only academic medical center and hosts its only two-year ACGME⁸-accredited Child Psychiatrist Training Program. The support will allow OHSU to provide ongoing training to the Child Psychiatry Fellows and subsequently, provide ongoing support through the Fellows to help train general Residents in

⁷ Additional scope of work information and overview of CPS Alliance is available at: www.ohsu.edu/cps .

⁸ Accreditation Council for Graduate Medical Education

Psychiatry in the CPS model. As part of this training support OHSU will present the CPS model at a Grand Rounds for the general Pediatricians at OHSU Doernbecher Children's Hospital.

Since 2012, the OHSU CPS team has provided support to the Foster Care Coalition, a coalition of many agencies and groups that take care of children at risk. These groups include:

- Maple Star (an education service district in the State of Washington),
- KAIROS (a community mental health coalition in Southern Oregon),
- Catholic Community Services,
- Greater Oregon Behavioral Health, Inc.,
- Boys and Girls Aid Society,
- Morrison Center, and
- Oregon Family Support Network.

Further, CPS provides ongoing support and case consultation services for Child Psychiatry Fellows and Residents caring for at-risk children in the outpatient clinics at OHSU.

Early Assessment and Support Alliance (EASA)

In 2007 the Oregon Legislature funded EASA to provide community education, outreach and engagement, evidence-based treatment, and transition into ongoing care for youth and young adults experiencing the early signs of psychosis. EASA uses an intensive multi-disciplinary approach during what is known as the "critical period" where intervention is most effective and may prevent the long-term morbidity associated with chronic psychotic illness. Early intervention and treatment of psychosis assists individuals in becoming independent, healthy and safe. The restoration of normal functioning helps individuals maintain employment and support themselves and their families. Utilization of this model has resulted in dramatic outcomes such as decreased hospitalization rates. The model is cost-effective in the short term and results in cost-savings in the long term.

Currently, EASA services cover 19 counties, with three new sites funded through local start-up funds. Community-based programs have been smoothly and rapidly established. Active planning and technical assistance is occurring in the remaining counties and a request for additional funds was included in the Governor's Balanced Budget, with the goal of EASA being implemented statewide by 2015. A statewide EASA Center for Excellence is being formed to provide ongoing technical assistance, training, credentialing, fidelity review, coordination and program development.

EASA is showing tremendous benefits in human lives and financial outcomes. Twenty-eight percent of EASA participants are under age 18, and the average age at intake is 20. Approximately 40 percent are enrolled as students in secondary or post-secondary settings. Of EASA clients age 18 and over, 19 percent were employed at intake. In the first three months of the program, this figure increased to 28 percent, reaching 33

percent by nine months. All EASA participants are supported to identify and pursue a career.

Twenty-three percent of EASA participants experienced legal involvement in the three months prior to intake, and 13 percent were arrested or incarcerated. In the first three months of service, these figures dropped to 13 percent of participants having any legal involvement and 1.9 percent had any arrest or incarceration during the three month period. This reduction is sustained over time.

Most EASA participants (63.5 percent) were not planning to apply for public assistance through the disability system at 12 months; for those who need the support of the disability system, EASA approaches it as a short-term bridge to self-sufficiency. Ninety-one percent of all EASA participants maintain active family involvement in treatment.

EASA's current structure offers the most robust and efficient model of care while mirroring many public health strategies through an integration of physical and mental health care.

Community-Based Behavioral Health Treatment Services

Establishment of System of Care for Children with Serious Emotional Disorders

Oregon manages a comprehensive community-based children's mental health system with the goal of maintaining the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system is family and youth driven and community-based with the strengths and needs of the child and family determining the types and mix of services provided. These services are individualized and may be as intensive and frequent as necessary and appropriate to sustain the child in treatment in the community.

Through legislative directive in 2005, the Children's System Change Initiative (CSCI) was established. Under this initiative, AMH requires the collaboration of the state and county child-serving agencies and providers of services across the continuum of care from least restrictive and intensive (prevention/outpatient services) to most restrictive and intensive (acute hospitalization and psychiatric residential and day treatment services). The goal is to make every effort to serve the child and family in their community. In recent years, many more children and families are being served in community-based settings under a locally-determined care coordination model with decreased reliance on facility-based care.

A uniform level of service intensity determination process has been established using the Child and Adolescent Service Intensity Instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII) and each region has been expected to develop a protocol for serving children in highest need of services using the process. Financial and administrative accountability for Psychiatric Residential Treatment Services and Psychiatric Day Treatment Services is managed through CCOs under the Oregon Health Plan. Care coordination, including use of child and family teams and service coordination plans has become a pivotal part of the system. Family and youth voice and

involvement directed under policy has increased. AMH contracts for services previously provided at the Oregon State Hospital with private non-profit agencies for the Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP), with admission being reviewed and approved by AMH children's mental health specialists.

Children and youth in Oregon may obtain a range of mental health services specific to their needs as determined by a mental health assessment and a level of service intensity determination process. Available services include peer delivered support, skills training, mentoring, medication management, community-based services, which vary by community but include:

- Home-based, school-based and other community located service delivery;
- Intensive outpatient services, behavioral support services, psychiatric day treatment, psychiatric residential treatment;
- Sub-acute and acute hospitalization and hospital-based emergency services, crisis stabilization and crisis respite; and
- Three secure, longer-term, inpatient programs (one for children under age 14 and two for youth ages 14-17) that are housed in community residential facility settings.

In many communities, intensive community-based services are provided using a Wraparound model of planning and service delivery coordination. The implementation of the Statewide Children's Wraparound Initiative in July 2010 has provided an opportunity for more intensive workforce development in the Wraparound model, for communities operating demonstration projects under the Initiative, as well as interested participants from other local communities. The Wraparound Fidelity Index-4 was administered in December 2011 and January 2012 with the demonstration project sites, with all placing at or above the national mean for fidelity to the evidence-based model. Wraparound project sites and other communities implementing Wraparound model and System of Care development will continue to do so under the Coordinated Care Organizations' contract.

AMH collects data relevant to the children's mental health system. Data being tracked includes level of service intensity determination, outcomes for children served in the integrated service array and the Statewide Children's Wraparound Initiative demonstration projects. AMH also tracks process measures and youth/family perception of outcomes using the Youth Services Survey and the Youth Services Survey for Families. An electronic web interface makes outcome data available in real time, improving the ability of those in the system to use data for decision making. Oversight of data issues throughout the system is provided through the Children's System Advisory Committee, and through periodic reporting to stakeholders. CCOs are required to meet benchmarks within their first year on several measures pertaining to children's behavioral health outcomes.

All CCOs are required to establish linkages with community support systems including local and/or regional allied agencies and substance use disorder treatment providers.

The CCOs are charged with providing integrated behavioral health and primary health care. Thus, enrollment in a CCO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary, so that children with serious emotional disorders can remain in their community. The OHP benefit package includes a full array of services such as preventive services, diagnostic services, medical and surgical care, dental services, and outpatient substance use disorder treatment services.

Oregon Psychiatric Access Line for Kids (OPAL-K)

The Child Mental Health Task Force of the Oregon Pediatric Society, the Oregon Council of Child and Adolescent Psychiatry, OHSU and the Oregon Family Support Network have partnered to create a foundation to link pediatric or other primary care providers with providers of psychiatric and mental health consultation to improve integration and quality of children's mental health and physical health care. Based on proven programs used in other states, the OPAL-K model has been developed through the collaboration of pediatricians and family medicine practitioners, child psychiatrists, public and private insurance groups, peer to peer parent services, and researchers.

This initiative has the full policy and fiscal support of the Oregon Governor's office, with a line item of \$1.5 million written into the Governor's Balanced Budget to launch the project. The current legislative session will take action on this proposal.

The creation of OPAL-K will provide a clinician to clinician consultation system, linking child psychiatry expertise with primary care providers (PCPs). Objectives include:

- Same day consultation through phone or videoconferencing capacity;
- Provision of referral information to PCPs to assist them in finding appropriate links within their community;
- Provision of continuous mental health education for PCPs; and
- Face-to-face or telemedicine consultation for complex cases in remote communities without access to child psychiatry services.

This service will improve mental health care delivery in primary care, improved access to timely mental health consultation and triage within primary care settings, and improving the cost effectiveness of mental health care for children and youth through early identification, consultation and access to mental health treatment.

OPAL-K is a better way to prevent mental illness disorders from developing in children and to identify and treat children who experience mental illness disorders. The majority of children and youth with mental health challenges and diagnosable illness are seen and identified by primary care clinicians, not mental health professionals.

Child Welfare (CW) Collaboration

Oregon has continued working to assure that children in foster care receive appropriate psychotropic prescribing practices. A mental health assessment is obtained before more than one new psychotropic prescription or any antipsychotic medication is prescribed to a child in foster care. Annual reviews are conducted for psychotropic medications for

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children in foster care prescribed more than two psychotropic medications, or for any child in foster care under the age of six prescribed any psychotropic medication.

Oregon, through a technical assistance grant from the Center for Health Care Strategies, has begun a quality improvement effort as part of a multi-state collaborative, to design, pilot and evaluate effective practices to improve psychotropic medication use among children in foster care. State goals are:

- Improve the effectiveness of the consent process for psychotropic medication use for Oregon children in foster care;
- Expand collaboration among key stakeholders including foster parents, child welfare management and caseworkers, medical and mental health care providers, CCOs and children in foster care who are being prescribed psychotropic medication;
- Improve safety and effectiveness of psychotropic medication use in this population through utilization of best practices;
- Reduce use of antipsychotic medications for unapproved indications in this population by improving the understanding and availability of non-pharmacological treatment for sleep disorders and aggression; and
- Reduce the practice of polypharmacy with psychotropic medications in this population.

Data are being examined to determine the percentages of:

- Children in the custody of child welfare;
- Children in the custody of child welfare with developmental disabilities;
- Children with developmental disabilities; and
- All children in the Oregon Health Plan receiving:
 - More than two antipsychotic medications;
 - Multiple psychotropic medications;
 - Medication with lack of age appropriate indication for use;
 - Antipsychotic medication without appropriate medical monitoring (e.g. glucose/lipid monitoring); or
 - Psychotropic medications with concurrent or recent mental health services.

Another area of focus in AMH work with Child Welfare is on obtaining informed consent for psychotropic medication. The state has implemented changes in the administrative rules for this area of consent to reflect the identification of psychotropic medication prescribing as a special medical procedure.

Child Welfare and AMH share the contracted services of a child psychiatrist to provide medical direction to both Divisions. This collaborative approach has facilitated a shared understanding and a common approach to addressing the complex mental health needs of children in the child welfare system.

DHS policy and contracts require that children who are placed in substitute care through Child Welfare receive a mental health assessment. Child Welfare policy states that all

children in substitute care will be referred for a mental health assessment within 21 days of placement. CCO contractual expectations, including an outcome based incentive, require that comprehensive mental health assessments for children placed in substitute care by Child Welfare be provided no later than 60 days following the date of placement. A service improvement goal has been identified to increase the percentage of children who receive timely mental health assessment to 90 percent. This measure has been incorporated into accountability measures for the Coordinated Care Organizations.

Longer term goals include developing capacity for mental health assessment for children younger than age three, and that system changes extend beyond improving compliance with the assessment requirement and lead to increased capacity to provide appropriate treatment for traumatized children.

For the past several years, Child Welfare has piloted three different ways to acquire Child and Adolescent Needs and Strengths (CANS) assessment, and it has been determined that obtaining this information in conjunction with a mental health assessment is the better option. Efforts are being made to explore ways to facilitate reimbursement when the CANS is conducted on the same day as the mental health assessment. A new administrative rule was brought forward in February 2013. This effort will solidify collaboration between the children's mental health and child welfare systems.

Child Welfare sponsors the Target Planning and Placement Committee to review complex cases of children involved in Child Welfare. Caseworkers prepare a packet of case materials for review and present the case to the committee to obtain assistance in planning and consultation. The committee is represented by Child Welfare, AMH, Education, county mental health, and Aging and People with Disabilities. This committee assists caseworkers in obtaining appropriate services for children and young adults in their care and identifies the system access and service gaps and barriers.

AMH works with CW to co-finance and co-manage much of the out-of-home mental health treatment services provided to children served through Child Welfare. CW contracts with public and private child serving agencies to provide Behavioral Rehabilitation Services for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

Treatment Foster Care is a collaborative effort with CW. Considered the least restrictive of residential treatment options for children in the care and custody of the state, Treatment Foster Care is provided by trained foster parents and supervised by the local community mental health program. It is a critical treatment option for children, especially in rural counties.

Trauma Informed Services and Supports

The Children's System Advisory Committee has approved an Issue Brief on Trauma and Trauma Informed Services and Supports. The recommendations for AMH suggest utilizing a public health approach regarding trauma awareness and incorporation of a trauma-informed approach to health care integration and transformation, including developing a statewide children and family services system of care. The recommendations are:

1. AMH shall make a revision of the 2006 Trauma Policy. An updated definition of trauma was written to be incorporated in this revision.
2. Prioritize the inclusion of trauma-informed care language, and practice in policies, procedures, contracts, and future Oregon Administrative Rules revisions.
3. Provide information/resources to enhance cultural and linguistic competence in the context of mitigating trauma.
4. Establish a Trauma Learning Collaborative to educate and guide the promotion of trauma-informed care. It would be advisable for the Learning Collaborative to participate and make recommendations for an overall update to the AMH Trauma Policy, with an eye to the adoption of an OHA Trauma Policy.
5. Information about trauma informed care, trauma itself and how to recognize it, where to go for trauma related treatment and assistance, and tools for those providing services to prevent, or manage and cope with vicarious trauma shall be made available as part of health care transformation. The Trauma Learning Collaborative would be an ideal home for these resources.
6. The Learning Collaborative shall:
 - Conduct mapping of trauma specific resources, list valid and reliable trauma screening instruments, provide resources for those who conduct trauma screening, guidelines for trauma screening and trauma assessment.
 - Develop trauma resource mapping of services and supports such as music therapy, movement therapy, sensory integration, behavioral health therapy and best or promising practices.
 - Communicate information about state, national and online training opportunities in trauma and trauma informed care.
7. Adopt guidelines for behavioral health providers to screen, assess and treat basic and complex trauma. Screening and assessment guidelines, and strategies to respond to and support those who have been traumatized should be developed for other systems and partners, such as peer delivered services, child welfare, pediatrics, schools, primary care, juvenile justice, and others.
8. Recognizing the need to support natural and professional caregivers and support providers, AMH should:
 - Provide technical assistance to organizations/agencies as they move to trauma-informed practice regarding workplace practices/innovations that promote holistic wellness and self-care.
 - Provide strategies and training that incorporates emotional intelligence in the workplace.
9. Develop fact sheets, using a provided template, to educate CCOs, families, child-serving systems, and other interested and impacted stakeholders. Examples of stakeholders who may benefit from this information are pediatric

providers, primary care practitioners, behavioral health care staff, consumers and members of family run organizations, elementary, secondary and college teachers, child welfare workers, law enforcement/emergency responders, adult correctional and juvenile justice system staff, Aging and People with Disabilities providers, faith-based groups, pre-schools/ other early childhood education settings, and after school program staff.

10. OHA shall develop a communication plan regarding trauma and trauma informed care that includes traditional outreach as well as social networking and other technological communication advances as they emerge. Provide public service announcements, and other education regarding trauma impacts, strategies for trauma healing, and developing a trauma-informed system.

Funding and staff resource limitations may prevent all the recommendations from being carried forward.

Addressing the Needs of Commercially Sexually Exploited Children (CSEC)

Work is being done in Multnomah County to significantly address issues faced by children and youth who have been commercially sexually exploited. The County has hired a person full-time to coordinate services and planning efforts for this population.

Statewide, there are three established committees working on training for general intervention, medical interventions, and housing for this population. The FBI, Senator Wyden's office and the Multnomah County Commissioner's office participate in these committees.

In Multnomah County a group of professionals from multiple agencies have been trained to identify and serve this population. This group provides training at no cost to anyone who requests it. Several outpatient and residential programs are training their therapists and skills trainers to specifically work with this population and to provide specific services needed by this group of young people. One facility has a five-bed shelter program for children who have been commercially sexually exploited.

Child Welfare in Multnomah County developed a CSEC specific unit that only assists cases of children who are or have been involved in trafficking and has identified 72 children in their system who have been exploited.

Adult Mental Health Services

Each CMHP provides or ensures the provision of a continuum of care for adults with serious mental illness, subject to the availability of funds. These services include, but are not limited to:

- Screening and evaluation to determine the individual's service needs;
- Crisis stabilization to meet the needs of people experiencing acute mental or emotional disorders, including the costs of investigations and prehearing detention in community hospitals or other facilities approved by the Authority for people involved in involuntary commitment procedures;
- Psychiatric care in state and community hospitals;

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- Residential services;
- Medication monitoring;
- Individual, family and group counseling and therapy.

Within the limits of available funds, CMHPs provide the above services in the following order of priority:

1. Individuals who, in accordance with the assessment of a mental health professional, are:
 - at immediate risk of hospitalization for the treatment of mental or emotional disorders, or
 - are in need of continuing services to avoid hospitalization, or
 - pose a hazard to the health and safety of themselves, including the potential for suicide, or
 - others and those persons under 18 years of age who, are at immediate risk of removal from their homes for treatment of mental or emotional disorders or exhibit behavior indicating high risk of developing disorders of a severe or persistent nature;
2. Individuals who, because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and
3. Individuals who are experiencing mental or emotional disorders but will not require hospitalization in the foreseeable future.

Individuals participating in mental health services assist their service providers to develop an Individual Service and Supports Plan (ISSP) – a comprehensive plan for services and supports provided or coordinated for an individual and his or her family. The ISSP should be reflective of the assessment and the intended outcomes of service. The ISSP documents the specific services and supports to be provided, arranged or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes. At a minimum, each ISSP must include:

- Measurable or observable intended outcomes;
- Specific services and supports to be provided; and
- Applicable service and support delivery details.

Assertive Community Treatment

Mental health service providers implement an array of services and supports based on the needs and goals of the individuals they serve. Of particular note is the collaborative effort between AMH and the Division of Medical Assistance Programs to expand Assertive Community Treatment (ACT) services statewide. This expansion is reinforced in both the County Financial Assistance Agreements and CCO contracts. County Financial Assistance Agreements require LMHAs to meet fidelity benchmarks for any ACT services funded in all or in part by flexible funds. CCO contracts require all adults with serious mental illness to be assessed for ACT services. If an individual would benefit, the CCO must make the services available. ACT services funded in all or in part by Medicaid funds in a CCO's global budget must also meet fidelity benchmarks.

AMH will contract with a private, non-profit organization to implement an ACT Center for Excellence to provide training, technical assistance and fidelity monitoring for ACT providers throughout the state. Oregon currently has approximately ten ACT programs. The ACT Center for Excellence will work with these providers to ensure they meet the fidelity benchmark as well as assisting programs implementing ACT teams.

Mental Health Services for Older Adults

Mental health services for older adults are provided through Oregon's CMHPs. CMHPs are required to submit a biennial implementation plan outlining how the CMHP will address the unique needs of this population. In the 2011-2013 plans, nearly every county addressed the gap in mental health services for its older adult population.

Several counties use multidisciplinary teams to address the gap in mental health services for older adults. The teams vary depending on the county, sometimes including representatives from the CMHP, Aging and People with Disabilities (APD), Adult Protective Services, law enforcement, and private non-profit mental health service agencies. The primary focus of all counties regardless of format is to link vulnerable older adults with necessary mental health and social services.

Some counties or their subcontractors have developed and maintained age specific services providing senior peer counseling services. For example, Age Wise, Age Well or other senior peer programs provide supportive individual, group and psychoeducational counseling by incorporating successful aging, physical health, spiritual and behavioral health approaches or other unique approaches to the provision of mental health services for older adults. One county contracts with a Psychiatric Mental Health Nurse Practitioner to provide mental health, behavioral health and psychiatric medication recommendations to older adults living in Department of Human Services APD long-term care and Home and Community Based Care Waivered Programs.

Pre-Admission Screening and Annual Resident Review (PASRR)

PASRR is a federally mandated program that requires all states to develop a comprehensive process to pre-screen all individuals applying for admission to a Medicaid-certified nursing facility care. The mandate requires a personalized assessment and personalized care recommendations for any person who may have mental health conditions. The mandate requires a personalized assessment to create personalized care recommendations and provide a means to follow-up to determine whether those needs are being met within the nursing facility.

Oregon maintains a PASRR program consistent with federal regulations in partnership with APD. In most counties, CMHPs are contracted to provide PASSR level II services and are expected to link individuals with a serious mental illness with the appropriate outpatient mental health services. Personnel completing PASRR-II evaluations are in most cases on the same mental health team as those providing outpatient mental health services to older adults, so a direct link between the PASRR-II evaluator and an outpatient mental health clinician with geropsychiatric expertise is available.

Enhanced Care Facilities/Enhanced Care Outreach Services (ECF/ECOS)

This program is a collaborative/partnership program between Addictions and Mental Health and APD. It serves both older adults and disabled adults in settings including APD-licensed nursing facilities, residential care, assisted living and adult foster care. The individualized mental health services include: assessment, treatment planning, counseling, skill building, community integration, psychiatric medications, 24-hour crisis services, and provider consultation and training.

The Adult Mental Health Services Unit in AMH works closely with OSH staff around discharge planning and diversion, and works with acute care hospitals in discharge planning to the appropriate level of care and collaboration with APD at both the state and local levels. The Adult Mental Health Services Unit is developing collaborative working relationships with the Coordinated Care Organizations in restructuring current programs in order to provide the best care possible to the older adult population. Identification of needed services and supports is part of this process.

Addictions Services

Addiction services and supports provided with public funds fall into the following categories:

- Detoxification (social, medically managed and inpatient/hospital)
- Outpatient (regular, intensive, case management and medication assisted treatment)
- Residential (adolescent and adult, including specialized services for parenting women and men)
- Housing Supports (Oxford Houses, rental assistance)

Oregon contracts with nonprofit agencies, CMHPs, and nine federally recognized tribes to provide addiction treatment and recovery support services. Publicly funded programs must hold a current letter of approval to provide services and are licensed and monitored by the AMH Quality Improvement and Certification Unit.

Evidence-Based Practices (EBPs)

Providers use an array of nationally recognized and AMH approved evidence based practices in providing addiction treatment services for adults:

- Screening & Brief Intervention & Referral to Treatment (SBIRT)
 - Primary care providers, emergency rooms, and other community based providers can assess and provide early interventions for at-risk substance users.
- Moral Reconciliation Therapy (MRT) (Criminal Justice clients)
 - MRT is an effective treatment strategy that reduces recidivism by increasing moral reasoning.
- Cognitive Behavioral Therapy (CBT)
 - Treatment is problem focused and action oriented to assist individuals in developing strategies to address emotional and maladaptive behaviors.
- Seeking Safety

- Seeking Safety is a therapy for individuals experiencing trauma, PTSD, and or substance abuse.

AMH approved providers in Oregon utilize the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R)⁹ to match adults to appropriate level of care needed for addiction treatment services. Patients who are assessed in needing Levels I outpatient, Level II intensive out patient, and Level III residential care models receive: a minimum amount of care hours required by particular level, group and family therapy, alcohol and other drug education, drug testing, infectious disease risk assessment and screening, treatment planning, and recovery support services. Addiction services and supports provided with public funds fall into the following categories:

Adult Detoxification Services

Residential medical detox services are provided to individuals who experience acute withdrawal symptoms and/or co-occurring chronic medical conditions, and who need monitoring in order to safely detox from alcohol and other drugs. Upon entrance, a medical assessment conducted by the program's medical director determines appropriate placement for individuals. Detox facilities must provide Level III.7.D services that include; 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care for patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care and consequently concentrates on patients who are experiencing high-risk ASAM (dimension 3) problems.

Detox Enhancement Investment

In 2011, AMH assisted Oregon detoxification programs that received AMH funds either by direct contract or through the Local Mental Health Authority to implement currently recognized standards of best-practice documented in the literature. The detoxification enhancement plan increased the capacity of existing funded detoxification programs in the shift from providing social detox (ASAM Level III.2) to delivering enhanced medical services, meeting ASAM Level III.7 D criteria for Medically Monitored Inpatient Detoxification. \$4.5 million in funds was invested for this initiative to be used over two biennia (2011/13-2013/15). This revenue is from unobligated Substance Abuse Prevention and Treatment (SAPT) block grant funds. Availability of these funds does not rely on increases to the SAPT block grant allocation in 2012, 2013 or beyond.

AMH used the following four source documents to build standards of care and service expectations in future policy work:

1. American Society of Addiction Medicine Patient Placement Criteria, Second Edition Revised
2. ASAM Patient Placement Criteria Supplement on Pharmacotherapies for Alcohol Use Disorders¹⁰

⁹ Link to order ASAM PPC-2R: <http://www.asam.org/PPC2R.html>

¹⁰ Link to order ASAM Patient Placement Criteria Supplement on Pharmacotherapies for Alcohol Use Disorders: <http://www.asam.org/PPCSupplement.html>

3. Treatment Improvement Protocol (TIP) 45 – Detoxification and Substance Abuse Treatment¹¹
4. The National Quality Forum (NQF) National Voluntary Consensus Standard for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices¹²

Table 1.

Detox Programs and CMHP Regions	
BestCare	Through Oregon Treatment Network
Hooper Detox, Central City Concern	Through Multnomah County
Bridgeway	Through Marion County
Buckley House, Willamette Family Treatment Services	Through Lane County
CODA, Tigard Recovery Center	Through Clackamas and Washington Counties
Eastern Oregon Alcoholism Foundation	Through Umatilla County

AMH offers quarterly learning sessions for all providers. Learning sessions focus on startup issues and concerns, communicating block grant spending restrictions, and provides opportunities for cross-site information sharing, collaboration, and strategy development.

Synthetic Opiate Replacement Therapy

There are currently 14 methadone treatment programs in Oregon. All programs are along the Interstate 5 Corridor from Portland to Medford. Eight clinics are located in Washington and Multnomah Counties, Marion and Lane counties each have two, and Jackson and Clackamas counties have one clinic each.

Programs are a mix of private, private non-profit and government operated clinics. As of January 31, 2013 the number of people receiving methadone treatment services in Oregon is 5282. Methadone treatment is a mandated covered benefit through the Oregon Health Plan. Payments from OHP are made based on the services provided by the clinic. For self-pay patients providers charge a monthly or daily rate for services. The range of fees for self-pay patients would be in the \$200.00 per month to as high as \$350.00 per month (depending on the agency, funding streams, etc.).

Regulatory Requirements

Programs must comply with both federal and state regulations. Nationally, all programs must be approved by a federally recognized accreditation body. In Oregon 13 of the programs are accredited by the Commission on Accreditation of Rehabilitation Facilities

¹¹ Link to Treatment Improvement Protocol 45: <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA08-4131>

¹² To download the abridged National Quality Forum Consensus report go to: http://www.qualityforum.org/Publications/2007/09/National_Voluntary_Consensus_Standards_for_the_Treatment_of_Substance_Use_Conditions_Evidence-Based_Treatment_Practices.aspx

(CARF), and one program is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Agencies are reviewed by their accreditation agencies at least once every three years. In addition all programs must have their dispensary and dispensing process approved by the Drug Enforcement Agency (DEA). The DEA conducts inspections of clinics generally once every three years.

The Addictions and Mental Health Division approves methadone programs in Oregon. Each program is reviewed at least once every three years. In addition, current state statutes prohibit methadone programs from operating within 1,000 feet of a school or licensed child care facility. Statutes also require methadone programs to obtain approval from a patient's parole/probation officer, if applicable, upon admission.

Admission Requirements

All admissions are approved by a physician who is the Medical Director for the program. Individuals being considered for methadone treatment must have a one year history, immediately prior to admission, of a continuous physical dependence on narcotics or opiates as documented by medical records, records of arrests for possession of narcotics, or records from drug treatment programs. The program must have evidence of current physical dependence on narcotics or opiates as determined by the program physician or medical director. The agency may also admit individuals where there is documentation demonstrating that medically supervised withdrawal or medically supervised withdrawal with acupuncture and counseling has proven ineffective, or that a physician licensed by the Oregon State Board of Medical Examiners has documentation in the patient record that there is a medical need to administer opioid agonist medications.

Daily Operations

Clinics in Oregon are required to be open Monday through Saturday. Clinics are open early morning through early afternoon and provide dosing, counseling and urinalysis testing. Upon admission patients are required to pick up their medication at the clinic six days a week. Over time and documentation of progress, patients are eligible for "take home" privileges that enable them to come to the clinic less often. The criteria and time frame for these are privileges described in federal and state regulations.

Individuals may be enrolled and participate in methadone treatment for as long as they benefit and believe they need to be on medication to maintain the positive changes and stability they have achieved since enrolled in treatment. An average length of stay is between one and three years. If both the patient and the clinic believe the person may be able to be titrated successfully off methadone, then a therapeutic detoxification can occur. Generally this detoxification period is several months or longer depending upon how the person responds.

AMH will continue to collaborate with partners including OHA Public Health Division, the Alcohol & Drug Policy Commission, the Prescription Drug Monitoring Program, the Governor's Prescription Drug Abuse Task Force, Local Mental Health Authorities, and Oregon medication assisted treatment providers to address issues related to

prescription opioid poisoning. Technical assistance and training is used to increase awareness and promote implementation of medication assisted treatment to treat opioid addictions. AMH works with CMHPs, counties, sub-contractors and other providers to monitor and ensure that priority populations receive services required by the SAPTBG by implementing the Oregon Web Infrastructure for Treatment Services (OWITS) Capacity Management System. Treatment outcome improvement measures continue to be refined as part of the outcome-based contracting process and in response to any new measure or performance domains included in the National Outcome Measures.

Driving Under the Influence of Intoxicants (DUII) Treatment

Whether an individual enters into a diversion agreement or is convicted of Driving Under the Influence of Intoxicants, the court will order the individual to set and keep an appointment with an Alcohol and Drug Evaluation and Screening Specialist (ADES). The ADES has two roles in the DUII service system:

- Screen for an appropriate referral to a state approved DUII alcohol and drug treatment program; and
- Monitor and provide the court with individual alcohol and drug treatment compliance.

During screening, the ADES will determine if an individual should be referred to DUII alcohol and drug treatment or to a DUII information program. Factors that the ADES will take into consideration in making a referral include blood alcohol content at the time of the arrest, previous arrests, and other factors related to an individual's situation.

Those who are referred by the ADES for DUII alcohol and drug treatment will be assessed by the treatment provider to develop an individualized treatment plan. While in treatment, individuals will be required to demonstrate at least 90 days of abstinence from alcohol and other drugs. The 90 days of abstinence must continue through to the individual's successful discharge from alcohol and drug treatment. Individuals who produce a positive drug test will have the 90 day requirement restart and they will not be able to complete alcohol and drug treatment until 90 days have passed without an additional positive test. Level of care, including the number of clinical treatment hours per week, is individualized per ASAM Assessment. Average hours per week are two to eight, but can be more depending on level of addiction severity.

DUII Information Program

The requirements for DUII Information Program are outlined in Oregon Administrative Rule and include 12 to 20 hours of alcohol and drug education. The alcohol and drug education is over a minimum of four sessions over four consecutive weeks. In addition to the drug and alcohol education requirements individuals are required to submit at least one random urine sample for testing within the first two weeks of the DUII Information Program. Individuals who produce a positive alcohol and drug test will be required to enter and successfully complete an alcohol and drug treatment program including the 90 days of abstinence as outlined above.

DUII Recovery Supports

As part of the continuum of care, recovery support services are encouraged for individuals who engage in addiction treatment for DUII. Specifically, community-based programs serving individuals in the criminal justice system must incorporate strategies that promote relapse prevention. A large number of individuals engaged in addiction treatment for DUII will participate in community recovery support while in treatment and after successful completion.

2011 DUII Investment

Effective January 1, 2012, House Bill 2104 increased the fee paid by DUII offenders that credits the Intoxicated Driver Program Fund (IDPF). The IDPF was created in 1981 to fund alcohol and drug treatment services for indigent DUII offenders. The structure of the fund and the fees paid by DUII defendants has varied over the past thirty years. Over the past decade, funds have been allocated to the counties through the general service element (SE) process; amounts have been based on historical utilization. The fund is administered by OHA and is credited \$150 (up from \$25) for each DUII. Funds support indigent DUII treatment, indigent interpreter services, indigent ignition interlock device installation and monitoring, and a small number of administrative costs. Upon notification of the increase, the OHA convened a workgroup representing county addiction representatives, local treatment providers, an Alcohol and Drug Evaluation and Screening Specialist (ADES), the Transportation Safety Division of the Department of Transportation, and OHA staff to solicit input on a plan for IDPF distribution over the 2011-2013 biennium. The outcome was a distribution plan pursuant to this budget.

Problem Gambling Treatment

Oregon's problem gambling services program is funded by proceeds from the State Lottery which are directed to the Oregon Health Authority to mitigate the harm caused by state-operated gambling. Allocation decisions, system and policy development, technical assistance, contract/outcomes and quality assurance monitoring are provided at the state level. Treatment services are provided locally by certified gambling counselors in substance abuse treatment and mental health treatment agencies. Problem gambling co-occurs frequently with substance abuse and mental health disorders. Oregon can provide a more integrated system of care by including problem gambling screening and treatment. Oregon provides a 24-hour helpline staffed by problem gambling counselors whose job is to engage the caller and refer them to their local treatment provider. The helpline offers chat, instant message and email contact as well as a more traditional phone-based approach.

Outpatient problem gambling treatment includes:

- Assessment,
- Individual treatment planning,
- Individual, group, and family counseling,
- Treatment for concerned others if appropriate,
- Case management, and
- Aftercare planning.

Oregon has approximately 42 problem gambling outpatient treatment programs statewide including specialized, culturally competent programs for Asian and Hispanic communities.

GEAR

Oregon's Gambling Evaluation and Reduction Program (GEAR) is designed to meet the needs of less severe problem gamblers. GEAR is an evidence-based, structured program that offers home-based change tools such as self-change guides, telephone counseling, internet support groups, and educational videos. Pilot projects on offering video conferenced counseling are also being conducted

Residential Care

Oregon funds one statewide inpatient gambling treatment program and 1 regional center that offer crisis-respite services; as with outpatient treatment, these services are co-located within mental health and/or addiction residential care programs. Individuals utilizing this level of care are referred from an outpatient gambling treatment program.

Recovery and Maintenance

Part of treatment planning includes aftercare, relapse prevention, and ongoing support through the recovery process. Alumni groups offered within treatment programs and client involvement with Gamblers Anonymous are two examples of this level of care.

Family Support Services

Oregon provides addiction treatment and recovery support services for pregnant women and women with children. SAPTBG funds are used to fund capacity for dependent children to accompany their parent to residential treatment. As a supplement to SAPTBG funding for specialty treatment services, AMH will continue to monitor the legislatively approved Intensive Treatment and Recovery Supports (ITRS) initiative for non-Medicaid eligible parents needing outpatient treatment services and for those Medicaid eligible parents who are, or are at risk of becoming, involved with Child Welfare and are in need of residential treatment.

ITRS is a cross-system collaborative approach that encompasses DHS Child Welfare, addiction providers, recovery support services (peer delivered services and housing supports), and early childhood system partners. ITRS capacity plays a significant role in serving priority populations designated by federal regulations.

Since 2007, Oregon's ITRS initiative has provided residential treatment for parents and children. Services include regular outpatient treatment, intensive outpatient treatment, and residential treatment for parents and children. Additionally ITRS provides clean and sober housing options, case management, recovery support services (peer mentors, transportation to meetings, mental health therapy, etc.), and parent skill development. Since inception, over 2,000 children have been reunited with their parents and are no longer in family foster care after their parents obtained addiction treatment and recovery services through the ITRS initiative. With help from these programs, adults learn how to manage their recovery and develop the skills to be better parents.

Oregon Women's Commission

The mission of the Women's Commission on Alcohol and Drug Issues in Oregon (WCADIO) is to increase public awareness on the need for specialized treatment and recovery services for women and girls affected by alcohol or other drug use. Their plan is to meet government officials and the public when necessary to educate them to the need that all women should receive research-based specialized substance use treatment and recovery services that support both their individual needs as well as family needs.

WCADIO's goals are to ensure the equity and quality of services for women in the state of Oregon affected by alcohol and other drugs, receive and evaluate information from Oregon's citizens and the alcohol and drug abuse treatment community regarding women's alcohol and drug issues, and to provide information and education to the general community.

Local Alcohol and Drug Planning Councils

Supported by OAR 415-056 the Local Alcohol and Drug Planning Committee (LADPC) is a statutorily required board in every Oregon county charged with identifying needs and establishing priorities for alcohol and drug prevention and treatment services that best suit the needs and values of the community.. The LADPC works closely with the Health Advisory Board on community education, advocacy and establishing priorities for future development. The committees have a diverse membership with expertise and interest in juvenile and adult corrections, drug court, treatment, education, and issues related to youth and seniors.

Oregon's Integrated Planning Group for HIV

The (OHA) Public Health Division is committed to lifelong health for all people in Oregon. The Public Health Division's mission is to promote health and prevent the leading causes of death, disease and injury in Oregon, including HIV, Viral Hepatitis (VH), and other sexually transmitted infections (STIs). In 2012, the HIV/STD/TB Section of the Oregon Health Authority convened a statewide planning group to promote and support a comprehensive and integrated approach to:

- Preventing HIV infection and co-infections with VH and STI; and
- Providing quality care for those who are infected with HIV and co-occurring VH and/or STI.

This planning group, called the Integrated HIV/VH/STI Planning Group (IPG) represents a departure from past planning efforts, in which responsibility for planning HIV prevention, HIV care services, STI prevention and care, and VH prevention and care activities was held by separate entities. In addition, AMH provides support to the planning group by providing designated staff at each meeting. The IPG aims to create the knowledge, tools, and networks that people and communities in Oregon need to protect their health from all of these related infections.

Governor's Advisory Committee on DUII

The Governor's Advisory Committee on DUII shall broadly represent the Legislative Assembly; public and private organizations involved in DUI countermeasures, victims of drunk drivers, and the general public. Their charge is to heighten public awareness of the seriousness of the dangers of driving while under the influence and persuade communities to attack the drunk driving problem in a more organized and systematic manner, including plans to eliminate bottlenecks in the arrest, trial and sentencing process that impair the effectiveness of many drunk driving laws. Additionally, the committee generates public support for increased enforcement of state and local impaired driving laws and educates the public as to the drunk driving problem and its effects on life and property.

Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program is a new program to help health care providers and pharmacists provide patients better care in managing their prescriptions. The program was started in 2011 to help people work with their health care providers and pharmacists to know what medications are best for them. Pharmacies will contribute data to the program on certain prescription drugs dispensed to patients. The information will support the appropriate use of prescribed medications.

Specialty addiction treatment services are delivered by CMHPs, tribes, nonprofit agencies and statewide contractors in outpatient programs and residential treatment programs. Some individuals may need residential services, while others may need outpatient services; some individuals may require both outpatient and residential services to successfully recover and manage their disease. Outpatient services may include specialized programs that incorporate medications used to treat addictions, with other treatment and recovery support services. Education and treatment are available for people who are diverted or convicted after being arrested and charged for driving under the influence of intoxicants (DUII).

Youth Substance Abuse Treatment Services

AMH, as authorized by Oregon Revised Statutes (ORS) 430.640, can establish facilities and provide comprehensive treatment services for children and adolescents throughout the state Oregon. These services may include but are not limited to the prevention and treatment of substance use disorders. Providers must have a letter of approval from AMH to provide services to youth. All programs are monitored and reviewed by the Quality Improvement and Certification Unit of AMH.

The rate of current illicit drug use shown in Table 1¹³, among youth ages 12 to 17, remained similar from 2009 to 2010 (10.0 vs. 10.1 percent), but higher than the rate in 2008 (9.3 percent). Between 2002 and 2008, the rate declined from 11.6 to 9.3 percent.

¹³ www.samhsa.gov/data/nsduh

Table 1.

	2008	2009	2010
Illicit Drugs	9.3%	10.0%	10.1%
Marijuana	6.7%	7.3%	7.4%
Psychotherapeutics	2.9%	3.1%	3.0%
Inhalants	1.1%	1.0%	1.1%
Hallucinogens	1.0%	0.9%	0.9%

Rates of current, binge, and heavy alcohol use among underage persons declined between 2002 and 2010. The rate of current alcohol use among 12 to 20 year olds went from 28.8 percent in 2002 to 26.3 percent in 2010. The binge drinking rate went from 19.3 to 17.0 percent, and the rate of heavy drinking went from 6.2 to 5.1 percent. Table 3 lists the Oregon Adolescent Treatment Practice Guidelines.

Currently, there are seven regional residential centers and more than 30 Oregon counties that provide regional outpatient treatment services to youth between the ages of 12 and 20 years old. Providers use the American Society of Addiction Medicine (ASAM PPC-2R) Patient Placement Criteria to match youth to appropriate level of treatment needed, when youth and their families are seeking residential and outpatient treatment services.

Evidence-Based Practices

The use of evidence based practice tools for determining best treatment options for adolescents needing treatment for alcohol and other drugs are essential in obtaining the best outcomes.

- The Screening, Brief Intervention and Referral to Treatment (SBIRT) model is the most effective method to intervene in alcohol and drug misuse. SBIRT is usually administered at the primary care physician's office to screen for need for treatment.
- The CAGE Assessment (Cut-back, Annoyed, Guilty, or Eye-opener) is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised.
- The CAGE Adapted to Include Drugs (AID) is a commonly used, 5- question tool used to screen for drug and alcohol use.
- The Global Appraisal of Individual Needs (GAIN) is a family of evidence-based instruments used to assist clinicians with diagnosis, placement, and treatment planning. The GAIN is used with both adolescents and adults in all kinds of treatment programs, including outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community and correctional programs.

Oregon has adopted the following treatment practice guidelines to address the range of service needs for youth across the state.

Table 2.

Oregon Adolescent Treatment Practice Guidelines	
<ul style="list-style-type: none"> • Developmentally Appropriate Care • Cultural Competence • Gender Competence • Recovery Oriented System of Care (ROSC) • Trauma Informed • Person Centered • Treatment Outcomes • Screening 	<ul style="list-style-type: none"> • Outreach • Engaging and Retaining Youth in Treatment • Assessment • Detox • Treatment Recovery Planning • Crisis Intervention • Family Involvement • Advocacy • Staff Qualifications

Residential Services

When youth need detoxification services they are sent to a local or regional hospital facility licensed by the Oregon Public Health Division. AMH licenses facilities to provide residential services to youth who are assessed as needing ASAM Level III services. Level III programs offer organized treatment services that feature a planned regimen of care in a 24 –hour residential setting.. Programs are designed for adolescents who need safe and stable living arrangements in order to develop their recovery skills. Treatment is delivered in accordance with defined policies, procedures and clinical protocols. Programs are housed in or affiliated with permanent facilities where youth can reside safely and are staffed 24 hours a day.

Outpatient Services

Outpatient service criteria for ASAM Level I is sometimes a step-down from Intensive Outpatient (IOP) services. Youth assessed at Level I are not at risk for sub-acute withdrawal from drugs or alcohol. ASAM Level II.1 is Intensive Outpatient and recommends meeting six hours per week in an after school setting. Both Level I and II services are tailored to each patient’s level of clinical severity and are designed to help each youth achieve permanent change in his or her using behavior. Treatment addresses major familial, attitudinal, behavioral and cognitive issues having the potential to undermine the goals of treatment or impairing a young person’s ability to cope with major life tasks without relapsing and turning to alcohol or other drugs to cope. Treatment interventions are designed to engage young people who are at varying stages in their developmental process.

Culturally Specific Services

“Culturally Specific Program” is defined in the Oregon Administrative Rule to mean a program designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture. There are few providers in Oregon who provide culturally relevant services to adolescents. Lifeworks

Northwest is a Portland based program that contracts with their local County Mental Health Provider to provide culturally specific addiction treatment services to underserved African-American and Latino(a) youth. SAPTBG dollars are used to enhance treatment services by providing culturally relevant treatment support, using African American mentors, artists, and story tellers. Additionally, Block Grant funding is used for culturally relevant community experiences for social learning.

Juvenile Crime Prevention Advisory Committee

The committee is responsible for reviewing the budget and allocation formula for appropriations for the purpose of juvenile crime prevention, recommend juvenile crime prevention policies to the legislature, ensure high risk juvenile crime prevention planning criteria are met by state, local, and private entities, and to review the components of the local coordinated comprehensive plans for children and families created pursuant to [ORS 417.775 \(Purpose and duties of local commission\)](#) that address local high-risk juvenile crime prevention plans developed under [ORS 417.855 \(Local high-risk juvenile crime prevention plan\)](#) and make recommendations to the governor about the local plans.

Beginning July 1, 2013, the Juvenile Crime Prevention Advisory Committee is being legislatively phased out and the duties have been assumed by the Oregon Youth Development Council. The Youth Development Council (YDC) was established by House Bill 4165 in 2012 to assist the Oregon Education Investment Board in overseeing a unified system that provides services to school-age children through youth 20 years of age in a manner that supports academic success, reduces criminal involvement and is integrated, measurable and accountable.

The council consists of no fewer than 15 members who are appointed by the Governor. The membership of the council must satisfy federal requirements for membership of a state advisory committee on juvenile justice, and includes tribal representation. The council prioritizes funding for prevention and intervention services related to gang violence and gang involvement.

Residential Behavioral Health Treatment Services

Children's psychiatric residential treatment services (PRTS) and psychiatric day treatment services (PDTS) funding was transferred to the Oregon Health Plan in 2005 and is managed today through CCOs as part of their global budget.

Programs for children who are Medicaid eligible but not enrolled with a Coordinated Care Organization (fee for service), PDTS and PRTS are co-managed with the Community Mental Health Programs. The Community Mental Health Programs conduct level of need determination and approve referrals to PDTS and PRTS programs.

All CCOs are required to create linkages with community support systems including local and/or regional allied agencies. Integration of physical and behavioral health care is a requirement of their transformation plans. Enrollment in a CCO provides coordination between medically appropriate treatment services for children eligible for

Medicaid and many of the social supports necessary so children with severe emotional disorders can remain in their community. The OHP benefit package includes a full array of services such as:

- Preventive services;
- Diagnostic services;
- Medical and surgical care;
- Dental services; and
- Outpatient addictions treatment services

Residential and day treatment service providers are expected to collaborate with the local Child and Family Team to coordinate transitions back into the community with the goal of maintaining the child in the least restrictive setting.

Residential Services for Young Adults in Transition (YAT)

Statewide Residential Programs and supported housing specifically designed to meet this group’s needs are expanding, in transitioning from children’s mental health system to the adult system. Programs serve young adults ages 17-25 who have mental health challenges and who may have a history of institutional care.

Currently there is one young adult Secure Residential Treatment Facility (SRTF) that is used as an alternative to state hospital level of care and three young adult Residential Treatment Homes (Table 4). Three more Residential Treatment Homes are due to open in April 2013.

Table 4.

Young Adult Residential Treatment Homes		
	Provider	County
Three Bridges (SRTF)	Kairos Northwest	Josephine
Sender House	Trillium Family Services	Linn
Mosaic	Youth Villages	Clackamas
Momentum	Kairos Northwest	Josephine
OPENING APRIL 2013		
Tempo House	Kairos Northwest	Lane
Zora House	LifeWorks NW	Washington
TBD	Cascadia	Multnomah

AMH has developed specific programming at various levels of care targeting YAT age 17-25 that are transitioning out of a hospital level of care setting. These residential options are needed to address the dramatic shortfall in services that occur due to categorical eligibility when an individual turns 18. YAT specific programming is being implemented within the Oregon State Hospital system and these housing projects support that system.

Services delivered in the homes should be engaging and relevant to young adults, and include feedback from the young adults whenever possible. Programs should

accommodate the critical role of peers, families and friends in service delivery. These services may include, but are not limited to, the following:

- Money and household management;
- Supervision of daily living activities such as skill development focused on nutrition, personal hygiene, clothing care and grooming, and communication skills for social, health care, and community resources interactions;
- Assuring the safety and well-being of individuals in the program;
- Administration, supervision and monitoring of prescribed and non-prescribed medication;
- Provision or arrangement of routine and emergency transportation;
- Developing skills to self-manage emotions;
- Management of physical or health issues including diabetes and eating disorders;
- Access to mentoring and peer delivered services;
- Promoting positive use of leisure time and recreational activities;
- Access to Supported Education and Supported Employment;
- Individual, group and family counseling;
- Social and Independent Living Skills training;
- Timely, appropriate access to crisis intervention to prevent or reduce acute emotional distress;
- An Individual Service and Support Plan (ISSP) with a safety component to ensure that a developmental and trauma informed perspective is incorporated; and
- The ISSP has a specific section addressing services and supports unique to the developmental challenges of a transition-age young adult including:
 - School completion,
 - Sexual orientation and cultural values and norms,
 - Employment,
 - Independent living skills,
 - Budgeting,
 - Finding permanent housing,
 - Making friends, and
 - Parenting skills when applicable.

Adult Mental Health Residential Treatment Programs

Three levels of community-based residential treatment services are offered for adults with serious mental illness:

- Residential Treatment Homes (RTHs) are homes operated to provide services on a 24-hour basis for five or fewer residents;
- Residential Treatment Facilities (RTFs) are facilities operated to provide services on a 24-hour basis for six or more residents; and
- Secure Residential Treatment Facilities (SRTFs) are any Residential Treatment Facility, or portion thereof, that restricts a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. SRTFs have 16 or fewer beds.

Individuals are assessed for the appropriate level of care and inform the ISSP; an individualized, written plan outlining the care and treatment to be provided to a resident in the RTH/RTF/SRTF based upon an individualized assessment of strengths and treatment needs.

AMH staff in the Residential Programs and Services Unit work closely with community-based residential treatment providers to identify system needs and gaps. The following projects were developed in the 2011-2013 biennium¹⁴:

- **Autumn Ridge - Residential Treatment Home, Clackamas County (4 beds)**
This RTH serves up to four adults that are over age 18 discharged from the state hospital. This home requires the ability to serve individuals with psychiatric, minor behavioral and assistance in activities of daily living (ADL) needs. Although the ADL needs of these individuals exceed the ability of the average RTH to provide, they are not so serious as to require a specialized medical home/facility. These individuals are not eligible for services from Department of Human Services (DHS) Aging and People with Disabilities (APD).
- **Bell Cove - Residential Treatment Home, Curry County (5 beds)**
This home serves people under the jurisdiction of the Psychiatric Security Review Board and who have significant medical needs that cannot be addressed in a typical residential treatment home. The facility is an ADA accessible single-level five-bed facility serving residents who require a moderate-level of medical care for physical and mental health care needs. Nursing staff are present six-eight hours a day, seven days a week, and are part of the staffing pattern to assure individual medical needs are addressed and residential staff is trained in any nursing delegation. Examples of medical issues that clients may present with include diabetes, COPD, seizure disorders, and chronic pain.
- **Freestone – Residential Treatment Home, Polk County (2 beds)**
This home was created as a joint partnership between DHS Aging & People with Disabilities and AMH for two individuals with needs that cross both agencies. The individuals for which this home was created have diagnoses of PTSD and Borderline Personality Disorders that result in on-going patterns of self-harm and other aggressive behaviors.

Table 5 shows, by county, the current licensed-residential housing capacity.

¹⁴ Development for 2013-2015 will be based on the amount allocated in the budget approved during the current Oregon Legislative Session.

Oregon's 2014-2015 State Plan for Behavioral Health Services

Table 5.

County	Residential Treatment Home Beds	Residential Treatment Facility Beds	Secure Residential Treatment Facility Beds
Baker	0	0	0
Benton	8	13	0
Clackamas	33	46	48
Clatsop	0	0	0
Columbia	0	25	0
Coos	5	6	0
Crook	0	0	0
Curry	5	8	0
Deschutes	15	0	16
Douglas	0	0	0
Gilliam	0	0	0
Grant	0	0	11
Harney	0	10	0
Hood River	0	0	0
Jackson	0	0	16
Jefferson	0	0	0
Josephine	5	10	54
Klamath	0	0	16
Lake	0	0	0
Lane	10	43	33
Lincoln	9	0	0
Linn	17	7	0
Malheur	0	0	0
Marion	15	60	129
Morrow	0	12	10
Multnomah	65	195	91
Polk	5	13	0
Sherman	0	0	0
Tillamook	0	0	0
Umatilla	5	0	32
Union	0	0	0
Wallowa	0	43	0
Wasco	0	12	0
Washington	27	22	0
Wheeler	0	0	0
Yamhill	0	16	0
Total	229	541	456

Oregon funds one statewide inpatient gambling treatment program and one regional center that offer crisis-respite services; as with outpatient treatment, these services are co-located within mental health and/or addiction residential care programs. Individuals utilizing this level of care are referred from an outpatient gambling treatment program.

In promotion of behavioral and physical health coordination, AMH is transitioning Medicaid funded Addictions and Mental Health Residential treatment to Oregon's Coordinated Care Organizations effective July 1, 2013. To aid in this transition, an advisory group comprised of consumers, CCOs, community mental health program representatives, alcohol and drug residential providers, and mental health residential providers was established to advise the Oregon Health Authority on the transition. Outreach efforts are underway to inform CCOs of the importance of behavioral health stabilization including detox and residential capacity within the continuum of care in Oregon communities.

Hospital-Based Behavioral Health Treatment Services

Children's Mental Health Services

AMH has developed systemic alternatives to state hospitalization for children. The Secure Children's Inpatient Program (SCIP) provides 24-hour secure residential treatment designed to provide intensive psychiatric treatment for children age 14 or younger, including a therapeutic school program on the residential campus. SCIP replaced the children's unit within the Child and Adolescent Treatment Services located at the Oregon State Hospital and opened in January 2002. It is housed in a residential facility in the Portland metro area.

Children and youth are recommended to this level of care by their Child and Family team. The referral is approved at the local level and sent to AMH for final authorization for admission. The level of care needed must be between acute care hospitalization and psychiatric residential treatment service levels.

The Secure Adolescent Inpatient Program (SAIP), located in Corvallis, Oregon, provides secure residential treatment for adolescents age 14 to 17 years. The SAIP program also provides secure forensic mental health treatment for youth who are court mandated for aid and assist evaluations¹⁵, for the Oregon Youth Authority Crisis and Petition Admissions, and for the Juvenile Psychiatric Security Review Board (JPSRB) secure residential treatment.

Intensive psychiatric services are provided in coordination and with the collaboration of a Child and Family team. Services are delivered in an integrated and holistic approach in a safe and comfortable living environment that is as normalized as possible and matches the individual developmental level of the child. Both the SCIP and SAIP programs are transitioning to trauma informed practice under the Sanctuary Model. Therapies employed include:

- Collaborative Problem Solving;

¹⁵ Under ORS 161.370

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- Dialectical Behavioral Therapy (SAIP);
- Cognitive Behavioral Therapy for multiple symptoms; and
- Dr. Bruce Perry's Neurosequential Model.

AMH continues direct contracts with private non-profit agencies for SCIP and SAIP, with admissions being reviewed and approved by AMH children's mental health specialists. Both programs are committed to delivering care to children and youth that:

- Delivers active psychiatric treatment in an individual plan of care developed by an interdisciplinary team under the direction of a psychiatrist who is board eligible or board certified in child psychiatry by the Oregon Board of Medical Examiners.
- Employs a multi-disciplinary approach to care that includes community mental health programs, coordinated care organizations, the child's school, family representatives and advocates, acute care psychiatric hospitals, juvenile justice, and children's intensive treatment service providers as indicated and appropriate for each child.
- Employs culturally relevant and competent treatment that is appropriate for the gender, age, culture, ethnicity, strengths, and individualized treatment needs of the child.
- Has a staffing model that allows for a child's frequent contact with a child psychiatrist, psychologist, psychiatric nurses, psychiatric social workers, rehabilitation therapists, and milieu staff with specialized training 24 hours a day. Additionally, a psychologist with specialized training in forensic evaluation is available.
- Provides linkages with various levels of care and provides for case coordination with guardians, community partners, and continuing care providers to ensure the child's treatment is provided in the most appropriate and least restrictive setting.

Adult Mental Health Services

Oregon State Hospital (OSH) is a psychiatric hospital that inspires hope, promotes safety and supports recovery for all. The mission of OSH is to provide therapeutic, evidence-based, patient-centered treatment focusing on recovery and community reintegration all in a safe environment.

OSH provides long-term intensive psychiatric treatment for adults suffering from serious mental illness who are under civil or forensic commitment. People who come to OSH through a civil commitment require physically secure 24-hour care that is not available through community programs. They have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs, such as health and safety, because of a mental disorder.

People who come to OSH under a forensic commitment are individuals who have been charged with or convicted of criminal behavior related to their mental illness. Some are referred by the courts under Oregon law ([ORS 161.370](#)) for treatment that will help them to understand the criminal charges against them and to assist in their own defense. Others are admitted after they have been found guilty of a crime except for insanity. Depending on their age and the nature of their crime, these patients are under the

jurisdiction of the Juvenile Psychiatric Security Review Board (JPSRB), Adult Psychiatric Security Review Board (PSRB) or the Oregon State Hospital Review Panel (SHRP).

In 2012 OSH served 571 individuals. Table 6 represents the average census for 2012.

Table 6.

2012 OSH Average Census		
Forensic	Guilty except for insanity (PSRB and SHRP)	295 individuals (52%)
Forensic	Aid & Assist (ORS 161.370)	107 individuals (19%)
Civil	Neuropsychiatric and geriatric	81 individuals (14%)
Civil	Adult Treatment Services	88 individuals (15%)

The construction of the first new psychiatric treatment and recovery facility in more than 50 years was funded in the 2009-2011 budget. This budget funded additional staff, equipment and supports needed to operate the new hospital and allow progress toward meeting the federally mandated minimum of 20 hours of active psychiatric treatment per person per week. These resources will help patients recover and gain the skills needed for successful community living. The new hospital is designed with patients’ needs foremost in mind, including healthy food, access to education, assistance in reaching personal goals, and access to open outdoor space and fresh air in a secure, nurturing environment.

OSH has implemented central intensive treatment malls at the Salem and Portland campuses. The use of treatment malls is based on a philosophy of active patient-driven treatment with the goal of preparing patients for successful discharge. It employs a community design of centralized care in which the patients’ living areas are connected to a “neighborhood” mall that connects to a larger “downtown” mall so that patients can access services provided in the facility and have more opportunities for healthy socialization. In the past, all of a patient’s meals, care and treatment have been provided on the ward. Activities were limited and patients spent a lot of time sleeping and watching television. While patients live on a unit, they receive treatment, eat meals, attend classes and participate in activities in the mall areas. There is growing evidence that this centralized model can provide lasting benefits, including a decrease in hospital readmission rates, increased skills in symptom management and improved quality of life.

Civil programs

Springs (Four Units – 96 Beds, eight of which are medical beds)

The Springs program is for patients who require a hospital level of care for dementia, organic brain injury or mental illness. These patients often have significant medical issues. The program's goal is for everyone to return to a community-care setting. From the day of admission, the treatment team works with the patient toward this goal. Springs uses treatments that include sensory and behavioral therapy such as daily

living skills and recreation; coping and problem-solving skills learned through group and individual therapy; and classes or activities in the treatment mall.

Adult Treatment Services - Portland (Three Units – 72 Beds)

The Portland campus of Oregon State Hospital currently houses the adult treatment services program for adults who have been civilly committed or voluntarily committed by guardian. Patients each have an individual treatment care plan and attend the treatment mall every weekday. The primary focus of treatment mall programs is to prepare patients to return to the community. Skill-building treatment groups are facilitated by nursing staff, social workers, psychologists, community reintegration specialists, and music, occupational and recreational therapists. Groups help patients learn how to manage their symptoms and medications, develop coping and recreational skills, budget and manage their money, and plan and prepare meals. Community integration is the focus of weekly group trips to community settings. Separate programs provide educational support or psychotherapy to help patients understand and deal with the effects of alcohol and other drug abuse on their mental illness.

Forensic programs

Harbors (Five Units – 104 Beds)

Harbors is the admissions and stabilization program for the hospital, where patients receive an initial assessment and have an opportunity to stabilize their symptoms. From the first day of their stay, patients begin planning for discharge and eventual transition to the community. They begin meeting with a treatment team within three days of admission to develop a recovery plan that includes classes and activities on the treatment mall, which they are expected to attend every weekday. Length of stay in Harbors varies, depending on each patient's needs. Harbors' goal is to evaluate, stabilize and move each patient to a less restrictive program within 21 to 30 days.

Trails (Eight Units – 208 Beds)

Patients continue in their recovery by transferring to Trails, the hospital's community rehabilitation program for forensic patients, after assessment and stabilization in Harbors. Trails offers many more choices for patients, including more options for treatment, free time and meals. These additional choices help patients build on their strengths and manage their illness while in the hospital and after discharge. Length of stay in Trails depends on the stage of recovery, patient and community safety, the patient's legal status and other factors.

Bridges (Four Units – 114 Beds and Four Cottages – 26 Beds)

Bridges is the transition program for forensic patients who are nearing the point where they no longer need hospital-level care. In addition to four traditional living units, Bridges includes six cottages on the hospital campus that provide a treatment setting much like a group home, where patients cook their own meals and share other household responsibilities. Bridges' goal is to help patients achieve their highest level of health, safety and independence as they prepare for discharge or conditional release to a less-restrictive community setting. Individuals work on living skills through daily treatment

mall activities and classes and through approved outings. They also participate in discharge planning with treatment team members.

2012 highlights

- The move into the new Salem campus was completed after more than a year of transition.
- In order to provide better care to civilly-committed patients, OSH selected and moved 20 patients from the Portland campus to the Salem campus. These patients are benefiting from the resources offered by the treatment malls, and Portland's staff now has the resources and space they need to increase the weekly active treatment time of the remaining patients from 10 to 20 hours.
- OSH completed a successful Joint Commission survey, receiving full accreditation and an abundance of praise from the surveyors.
- Progress has continued in the three hospital-wide priorities set earlier in 2012
 - **Safety:** There has been a decrease in the number of serious injuries to patients and staff resulting from assaults;
 - **Patient care:** Expanded use of electronic health records by introducing additional features, moving closer to having a truly comprehensive tool for managing patient information; and
 - **Fiscal:** By introducing a new scheduling system and making some adjustments to staffing, OSH has significantly reduced the use of overtime and agency staff, cutting down on one of its largest expenditures. In addition, OSH has seen a considerable reduction in mandatory overtime.

Blue Mountain Recovery Center (BMRC)

Blue Mountain Recovery Center is an inpatient adult mental health care facility in Pendleton, Oregon. Located in the admission and treatment building of the former Eastern Oregon State Hospital, BMRC was built in 1948. Blue Mountain Recovery Center consists of two residential units of 30 beds each. Sunrise serves men and women, and Sunset serves men only.

BMRC admits clients from all areas of the state and is the primary state hospital resource for Eastern Oregon. BMRC serves civilly committed individuals with serious mental illness who have been found to be a danger to themselves or others, or are unable to care for their basic needs due to a mental illness. In addition, BMRC provides care and treatment for a small number of forensic clients who have close family ties in Eastern Oregon.

BMRC embraces the recovery model which aims to enable patients to take charge of their lives and to live well with the least amount of professional intervention. Patients learn to manage their emotions in various settings, to avoid conflicts, use medications wisely, and avoid illicit drugs and alcohol. BMRC's physicians, nurses, therapists and other staff are committed to providing high-quality psychiatric and medical care that includes:

- Personalized recovery services for all clients;
- Client participation in individualized treatment planning;

- Promoting family involvement as appropriate to enhance recovery; and
- Partnering with community members to provide vocational, educational, social, recreational and spiritual opportunities.

Junction City

The Oregon State Hospital in Junction City will be co-located with two state prisons on a 90-acre campus. The hospital will include single and double occupancy patient rooms, staff offices, counseling and treatment rooms, and indoor and outdoor recreation areas.

The design for the Junction City state hospital is based on a centralized treatment model within a secure perimeter as the means of providing comprehensive and consistent therapeutic opportunities to all its patients. In keeping with the Recovery Model for mental health, the design for the new facility and its campus was driven by programming needs to ensure a patient-first, patient-driven and patient-focused mental health system.

The siting of both the Salem and Junction City hospitals has been an open and public process. The State has received letters of support from elected officials with an interest in the Department of Corrections-Junction City site.

Adult Mental Health Initiative (AMHI)

In order to ensure individuals receive the appropriate level of care for the appropriate duration, the Adult Mental Health Initiative (AMHI) was implemented in September 2010. The initiative re-allocated a portion of resources historically used to develop community based licensed residential care facilities. These resources were directed to non-traditional person-centered supports in care management, a broad range of treatment services, discharge planning, and community based supports such as rental assistance.

AMHI has increased local accountability for improved treatment outcomes through performance based contracting. Increased local control and accountability help AMH's community partners provide high quality care at the right time, for the right duration, and at lower cost.

The first year of AMHI reduced the average Length of Stay (LOS) for those deemed "ready to transition" who are awaiting discharge from the state hospital. In year one the LOS dropped by half, and dropped by half again during the second year. Targeted reductions employed during the third year of AMHI have reduced LOS for those with long residency in more restrictive levels of community-based licensed residential care. In addition, the successful initiation of the Medicaid managed care transition to local CCOs will prioritize preventive integrated health care, and is expected to further improve health outcomes while continuing to lower health care costs.

Diversion Strategies and Community Reintegration

Criminal Justice Diversion

During the 2011 session, the Oregon Health Authority received a legislative directive to convene a statewide workgroup to identify the needs of people who are involved in the criminal justice system for minor violations, who have mental health disorders and could be placed more appropriately in settings where they could receive mental health treatment. The group developed recommendations for diverting this group for appropriate and effective mental health care in the community.

The workgroup was comprised of individuals representing:

- AMH
- Behavioral Health Service Providers
- Judges
- The Psychiatric Security Review Board
- Disability Rights Oregon
- National Alliance on Mental Illness Oregon
- Association of Oregon Community Mental Health Programs
- County Behavioral Health Services
- Municipal Police Agencies
- Oregon State Police
- Consumers
- Oregon Consumer Defense Lawyers Association
- Oregon Association of Community Corrections Directors
- Oregon Association of Chiefs of Police
- The Oregon Association of Hospitals and Health Systems

In order to appropriately respond to the legislative directive the workgroup focused on recommendations in three categories:

- Alternatives to arrest and incarceration;
- Alternatives to incarceration (including individuals referred for evaluation under ORS 161.370 for ability to aid and assist in their own defense) once formally charged and/or sentenced; and
- Services, resources and supports to assist successful transition into the community.

Recommendations within these categories were then discussed and placed in the Sequential Intercept Model (SIM). The SIM is a visual national model produced by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation to aid in the development of a comprehensive plan for mental health and criminal justice collaboration. This model outlines action for system level change through five intercepts:

1. Law Enforcement
2. Initial Detention/Initial Court Hearings
3. Jails/Courts
4. Reentry
5. Community Corrections

The intercepts aid in understanding the interactions between the criminal justice and mental health systems. The intercepts identify where to intervene with individuals with mental health disorders as they move through the criminal justice system, and suggests which populations be targeted at each point of interception. The intercepts also identify decision makers who can authorize movement from the criminal justice system, and who needs to participate in developing interventions at each point of interception.

The workgroup identified category headings that fit into one or more of the intercepts and the specific recommendations focused on methods, services or programs that would aid in diversion of those with minor violations to settings more appropriate than jail. The specific recommendations can be viewed in the full report in Attachment #1.

Aid and Assist Programs

The "370 Project" was created in 2007 to increase the utilization of outpatient restoration services for individuals with serious mental illness who are unable to aid and assist in their own defense. The project functions to provide case management services to individuals who have been court ordered under Oregon Revised Statute 161.370 for detainment to the Oregon State Hospital or to outpatient restoration in the community. Currently there are four counties participating in the 370 Project:

- Lane
- Marion
- Multnomah
- Douglas

The case management provided in each county includes the provision of funding for rental assistance; assessments; medications; aid and assist training; the creation of diversion agreements with county courts and jails; assisting OSH in discharge planning; and promoting the utilization of Dual Diagnosis Anonymous services whenever appropriate.

Low level offenders with Treat until Fit (370) orders who are willing to engage in community mental health treatment are considered for community restoration. They are then assisted in obtaining a community mental health provider, benefits, and housing. They participate in legal skills training. When forensic diversion staff feel they are ready they are re-evaluated for competency and brought to court to face their charges. Forensic diversion staff also partner with "close street supervision" on these offenders and work with them until they are no longer involved in the legal system and are connected with community resources.

Offenders who fit better into the mental health system than the criminal justice system are considered for jail diversion. Offenders do not need to be "unable to aid and assist," but rather, need to be connected with resources to end the cycle of being stuck in the "revolving door." As with the other parts of the program, offenders are connected with community mental health, benefits, and housing. They also work with Close Street Supervision or Probation. These offenders can be either pre- or post-adjudication.

Forensic Evaluator Certification

House Bill 3100 was passed in the 2011 legislative session and took effect on January 1, 2012. This legislation created a certification process for psychiatrists and licensed psychologists who perform forensic evaluations assessing adjudicative competence (fitness to proceed) and criminal responsibility (guilty except for insanity). Responsibility for development, implementation and oversight of the certification program was delegated to the Oregon Health Authority.

The certification process and accompanying Oregon Administrative Rules were developed through a combination of researching other states which certify forensic evaluators, and extensive public input. Common criteria for certification in other states included submitting applications, participation in training, and providing redacted forensic evaluations for peer review. The rule development process incorporated a Rule Advisory Committee consisting of a diverse group of stakeholders and partners including service providers, the Oregon State Hospital, the Psychiatric Security Review Board, District Attorneys, defense attorneys, victim's advocacy groups, Pacific University, and consumer advisory groups and representatives. Public comments received during the formal rulemaking process were also considered in development of the final rule and process for certification.

OHA developed an application form and contracted with Pacific University School of Professional Psychology to develop a statewide training program and exam constituting mandatory elements of the certification process. The certification period lasts for two years. Candidates who wish to perform juvenile evaluations must attend an additional training and take an additional exam specific to juvenile evaluations. The third element of the certification process is submission of three redacted forensic evaluations by each candidate, which are reviewed by a panel convened by OHA. Members of the review panel consist of psychiatrists, psychologists, and attorneys who were chosen from a list of individuals submitted by professional organizations. Candidates are expected to submit evaluations regarding criminal responsibility and competency if their work encompasses both areas. Candidates who perform juvenile evaluations must submit a juvenile evaluation as part of their work sample. Certified evaluators must submit an additional three work samples when they apply for recertification.

Currently there are 113 evaluators who have completed the training and certification process. Two more trainings will be scheduled prior to July 1, 2013. The current demographic information for evaluators includes 24 psychiatrists, 56 PhDs, 31 PsyDs, 2 EdDs. Geographically, evaluators are spread throughout Oregon with the majority being located in the population center of the Willamette Valley region. There are additionally 10 evaluators in the Eastern region and 12 evaluators in the Southern region and two out of state evaluators currently certified.

Proposed metrics to measure effectiveness of the certification program include:

- Number of applicants successfully completing training and exam;
- Number of valid complaints received;

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- Comparisons of redacted evaluations to standards required by rule; and
- Comparisons of redacted evaluations written after development of rule and training to baseline evaluations which were written prior to January 1, 2012.

Oregon's largest proportion of individuals seeking and receiving substance use disorder treatment are referred through the criminal justice system. Referrals come from courts, parole and probation departments or specialized dockets. Criminal justice referrals are adults and juveniles and include parents involved in child welfare and dependency cases. AMH partners with the Oregon Department of Correction and encourages communities to partner with local community corrections departments to establish connectivity to a continuum of substance use disorder and other behavioral health care. Collaboration between AMH, the legislature, and criminal justice partners has resulted in a minimum of 75% of substance use disorder treatment funds being spent on evidence-based treatment practices. AMH continues to work with communities to identify resources focusing on underserved men in the criminal justice system in need of substance use disorder treatment. Communities also assist with identifying community-based services and supports as an alternative to incarceration.

AMH collaborates with Oregon communities in support of drug courts providing an alternative to traditional incarceration. Judicial oversight is paired with substance use disorder treatment, other behavioral health and ancillary services such as education and work force training. Community agencies partner to offer opportunities to individuals that prepare them with the structure required for recovery. AMH continues to identify populations that are underserved by drug courts and works with drug court teams to identify practices that may pose a barrier to successful completion.

Recovery Support Services

Peer Delivered Services

The Center for Medicaid and Medicare Services (CMS) recognizes Peer Delivered Services (PDS) as an evidence-based practice for treating behavioral health disorders. "Peer Delivered Services" means an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience. A peer is defined as one of the following:

- A self-identified person currently or formerly receiving mental health services; or
- A self-identified person in recovery from a substance use disorder who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
- A family member of an individual who is a current or former recipient of addictions or mental health services.

Peer Delivered Services are services offered for people with mental health or substance use disorders or parents of children with mental health disorders. The services are provided at all levels including health promotion, outreach, recovery support, crisis intervention and respite care.

Peer Delivered Services Steering Committee

AMH employs a Peer Delivered Services Coordinator to support development and implementation of PDS services in Oregon. The PDS Coordinator leads the AMH Peer Delivered Services Steering Committee (PDS SC) which meets monthly to develop recommendations to increase access to quality peer delivered recovery support services. The PDS SC consists of AMH program staff representing substance abuse prevention and treatment, problem gambling prevention and treatment, children's mental health, adult mental health, older adult mental health, and OSH to ensure inclusion of PDS throughout the work of AMH. The March 2013 PDS SC meeting was devoted to updating its work plan to further support inclusion of PDS to support the Triple Aim.

In spring 2012, in an effort to establish a baseline of PDS in Oregon, the PDS SC requested information from each of the Mental Health Organizations on the availability of PDS in their service regions. The Mental Health Organizations identified over 50 PDS programs with over 150 Peer Support Specialists and Recovery Mentors providing crisis intervention services, warm line services, recovery support groups and wellness activities.

In the summer of 2012, the PDS SC collaborated with the Association of Oregon Community Mental Health Programs (AOCMHP) to survey the 36 Oregon counties. Thirty-two of the counties employ Peer Support Specialists or contract with consumer-run organizations to provide PDS. The survey found that over 75 Peer Support Specialists are employed by CMHPs throughout Oregon. The survey has also resulted in initial discussions between AMH and AOCMHP about the development of a statewide PDS conference.

The PDS Coordinator works closely with the Peer Support Coalition of Oregon, a grass roots organization formed specifically to address the future of peer support specialists as a profession. The PDS Coordinator is also working closely with the Northwest Addictions Technology Transfer Center to implement training on best practices for supervision of peer support specialists and recovery mentors. They also are working with the Oregon Coalition of Addiction Studies Educators to develop appropriate training curricula for peer support specialists, recovery mentors and their supervisors in clinical settings.

To promote PDS information dissemination, the PDS SC produces a quarterly, electronic PDS newsletter. The newsletter promotes and supports PDS, provides career information, lists AMH approved PDS trainings and shares research links.

The AMH System Change and Oregon's Health System Transformation identify PDS as essential to achievement of the Triple Aim, and allow for greater flexibility to provide increased access to peer delivered services through Peer Support Specialists employed by behavioral health service providers and independent, consumer-run organizations. Legislation creating the CCOs specifically includes access to services provided by

“community health workers”, “personal health navigators”, and “peer wellness specialists” collectively termed non-traditional health workers (NTHW). This legislation also directed OHA to develop criteria and position descriptions of NTHWs that may be utilized by CCOs, as well as education and training requirements for such individuals. The Oregon Health Policy Board’s Workforce Committee established the NTHW Subcommittee to develop recommendations for core competencies, education and training requirements for NTNWs. The subcommittee consists of stakeholders as well as staff from the OHA Office for Health Policy and Research and the OHA Office of Equity Inclusion, and the AMH PDS Coordinator. The draft report is available at: <http://www.oregon.gov/OHA/oei/docs/nthw-report-120106.pdf>.

Peer Delivered Services in the Children’s Mental Health System

There are a growing number of trained Young Adult Peer Support providers and Family Peer Support Providers. Oregon Family Support Network’s (OFSN’s) Training and Curriculum Development Director is closely affiliated with the Federation of Families for Children’s Mental Health National Certification, resulting in requests from other states for information regarding OFSN’s peer delivered service training program. The restructured Peer Delivered Service (PDS) Foundations curriculum for young adults and family members is being offered quarterly. It includes training on: strengths, needs, culture, dreams and discovery, safety planning and goal setting. In 2012, 34 family members and eight young adults were trained.

Future goals include continued development of an online training center. The PDS Foundations curriculum has been updated to include more information on strategies for one-on-one peer work. OFSN is developing a peer coach training curriculum, which will be made available to experienced peer support providers later in 2013. AMH’s 2013-2015 contract with OFSN/ YouthMOVE (YMO) includes PDS training and involvement as one of the deliverables to meet the great need for continued development of peer delivered services both for young adults and family members.

Family leaders from across Oregon meet together with AMH staff on a quarterly basis for policy updates, to identify system issues, and to plan for advocacy and training needs.

There is a move to eliminate barriers for peer delivered services for young adults in transition, thereby increasing leadership opportunities for young adults and access to developmentally appropriate services and supports for young adults in transition, particularly in rural areas.

YMO opened a second drop-in center for youth needing help with addiction recovery, mental health or educational and vocational issues in Clackamas County. Today, the drop-in center welcomes about 40 youth daily, with some lining up waiting for doors to open at 11 a.m. Each day the center is open for youth to hang out, use computers, eat popcorn and talk with trained people their age who have gone through similar issues. Every Wednesday, the staff feed lunch to the youth and lead an open

discussion about different topics. The Clackamas chapter of YouthMOVE Oregon paves the way in peer delivered services in Oregon.

Other centers are located in Eugene, Salem, Albany, and Portland. The centers focus on helping at-risk youth who may have drug addictions, be homeless or have mental health challenges to cope with life. Youth experience a place to feel welcome and accepted in a community of peers. The YMO drop in Centers served 736 youth in winter months, and 552 youth in spring/summer months in the last year.

YMO has accomplished several milestones in the past year:

- Became a 501(c)(3) non-profit organization as of January 1, 2013 and will continue to develop and refine its mission to serve young adults
- Took the lead in organizing Children's Mental Health Awareness Day at the Oregon State Capitol, increasing awareness about mental health issues faced by children and young adults and their families.
- Developed a Peer Delivered Young Adult Drug and Alcohol Curriculum
- Developed an awareness-raising video in December 2012 to share the story of YouthMOVE and its mission to empower peers to support each other and to support leadership in young adults.
- Facilitated three workshops and two presentations by youth at the Alternatives Conference held in Portland, Oregon.
- Trained YouthMOVE Oregon staff on anti-oppression
- Provided additional YouthMOVE outreach, advocacy, and community education and engagement activities such as:
 - maintaining a "Speak Out Blog",
 - conducting Leadership Groups across the state,
 - conducting an Employment Group and a Homework Study Group,
 - organizing the Oregon Queer Youth Summit and Alternative Prom, and
 - providing multiple panel presentations on YMO Experience, MH Policy, Sharing of stories, Incarceration, recovery
- YouthMOVE Oregon will be replicating services and curriculum in Washington County, and in partnership with Kairos in Grants Pass in 2013.

Peer Delivered Services in the Adult Mental Health System

AMH promotes resilience and recovery for people of all ages with mental health and co-occurring substance use disorders, or who are at risk of developing mental health and substance use disorders. Services supported by AMH are guided by the principles of resilience and recovery. AMH believes recovery must be the common outcome of services, and develops and supports policies consistent with that outcome. Policies governing service delivery systems should be age and gender appropriate, culturally competent, evidence-based, and trauma informed and should attend to other factors known to impact individuals' resilience and recovery. These values are evident in the array of peer delivered services and supports provided by independent, consumer-run organizations throughout Oregon.

To support these values in traditional clinical services, AMH currently provides MHBG discretionary funds to four LMHAs to provide peer support services in the rural areas of eastern Oregon, southern Oregon and the mid-Willamette valley. A Request for Proposals (RFP) is in development for the MHBG discretionary funds allocated to the adult mental health system for the 2013-2015 biennium. The RFP will accept for proposals from local and county governments and private, 501(c)(3) non-profit organizations funding for up to two years to develop, implement or support peer delivered services and other innovative recovery support services.

The David Romprey Oregon Warmline

MHBG funds have also been used to support The David Romprey Oregon Warmline. The Warmline is designed and provided by persons who have or have had challenges in mental health and are able to support their peers who are struggling with a variety of mental health issues, and who may be experiencing huge and painful feelings. The Warmline is grounded in the principles of personal responsibility, mutuality, reciprocity, respecting others thoughts and beliefs as valid and important, growth beyond stigma, shame, and limits placed upon those living with mental illness.

The Warmline's confidential and non-judgmental peer support starts with the premise that people have learned to make meaning of their experiences and relationships out of everything they have learned in their lives. Warmline staff and volunteers believe that crisis is an opportunity to learn. In a mutual and respectful conversation, peers discover together how they have developed their beliefs about themselves and the world in which they live. Together, help and crisis are redefined and have new meaning. Each person has the opportunity to challenge themselves to learn how they might change their mental illness story and crisis story to one of mental wellness and an avoidance of crisis altogether.

Any Oregonian seeking support may call the David Romprey Oregon Warmline to speak to a trained peer. Warmline peers do not give advice but are there to listen and validate the caller's feelings and experiences. Together, the Warmline peer and caller, have a conversation in which both become more self-aware while learning and growing together. Warmline peers share experience and knowledge in order to discover ways in which both learn new ways of managing feelings and discovering healthier ways of being in relationships with others.

The use of The David Romprey Oregon Warmline may help people decrease the need for frequent doctor's visits, emergency room treatment, involvement with law enforcement, and the need for more intensive care such a psychiatric hospitalization.

Other Recovery Support Services

Community mental health programs, subject to the availability of funds, provide or ensure the provision of the recovery support services for youth, young adults, and adults with mental or emotional disorders including:

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- Vocational and social services that are appropriate for the individuals age, designed to improve the clients vocational, social, educational and recreational functioning;
- Continuity of care to link the client to housing and appropriate and available health and social service needs;
- Public education and information; and
- Consultation with other community agencies

Supported Education

In June of 2006, AMH implemented a Supported Education pilot project. This project developed three Supported Education programs serving three counties: Options for Southern Oregon in Josephine County, LifeWorks NW in Washington County, and Cascadia Behavioral Healthcare in Multnomah County. Pilot funding for these projects will end June 30, 2013; however, the RFP for MHBG adult discretionary funds will provide an opportunity for interested programs to apply for funding to develop and implement Supported Education programs. Publicly-funded Supported Education services must meet a minimum score of 85 using SAMHSA's Supported Education Toolkit Fidelity Scale. Fidelity monitoring is provided through a contract with the Oregon Supported Employment Center for Excellence.

Approximately 165 individuals received Supported Education services between July 1, 2011 and December 31, 2012. Supported Education provides supports for individuals interested in enrolling in General Education Development (GED), Adult High School Diploma, or post-secondary education programs. Six individuals have completed their education program in this biennium. The average age of Supported Education participants is 38.9 years old with young adults age 16-25 representing approximately 7 percent of those participants. Students receiving Supported Education services have enrolled in 839 credits and completed 619 credits representing a completion rate of 73.7 percent.

Supported Employment

Oregon currently has 22 Individual Placement and Supports (IPS) Supported Employment (SE) programs providing services in 19 counties for individuals 16 years old and older with mental health disorders. Publicly-funded SE services must meet a minimum score of 100 on the Dartmouth College IPS Fidelity Scale. Fidelity monitoring is provided by through a contract with the Oregon Supported Employment Center for Excellence.

Over 3,560 Oregonians have received IPS SE services since January 1, 2008. The statewide average employment rate for IPS SE participants is 38 percent – well above the 10-15 percent average employment rate for adults with serious mental illness not receiving IPS SE services. A study conducted by the Portland State University Regional Research Institute for Human Services¹⁶ utilizing data from AMH and the Oregon

¹⁶ <http://osece.org/wp-content/uploads/2011/10/Oregon-Supported-Employment-Cost-Benefit-Study-2011.pdf>

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Employment Department found statistically significant increases in the average number of quarters worked, average number of hours worked, and average earnings of individuals who received IPS. AMH is currently partnering with the OHA Office of Health Analytics to analyze Medicaid claims data to determine the impact of IPS SE participation on mental health service utilization.

The average age of IPS SE participants in Oregon is 37 years old, and nearly 15 percent of participants are young adults in transition. Significant savings could be realized through early access to IPS SE for youth and young adults experiencing psychosis. The Oregon Supported Employment Center for Excellence is providing technical assistance and training to EASA programs throughout the state to implement IPS SE with hopes of ultimately diverting them from the long-term disability system.

Oregon has implemented a two-prong approach to development of statewide access to IPS SE services. CCO contracts require all adults with serious mental illness to be assessed for SE services. If any individual would benefit, the CCO must make the services available. SE services funded in all or in part by Medicaid funds in a CCO's Global Budget must meet IPS fidelity benchmarks. County Financial Assistance Agreements require LMHAs to meet IPS fidelity benchmarks for any SE services funded in all or in part by Flexible Funds.

Access to Recovery

Access to Recovery (ATR) is a four year \$3.3 million per year competitive grant that was secured by AMH in 2010. This is part of a federal initiative supported by SAMHSA and the Center for Substance Abuse Treatment (CSAT) to develop person-centered, community-based services to those seeking recovery. ATR emphasizes participant choice by supporting the individual's decision about what services they believe will be helpful to their recovery, as well as where they would like to receive such services. ATR has bipartisan federal support and requires service linkages to include faith-based and community-based organizations who receive payment for services through an electronic voucher management system.

ATR is active in six counties: Umatilla, Multnomah, Lane, Douglas, Washington and Jackson. Any individual 18 years or older who lives in the ATR participating counties and seeks supportive services to help them enter or maintain their recovery is eligible for the program. Oregon is prioritizing the following populations:

- Veterans, particularly soldiers returning from Afghanistan and Iraq;
- ITRS eligible child welfare involved parents; and
- Individuals transitioning to communities from correctional institutions.

The total number of unique individuals to be served over the project period is 9,512.

ATR increases an individual's access to services and create a recovery oriented system of care comprised of clinical, community-based and faith-based services. Funding follows the individual through an electronic voucher management system. Individuals enrolling in ATR services are referred to a Recovery Management Center (RMC). An intake and assessment is completed and a care coordinator provides the enrollee with a

menu of services. The individual can then choose amongst faith-based, community-based and other service providers. The care coordinator creates vouchers for the individual and continues with care coordination throughout the individual's time in ATR, including monthly check-ins, discharge, and follow-up. Individuals complete a Government Performance and Results Act (GPRA) follow-up survey six months after discharge from ATR services.

Services available to ATR participants include:

- Family and marital counseling
- Mental health counseling
- Pastoral family/marital counseling
- Housing barrier removal
- Transportation
- Acupuncture
- Yoga
- Peer-to-peer mentoring
- Spiritual and faith based support
- Parenting education
- Parenting support group
- Life skills training and development
- General Equivalency Diploma (GED) and education assistance
- Employment services and job training

Housing Support Services

Stable housing is a primary factor in facilitating recovery for people with mental health and substance use disorders. "Having a place to call home is necessary for adequate psychological health. It is very difficult for people with psychiatric disabilities to stabilize their psychiatric condition or begin to move towards recovery without having a place to call home. A home is a universal human need"¹⁷. Oregon has clearly identified housing as a key factor in recovery. Oregon's historical focus has been to develop structured, licensed housing, but more resources are being utilized to develop scattered site supported housing and independent living opportunities.

Oregon Recovery Homes (Oxford Houses)

SAPTBG funds will continue to be used to support Oregon's commitment to maintaining and expanding democratically run, self-supporting, alcohol and drug free housing for people in recovery from substance use disorders as allowed for in 42 U.S.C. §300x-25. AMH will contract with Oxford House, Inc. to administer a Revolving Loan Fund and provide technical assistance and training for Oxford Houses of Oregon including the State Association, local Chapters, and individual Oxford Houses throughout the state. Oxford House Inc., will assist with the maintenance of existing Oxford Houses and development of new Oxford Houses as well as providing training and technical assistance regarding Oregon Landlord Tenant Law, the Federal Fair Housing Act, and the Americans with Disabilities Act.

¹⁷ Permanent Supportive Housing Toolkit, SAMHSA, 2010

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As of January 31, 2013 there are 158¹⁸ Oxford Houses in 15 Oregon counties housing up to 1,181 men and women¹⁹. While Oxford Houses are gender-specific, some houses do allow minor children to live with a parent in the home.

Housing Development

AMH provides funding to support development of transitional and permanent supported housing for people with mental health and substance use disorders. Table 7 identifies the housing development funded by AMH in the 2011-2013 biennium.

Table 7.

Project Name	Provider	Population Served	County	Number of Beds	Funding Awarded
Court Royal Apartments	ColumbiaCare Services, Inc.	Serious Mental Illness	Wasco	10	\$110,000.00
McKay House	Lifeways, Inc.	Serious Mental Illness	Umatilla	5	\$110,000.00
Greenburg Apartments	ColumbiaCare Services, Inc.	Serious Mental Illness	Washington	9	\$135,000.00
Jennings Lodge	ColumbiaCare Services, Inc.	Serious Mental Illness	Clackamas	5	\$135,000.00
Lincoln Park	ColumbiaCare Services, Inc.	Serious Mental Illness	Multnomah	5	\$135,000.00
Stepping Stones II	CODA Properties, LLC	Substance Use Disorders	Washington	7	\$200,000.00
Cottage Place	Polk Community Development Corporation	Substance Use Disorders	Polk	4	\$200,000.00
Northglen	Options for Southern Oregon, Inc.	Substance Use Disorders	Josephine	5	\$319,460.00
Camas Ridge Apartments	United Community Action Network	Substance Use Disorders	Douglas	10	\$200,000.00
Firestone Place	Polk Community Development Corporation	Substance Use Disorders	Polk	5	\$200,000.00

¹⁸ 110 men's houses and 48 women's houses

¹⁹ 871 men and 374 women

Workforce Development

Substance Abuse Prevention

The AMH Prevention Unit is committed to providing training and technical assistance to prevention providers across the state. The prevention certification board requires 150 educational hours of prevention training in order to meet the requirement of certification. Therefore, the state provides various training opportunities and coordinates a year-long Cohort training which results in participants taking the Certified Prevention Exam. In a typical year, there are many training opportunities provided including two Prevention Statewide Summits, and four Tribal Prevention Quarterly Meetings sponsored by the nine federally recognized Tribes.

In a recent study from 2008-2010, cohort participants had an over 75 percent pass rate on the National International Certification & Reciprocity Consortium Exam. In addition, the Strategic Prevention Framework grant has allowed the state to provide trainings in order to increase understanding and application of the of the SPF model.

Children's Mental Health System

The AMH Children's Mental Health Services unit, through the Statewide Children's Wraparound Initiative, provided workforce development on Wraparound and System of Care values and principles. The training sessions have been available to three demonstration sites and additional communities who are developing a System of Care using the Wraparound model. Wraparound is a definable, team-based planning process involving a youth and the youth's family that results in an individualized set of community services and supports for that youth and family to achieve a set of positive outcomes. Workforce development is being provided through an agreement with the Systems of Care Institute at the Center for Improvement for Child and Family Services at Portland State University.

The AMH Children's Mental Health Services unit also partners with Oregon Family Support Network to develop family and youth navigator training, training for peers in policy advocacy, and training for system participation by professionals, family members and young adults. Additional training is offered in conjunction with Collaborative Problem Solving and Parent Child Interaction Therapy workforce development projects.

Collaborative Problem Solving

OHSU/Think:Kids Alliance provides several CPS Advanced Trainings annually at OHSU. They have provided trainings in the Willamette Valley, Central Oregon, and Southern Oregon over the last 12-14 months. Opportunities to further this work with Eastern Oregon partners will occur in early 2013. These advanced trainings are applicable for professionals in the education, foster care and health care systems, as well as parents of high-risk children. It is important that each of these systems have training access and exposure to the model, as the complex systems that a child and family move through are interdependent, and continuity of care is essential. OHSU makes outreach efforts to communities and provides introductory trainings to the model. Table 8 indicates the trainings provided in 2012.

Table 8.

Date & Training Type	Location	Number of Participants	Systems Represented
November 2011 Advanced Training	Bend, OR	40	Education, Juvenile Justice, Residential, Social Work, Outpatient, Parents, Foster Care
June 2012 – Advanced Training	Portland, OR (OHSU)	89	Education, Foster Care, Child Psychiatry (MD), Social Work, Outpatient Providers, Case Management, Parents, Residential Providers
August 2012 – Introductory Training	Portland, OR (OHSU)	15	Child Psychiatry Fellows and General Psychiatry Residents
November 2012 – Advanced Training	Portland, OR (OHSU)	51	Education(WESD and Tillamook SD), Foster Care Leads(AMH), Social Work, CCO Providers, KAIROS
January 2013 – Advanced Training	Salem, Oregon	26	Willamette Educational Service District Early Child Assessment and Early Child Educators

Centers for Excellence

AMH currently contracts with the Oregon Supported Employment Center for Excellence to provide technical assistance, training, and program development free of charge to programs implementing evidence-based Supported Education and IPS Supported Employment. AMH seeks to replicate the success of this program through development of Centers of Excellence for both EASA and Assertive Community Treatment in 2013.

Cultural Competency and Health Equity

The AMH Prevention unit has a dedicated specialist who develops and sustains working relationships with nine federally recognized tribes in Oregon. The specialist meets at least quarterly in a joint meeting with all nine tribes. The specialist also participates in Government-to-Government meetings between the tribes and OHA/DHS.

Of special note is the work of the nine tribes with the support of the AMH Prevention unit in developing Tribal Best Practices (TBP). The current approved Tribal Best Practices are Adventure Based , Basketball Against Alcohol and Drugs (B.A.A.D.), Canoe Journey/Family , Ceremonies and Rituals , Cradle Boards , Cultural Camp, Domestic Violence Group Treatment for Men , Family Unity, Healthy Relationship Curriculum Horse Program, Native American Community Mobilization, Native American Story

Telling, Positive-Indian Parenting , Pow-wow, Round Dance, Sweat Lodge, Talking Circle, Tribal Crafts, Tribal Family Activities, Tribal Youth Conference. Additional information can be found on the Addictions and Mental Health web site at <http://www.oregon.gov/oha/amh/pages/ebp/main.aspx> .

Oregon supports a number of culturally specific providers serving individuals with mental health and substance use disorders:

- Best Care, located in Central Oregon, serves Hispanic adults in need of residential substance use disorder treatment.
- OHSU's Avel Gordly Center for Healing provides a mental health and addictions treatment infrastructure and system of care that is culturally appropriate to the African and African-American community in the Portland, Oregon metropolitan area. OHSU provides an active forum for community outreach, teaching, and the promotion of good mental health utilizing treatment expertise specific to mental illness disorders within the African and African-American community.
- The Miracles Club, an African-American recovery club and supported housing community, offers peer delivered services through Access To Recovery (ATR).
- YouthMOVE collaborates with Iron Tribe, a community organization of ex-cons in recovery – men and women who have been incarcerated and are now engaged in a program of living that is based on recovery, peer support and community building. Iron Tribe's mission is to provide peer support and guidance for the releasing ex-con and people in recovery, as they navigate successful integration into the community. Iron Tribe encompasses all nations, tribes, ethnicities, lineages and religious preferences; and celebrates the diversity contained within each individual, moving beyond simple tolerance to understanding that each individual is unique, encouraging each member in a safe, positive, and nurturing environment.
- Native American Rehabilitation Association of the Northwest (NARA-NW) provides culturally appropriate prevention, treatment, and recovery services to Native Americans, Alaska Natives and other vulnerable populations in the Portland Metropolitan area.

As of 2011, more than 78 percent of Oregon's population was non-Hispanic Whites with the remaining population being 12 percent Hispanic, 3.9 percent Asian, 2 percent African American, 1.8 percent Native American, with the remainder consisting of non-Hispanic ethnic groups. Oregon Administrative Rules (OARs) require that community mental health and addictions programs provide culturally and linguistically competent services.

Three of the eight elements of the Transformation Plans required of the CCOs focus on health equity. As the state diversifies, CCO member population will diversify as well. Over the past several months, roughly 500,000 people on the Oregon Health Plan have transitioned to membership in one of Oregon's 15 CCOs. Eighteen Oregon counties have a Medicaid population that is more than 25 percent non-white. Of those counties, eight have Medicaid populations that are more than 50 percent non-white. Despite the fact that non-white populations are growing rapidly, they continue to experience

significant health disparities. In order for Oregon to achieve the Triple Aim, each CCO was charged with developing targeted, culturally-specific, community-based strategies that are responsive to the unique needs of the diverse populations within their membership.

To address declining treatment outcomes for African Americans AMH partnered with the Urban League of Portland, OHSU Avel Gordly Center for Healing, Addictions Counseling Certification Board of Oregon, African American Recovery Counseling Association, and CareOregon (CCO) to plan the African American Treatment Summit held at the Miracles Club in September 2012. The project's goals were to:

- Collect meaningful directives for the care of African Americans;
- Increase awareness of current treatment outcomes;
- Provide a historical context for health equity issues;
- Develop recommendations for expansion of a culturally competent addictions and mental health infrastructure.

AMH utilized qualitative and quantitative survey results from the African American Treatment Summit to determine next steps:

- Addictions and mental health treatment that meets the cultural needs of African Americans needs to be established in areas where the population resides and those services need to be guided by African American administrators and providers;
- The Integrated Services and Supports Rule pertaining to cultural competency service delivery needs leadership support in changing to recognize current needs of the community; and
- Health equity must be elevated as a strategic initiative for AMH in order to successfully impact subpopulations.

To address the recommendations by the community and to support success, AMH created the Health Equity Workgroup. It has the overarching goal of systemically preparing AMH's workforce to promote policy that protects vulnerable populations and achieves health parity across all Oregon communities. AMH's Health Equity Workgroup will target the following areas of work to achieve that goal:

1. **Biennial Implementation Plans (BIP) – BIPs** are an essential part of the AMH System Change effort enabling counties to better serve individuals and specialty populations in their communities who need addiction and mental health promotion, prevention, treatment and recovery services.
2. **State of Equity Report (SOER) –** The first report of its kind for the Oregon Health Authority and the Department of Human Services, the State of Equity Report is a comprehensive look at departmental performance measures by race and ethnicity. The State of Equity report builds on work that was begun more than a decade ago by many of Oregon's committed and concerned health and human services advocates. The information in the report will be used for policy and program development and as a baseline to measure the agencies' progress toward eliminating disparities. The Health Equity Workgroup provides the AMH data and analysis for this annual report.

- 3. Integrated Services and Support Rule** – To improve access to appropriate services, the Integrated Services and Supports Rule (ISSR) requires cultural factors be one of the domains of comprehensive clinical assessment for all persons enrolled in state-funded behavioral health treatment services. Further, CCOs and other Medicaid providers are required to provide appropriate translation services for adults, children and families who require them. Community input is necessary to guide AMH to assure culturally responsive competent behavioral health service delivery to Oregon's vulnerable populations. Members from diverse communities participated in providing recommendations to the ISSR. This workgroup utilized the AMH Cultural Competency Plan, Culturally and Linguistic Appropriate Services (CLAS) Standards to align recommendations with contract standards set in rule for the CCOs.
- 4. Community Engagement** – AMH participated in two African American listening sessions held in 2012 and hosted by the Office of Equity & Inclusion. Community members provided the Oregon Health Authority and the Department of Human Services with feedback regarding issues of disparities in health care and child welfare identified in the State of Equity Report. Office of Equity & Inclusion will host a third follow up session in June 2013 in which AMH will again participate. The information collected will be used to inform agency leadership in implementing policy's that will improve health outcomes for African Americans in Oregon for the 2013-2015 biennium.

Native American and Alaskan Native Populations

Senate Bill 770, passed by the Oregon Legislature in 2001 enacted a Government-to-Government relationship between the State of Oregon and each of the nine Tribal Governments. AMH meets this statute by consulting with the nine tribes on a quarterly basis at the SB 770 Health Services Cluster, participating in an annual Tribal Relations cultural training, and communicating with tribal staff on a regular basis.

AMH has a dedicated staff person that serves as Tribal Liaisons to the nine federally recognized tribes. Tribal liaisons are present for tribal functions to continue building understanding and rapport with Native American communities. The liaisons listen for concerns, answer questions, assist in removing barriers, and look for opportunities to provide improved or additional services to the tribes. AMH staff solicits assistance and guidance from the liaisons to ensure that cultural considerations and tribal voices are included in planning efforts around substance abuse and problem gambling prevention, addictions treatment, and mental health.

Federally recognized tribes in Oregon are Sovereign nations, and therefore not required to go through the local community mental health authority in order to access mental health services off the reservation. Adjustments have been made in the Oregon Administrative Rules (OARs), and contract language to ensure direct access to treatment to better meet the cultural needs of Oregon tribes.

Regarding alcohol and drug services, Tribal Governments are not required to get their biennial plan approved by an LADPC (Local Alcohol and Drug Planning Committee);

these plans are approved by the Tribal Council, the Tribal Health Department, or through an entity authorized by the Tribal Council.

The Addictions and Mental Health Division is committed to providing culturally appropriate services to Native Americans in Oregon, and therefore supportive of Tribal Best Practices. Tribal Best Practices are cultural and traditional practices that have been reviewed and approved by a panel of scientific researchers, prevention and treatment practitioners and program managers across the state.

LGBTQI2-S Populations

Transgender and gender non-conforming people face injustice frequently: in childhood homes, in school systems, in exclusionary workplaces, at the grocery store, the hotel front desk, in doctors' offices and emergency rooms, before judges and with landlords, police officers, health care workers and other service providers.

The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a survey where 6,450 transgender and gender non-conforming study participants answered questions about the depth and breadth of injustice they perceived in their lives. A diverse set of people, from all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands, completed online or paper surveys. Their responses have created an overarching view of discrimination against transgender and gender non-conforming people in the U.S. It provides critical data points for policymakers, community activists and legal advocates to confront the realities documented here and press the case for equity and justice.

Findings:

Discrimination was pervasive throughout the entire sample, *yet the combination of anti-transgender bias and persistent, structural racism was especially significant.*

- People of color, in general, fare worse than white participants, with African American transgender respondents faring far worse than all others in most areas examined.
- Respondents *lived in extreme poverty*. The sample was nearly four times more likely to have a household income of less than \$10,000/year compared to the general population.
- Forty-one percent of respondents reported *attempting suicide compared to 1.6 percent of the general population*, with rates rising for those who lost a job due to bias (55 percent) were harassed/bullied in school (51%), had low household income, or were the victim of physical assault (61%) or sexual assault (64 percent).

In Oregon, Portland's LGBTQI2-S community is thriving. The Q Center offers best practice support services that foster connections within metropolitan Portland's LGBTQI2-S community. Q Center builds public awareness and support, and celebrates group diversity through art, culture, and collaborative community programming through four program areas: Arts & Culture, Health & Wellness, Education & Training and

Advocacy. Their mission is to change hearts and minds in favor of LGBTQI2-S diversity thereby creating a more just and compassionate Oregon.

Engaging the LGBTQI2-S community in policy development for behavioral health promotion, substance use and mental health disorder prevention and treatment is necessary. AMH is working to develop relationships with representatives of this community, spanning culture, promotion of inclusivity and geography (reaching those in urban and rural communities) in order to address health disparities. AMH will engage this diverse community using a multicultural approach, promoting community inclusiveness and guidance in accessing statewide prevention and treatment services.

Juvenile Justice and Criminal Justice

Oregon Youth Authority/Juvenile Justice Collaboration

The Statewide Multidisciplinary Assistance Committee (SMAC) is convened by the Oregon Youth Authority and also includes Child Welfare, OHA AMH, Department of Education, and Aging and People with Disabilities (representing both children and adult services). This meeting provides an opportunity for any agency to present cases where system gaps or barriers interfere with access to appropriate services for young people who are incarcerated. In some of the meetings, staff are able to educate one another as to the scope and mission of their respective agencies. The committee tracks trends or system issues that need to be addressed.

The Children's System Advisory Committee forwarded recommendations in an Issue Brief for improving collaboration between behavioral health services and the juvenile justice system. These recommendations include that AMH:

- Develop or update Memoranda of Understanding (MOU) with all state and county child and youth-serving agencies responsible for serving juvenile justice involved youth. MOUs should address the roles and responsibilities of each agency, and identify outcome measures to assess whether system improvements are being realized;
- Collaborate with OYA and county juvenile departments to develop training on accessing local mental health services;
- Work with CCOs and Innovator Agents to ensure that OYA and county juvenile departments have local contacts and the information needed to refer for mental or behavioral health services;
- Collaborate with OYA & Juvenile Justice to ensure that agency language used is not a barrier to referring for or receiving services;
- Ensure that contract and rule language is written to be inclusive of youth with behavioral health conditions and is at parity with behavioral or physical health;
- Collaborate with other child and youth-serving systems to identify existing barriers related to current funding streams for service provision and possible opportunities for new funding mechanisms for coordinating services;
- Evaluate options for youth who lose eligibility for OHP due to short term placements in detention facilities;
- Ensure child psychiatric services are available to juvenile justice-involved youth;

- Ensure that all juvenile justice-involved youth have access to primary care screening;
- Ensure meaningful family involvement at all levels of treatment;
- Ensure cross-over agencies engagement; and
- Develop options to reduce the use of detention or youth correctional facilities as 'secure alternatives to hospitalization for youth experiencing mental health crises'. Provide youth with diversion opportunities prior to involvement with judicial system.

Juvenile Psychiatric Security Review Board (JPSRB)

The Juvenile Psychiatric Security Review Board (JPSRB) was created by the 2005 Oregon Legislature and began supervising youth in 2007. The JPSRB maintains jurisdiction for youth adjudicated as responsible except for insanity. The Juvenile Psychiatric Security Review Board (JPSRB) is a Governor appointed, five member multi-disciplinary board made up of a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public. The mission of the PSRB is to protect the public through on-going review of the progress of persons found "Guilty Except for Insanity" (GEI) and determination of their appropriate placement.

As of July 1, 2012, there were 18 youth under the jurisdiction of the JPSRB; eight under Developmental Disabilities supervision and ten under AMH supervision. All 18 youth are male. Of the ten youth supervised by AMH, nine are over age 18. Youth who turn 18 while under the JPSRB jurisdiction have a hearing prior to turning 18 to determine whether to transfer them to the adult PSRB or remain with the JPSRB. Five are in the community under conditional release plans that provide for supervision, treatment and support. AMH monitors placements, supervision, treatment and support. AMH provides mental health treatment for youth through various providers. The providers or the CMHPs provide written progress notes monthly to the JPSRB.

Youth who require a secure setting reside at a secure inpatient community facility designated by AMH. This service is currently being provided by Trillium Family Services, Children's Farm Home, Secure Adolescent Inpatient Program (SAIP) for youth who come under the jurisdiction due to "mental disease" as defined by Oregon statute. Albertina Kerr's Intensive Treatment Program provides a secure setting for youth committed to the JPSRB due to "mental defects" as defined by Oregon statute. AMH works closely with the JPSRB, SAIP program and community providers to assure that youth are in the least restrictive setting possible to assure their safety, treatment and supervision.

Psychiatric Security Review Board

The Psychiatric Security Review Board (PSRB) is a Governor appointed, five member multi-disciplinary board made up of a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public. The mission of the PSRB is to protect the public through on-going review of the

progress of persons found “Guilty Except for Insanity” (GEI) and determination of their appropriate placement.

The State Hospital Review Panel (SHRP) is appointed by the Oregon Health Authority and consists of the same make-up of panel members and mission as the PSRB. This panel reviews the progress of individuals who are found GEI of crimes that are non-ballot measure 11²⁰ while placed at OSH. OHA has the responsibility for determining when these patients are ready to leave the state hospital. When they leave the hospital, PSRB is responsible for their supervision in the community.

The PSRB and SHRP maintain jurisdiction for individuals adjudicated as GEI. As of December 1, 2012, 587 individuals were under the jurisdiction of the PSRB and 112 individuals were under the jurisdiction of SHRP, totaling 699 individuals in Oregon's forensic system. Approximately 186 patients at OSH were under the jurisdiction of the PSRB. Approximately 55 percent of the forensic population resides in the community observing the requirements outlined in their individual conditional release plans and through supervision and treatment supports offered by CMHPs.

The PSRB reports to the Governor and uses conditional release orders to manage people under its jurisdiction. AMH is statutorily responsible for providing mental health services to these individuals. CMHPs also provide evaluations for the PSRB and the court to determine if treatment in the community is appropriate and to secure resources in the community. Determination of supervision requirements and treatment for persons conditionally released into the community is also provided by CMHPs. Individualized community placements include:

- Evaluation;
- Supervision;
- Case management;
- Psychotherapy;
- Residential supports;
- Supported employment and education services;
- Substance use disorder treatment services; and
- Medication management.

Legislation approved in 2011 removes misdemeanants from the jurisdiction of the PSRB, but still has a provision for commitment for involuntary treatment if warranted. Under this legislation those convicted of a Class C non person-to-person felony are mandated to have a community evaluation for possible placement in the community instead of commitment to OSH.

The PSRB, SHRP and AMH continue to work with OSH Treatment Teams and CMHPs to assure that individuals are placed in the appropriate level of care and receive the services needed to live as independently as possible. AMH continues its commitment to

²⁰ Ballot Measure 11 identified certain person-to-person crimes which, upon conviction, result in mandatory-minimum sentences.

develop necessary residential placements that will provide the necessary supports for this population to transition to the community. Five community placements have been opened during the 2011-2013 biennium, and development of an additional five placements is planned in the 2013-2015 biennium.

National Instant Criminal Background Check (NICS) Data Sharing

In compliance with Brady Handgun Violence Prevention Act of 1993, the National Instant Criminal Background Check System (NICS) was established to create a system for firearms dealers to identify whether transfer of a firearm to a specific individual would be in violation of Section 922 (g) or (n) of Title 18, United States Code, or state law. The Oregon State Police serves as the Oregon Point of Contact for all firearms background checks within Oregon.

AMH partners with the Oregon State Police to share information regarding those individuals who are prohibited from receiving firearms due to adjudication as a mental defective, involuntary commitment to a mental institution in Oregon or incompetent to handle their own affairs, including dispositions to criminal charges of found not guilty by reason of insanity (termed Guilty Except for Insanity in Oregon) or found incompetent to stand trial. Information for the Prohibited Persons File is transmitted automatically electronically once weekly from the OHA database to the Oregon State Police Law Enforcement Data System, which is then transferred into the national NICS system maintained by the FBI.

OHA has frequent contact with the Oregon State Police, the FBI NICS section, law enforcement agencies and the public, to resolve issues in which a person has been denied firearms transactions based on mental health information in the NICS file which the purchaser believes is factually incorrect. Due to privacy laws, only limited information is available in the NICS index, causing inappropriate "hits" to occur during background checks when the purchaser has a similar name and date of birth as a person in the mental health database. OHA has identified one person within the agency to serve as a point of contact for NICS challenges or verifications.

The Oregon State Police applied for, and received, a federal NICS Act Record Improvement Program (NARIP) grant of \$200,390 for resources to improve the quality and frequency of automated data transmissions between the Oregon Health Authority and the Oregon State Police. IT resources and business analysts from both agencies are working together on this shared effort and reporting as required by the grant.

In addition to identifying an OHA point of contact and partnering with the State Police to improve the data transmission process, OHA is also creating an informational web page and simplified contact information for agencies and individuals requesting NICS records verification. OHA is also partnering with the FBI NICS section to develop a form which the NICS appeals section will provide to appellants who were denied firearms transactions based on Oregon mental health information. This form will offer appellants an opportunity to voluntarily provide additional information which may be of assistance

in establishing whether they are the same person identified in the mental health database.

DRAFT

STEP TWO

Data Sources

AMH uses several administrative data systems to support monitoring of addictions and mental health services provided to residents of the State of Oregon. These data systems include the Client Process Monitoring System (CPMS), the Oregon Patient/Resident Care System (OP/RCS), and the Medicaid Management Information System (MMIS). Block Grant and planning data derived from these systems are supplemented with data acquired through annual administration of modified versions of the MHSIP Adult Services Survey, the MHSIP Youth Services Survey for Families and the MHSIP Youth Services Survey.

All three administrative data sources (the CPMS, the OP/RCS, and the MMIS) are needed to collect data on National Outcome Measures (NOMs) such as “*Access/Capacity: Number of Persons Served with Demographic Characteristics.*” Each of the data sources have significant limitations preventing optimal reporting of valid and complete individual-level data. The nature of each data system or data source and the strengths and weaknesses of that system/source are described below.

The Client Process Monitoring System (CPMS)

CPMS tracks community-based mental health treatment services. The CPMS data system only contains information that is collected by service providers at the onset and then again at the termination of an episode of care. Information about the client's clinical status or treatment progress between the intake session and the discharge session is not included in CPMS. CPMS data includes some demographic information, some general diagnostic information, limited service information, and minimal outcome information. The system as currently configured does not allow AMH to distinguish between the client's ethnicity (Hispanic vs. non-Hispanic) and the client's race.

CPMS data are recorded on various standardized forms by mental health providers, who then submit the forms to AMH, where the data are entered into a mainframe system. CPMS forms are submitted by service providers within 30 days of the beginning, and within 30 days of the end of a service episode.

The CPMS system has several limitations. First, CPMS provides only limited data on the nature of treatments provided (there are, for example, no data in the CPMS on EBPs being provided to clients). Secondly, CPMS provides only limited data on outcomes. The system provides only broadly categorized information, at intake and at termination, the client's employment status, school attendance, and housing status. Third, clients who do not complete a formal discharge session with their treatment

provider do not supply post-treatment CPMS data on important outcome measures such as their employment status, school attendance, and housing status. In these cases, it is impossible to determine whether the client's status on these important outcomes has changed over the course of treatment. Yet a *fourth* difficulty with CPMS is that the system is outdated and extremely difficult to modify; it is challenging to make needed changes to the system when new types of data (such as a newly defined measure) become of interest. Finally, a failure to submit accurate and timely data to CPMS has no immediate fiscal impact on the provider who fails to submit the data. CPMS was never built to be a system for billing for services.

Concerns about the numerous limitations of the CPMS system have resulted in AMH implementing a completely new data system (see COMPASS).

The Oregon Patient/Resident Care System (OP/RCS)

OP/RCS is the database for all publicly funded psychiatric inpatient care delivered in state hospitals and acute care units. OP/RCS has also functioned as the primary resource for tracking individuals who have been civilly or criminally committed for mental health treatment. State Hospitals and Psychiatric Acute Care Units of regional hospitals submit OP/RCS data about their clients at admission and at discharge. OP/RCS contains important data on hospitalized consumers, such as county of commitment, date of commitment, and type of commitment; the name of the facility where the patient has been committed; the dates that the patient was admitted and discharged; and patient demographics such as sex, date of birth, marital status, and living arrangement. Unfortunately, OP/RCS, like CPMS, does not allow AMH to record the client's Hispanic/non-Hispanic ethnicity separately from the client's race. OP/RCS is over 30 years old and is not meeting the current business needs of AMH. Continually upgrading the OP/RCS and CPMS systems to meet federal reporting requirements and state needs has become too costly and is impractical. The mental health system has evolved beyond the original needs that the data systems were designed to fill.

After consideration of the limitations of the OP/RCS system, AMH made the business decision to contract with Netsmart Technologies, Inc. to replace OP/RCS with the Avatar Electronic Health Record system, whose implementation was led by Oregon State Hospital's Behavioral Health Integration Project. The goal for replacement of OP/RCS with the Avatar system is to improve the quality, continuity, and transparency of mental health and addiction services provided to individuals in the Oregon State Hospital, to increase time spent by hospital personnel in treatment activities rather than in completing paper forms, and to improve the ability of the State to report accurate and timely information to a variety of funding sources. OP/RCS is still needed for tracking hospital services outside of Oregon State Hospital.

The Medicaid Management Information System (MMIS)

MMIS provides information on services provided to persons who are Medicaid-eligible. The information contained in MMIS includes eligibility, capitation payments, fee-for-service claims, and encounter data for persons receiving services via prepaid capitation programs. MMIS also includes all mental health, chemical dependency, pharmacy, dental, physical health services, and eligibility information for Medicaid-eligible persons.

Medicaid fee-for-service data and encounter data are submitted electronically and by fee-for-service billing. Managed mental health organizations and service providers have 180 days from the date of service to submit Medicaid data to the MMIS. Data from MMIS are downloaded and stored in a data warehouse for use by state analysts and actuaries responsible for rate setting.

The MMIS offers many advantages over our other administrative data systems. MMIS allows providers to record the client's Hispanic vs. non-Hispanic ethnicity separate from the client's race. There is some limited capability within MMIS to capture data on certain evidence-based practices (though many problems with the recording of these practices remain, as will be addressed later in this application). Unlike the other administrative data systems, MMIS captures patient and treatment information at every clinical encounter, rather than only at the time of admission and time of discharge. Data in MMIS are used for making payments and for setting reimbursement rates, providing a fiscal incentive for providers to enter complete and accurate data on their clinical encounters.

MMIS also has limitations which challenge AMH in the charge to provide the best possible services to clients. First, as providers have 180 days to submit their billings or claims for entry into the MMIS system, there is a lag between the time that services are delivered to clients and the time that AMH and other interested stakeholders can evaluate which and how many services are being delivered. MMIS was designed to track Medicaid eligibility, the clinical services being delivered, and payments for those services. The system was *not* designed to track data on clinical outcomes. MMIS, if not appropriately linked with other data systems, is not helpful to AMH in the goal to track NOMs such as increased employment or increased stability in housing.

The Youth Services Survey for Families and the Adult Services Survey

AMH makes efforts to collect information about providers and clients from sources other than administrative data systems. Much of the outcome and performance measure data are collected and compiled from consumer responses to modified versions of the MHSIP Adult Services Survey, the MHSIP Youth Services Survey for Families (or YSS-F) and the Youth Services Survey (YSS). The Adult Services Survey and YSS-F are

mailed annually to stratified random samples of over 10,000 Medicaid-eligible adults and over 10,000 parents or guardians of Medicaid-eligible children; the consumers selected to receive these surveys are chosen on the basis of having received Medicaid-billable mental health services at some time during the last 6 months of the previous calendar year. In the interest of better understanding the service experiences and service needs of Hispanic clients and clients of color, AMH sends the Adult and Youth consumer surveys to ALL clients who received services in the 6-month window of interest and who are identified in AMH data systems as either Hispanic and/or of non-white race. Surveys are available in Spanish.

Information obtained from the Adult and Youth Services surveys is used to:

- Provide feedback on AMH performance measures;
- Identify areas in need of improvement;
- Track improvement in the well-being of people served with public funds;
- Recognize those programs which are doing well; and
- Communicate results to the Governor, the Legislature, Department contractors, and the public.

AMH has worked carefully to modify the Adult and Youth Services surveys in ways that allow us to collect important information on several of the National Outcome Measures (NOMs) of Interest, including: employment status of adult consumers; school attendance among child consumers; stability in housing among child consumers; and criminal justice involvement among both adult and child consumers.

AMH survey data sources have limitations. First, because the data on services delivered to our Medicaid-eligible consumers are not available until (on average) six months after those services have been delivered. Therefore we are unable to even select the sample to which we will send the surveys until at least 6 months after the mental health services have been delivered. The substantial lag between the time that the mental health service is delivered and the time that the client is asked to describe that service is of obvious concern. Clients may no longer clearly remember the nature of the service that they received, the provider who delivered the service, and the exact outcome(s) of the service. Second, while response rates to the MHSIP surveys have been respectable (generally ranging between 20 to 25 percent), we have no hard evidence that responders to the survey are representative of the general population to whom the survey was sent. Third, by their nature, mailed surveys do not allow for dialogue between the clinician and the consumer. This can be problematic if a survey question is confusing to the consumer and needs to be rephrased or paraphrased to enhance the consumer's understanding of the question being asked.

Minimum Data Set (MDS)

MDS is the database that is used for state-wide collection of data. Each county and tribal program is responsible for entering prevention data into the system. These data are used for the SAPT Block Grant Application and by the Oregon State Legislature.

While the MDS has been effective in providing us with output data, it is unable to capture outcome data. Therefore, the state will be transitioning to a new database system through the Compass Project, which has the capacity to capture outcome-level data.

AMH collects data relevant to the children's mental health system. Data being tracked includes level of service intensity determination data, outcomes for children served in the integrated service array and the Statewide Children's Wraparound Initiative demonstration projects. AMH also tracks process measures and youth/family perception of outcomes using the Youth Services Survey and the Youth Services Survey for Families. An electronic web interface makes outcome data available in real time, improving the ability of those in the system to use data for decision making. Oversight of data issues throughout the system is provided through the Children's System Advisory Committee, and through periodic reporting to stakeholders. CCOs are required to meet benchmarks within their first year on several measures pertaining to children's behavioral health outcomes.

The Oregon Student Wellness Survey (SWS)

The Oregon Student Wellness survey is an anonymous and voluntary survey conducted in schools all over the state and administered to 6th, 8th and 11th graders. The survey is funded by SPF SIG and was started in 2010. It has been established that the survey would be conducted every even year. Confidential data gathered from the survey and reports compiled from the survey data are provided to all participating schools and school districts while the state and county data and data reports are for public access. The reports are found on the Oregon Health Authority website. The survey was designed to access a wide range of topics that included; school climate, positive youth development, mental health, physical health, substance use, problem gambling, violence and other problem behavior among Oregon youth.

The SWS results are used by schools, state and local agencies, organizations and communities to assess and monitor the health and well-being of Oregon youth and the environment in which they live. The survey data and report serve as a valuable tool for program planning, implementation, and evaluation. The data are essential information for communications with legislators and the public, and communities and local agencies

would find the data improves their ability to procure funding by providing baseline data needed for grant writing.

In 2010, 59,712 Oregon students and in 2012, 65,659 Oregon students participated in the survey: a 10 percent increase in participation. In total, 33 counties, 115 school districts and 422 schools were included in the survey and we are anticipating an even higher participation rate in 2014. The survey can be administered either by pencil-and-paper or online. The 6th and 8th grade survey is a subset of the 11th grade survey. The survey is very well received by prevention coordinators of counties all over the state and their interest in utilizing the survey data is ever increasing. The data is also being used to design prevention messages in the state for the Positive Community Norm practice. Analyzing the data from the SWS not only continues to give us clear epidemiological information on substance use and behavioral health in Oregon youth, but also helps us understand the associations amongst the various outcomes investigated in the survey.

Planning

Data from the administrative data sources and the surveys are used by program staff to work with AMH's contractors and help guide them in the improvement and development of services. In addition to the treatment and survey data AMH also collects and summarizes a great deal of epidemiological data for substance abuse and mental health. AMH directs the county contractors to work with all of this information to plan for services and remain accountable for services. This way AMH has the opportunity to guide statewide services while allowing for specific community needs that counties may identify.

LMHAs utilize these data sources in the development of Biennial Implementation Plans (BIP). AMH developed and implemented new guidelines in consultation with key county representatives and stakeholder advisory groups with the focus on what information is truly needed. As counties are receiving more of the Addictions and Mental Health funding in Flexible Funds, it is important that there is a mechanism for the counties to inform AMH and the community about the plans to administer those funds. The new BIP process facilitates that accountability.

Additionally, the BIP is designed to keep counties and AMH in compliance with statutes, Block Grants and other federal requirements. Information is required in three areas:

1. System Narrative;
2. Performance Measures; and
3. Budget Information.

To support success, AMH is providing further guidance and resources to help develop plans that will meet each community's needs. AMH has designated staff members as

points of contact for each LMHA. These points of contact answer questions, connect LMHAs with resources, and provide technical assistance.

COMPASS

AMH envisions a comprehensive behavioral health electronic data system to improve care, control cost and share information. The data system improvement project is called COMPASS.

This new system will allow AMH to meet business needs and requirements and will provide data that more readily supports the ability to track:

- Performance outcomes associated with services;
- Access, utilization and duration of services;
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

COMPASS consists of three components:

- **No Cost Electronic Health Record (EHR):**
Federal health care reform requires EHRs to be associated with all billing for Medicaid and Medicare services. Additionally, current State legacy systems are antiquated and lack integration among internal systems, which adversely affects AMH's ability to meet business needs, health information technology business needs, and the goals of Oregon's Health System Transformation.

A behavioral health EHR, the Oregon Web Infrastructure for Treatment Services (OWITS), is available to all publicly-funded behavioral health care providers or required reporters (e.g. DUII, methadone or detoxification service providers) free of charge. The advantage of using OWITS is that agencies will no longer need to submit CPMS data to AMH.

- **Electronic Data Capture:**
At present, the majority of AMH data is collected and housed in CPMS and OP/RCS. The information housed in the two main systems is collected at admission and discharge. The new system will collect status and encounter data: status data provides information during the treatment cycle, and encounter data provides information on the services provided during the treatment episode.

Collection of these data will allow AMH to better assess the array of services provided and outcomes achieved. AMH will be able to provide better data and information to stakeholders, legislature and other requesters, in addition to providing better access and analysis of data for CMHPs and their subcontractors.

AMH expects to be accepting electronic data submission in July 2013. Providers and other required reporters will have access to three methods for this data submission:

- OWITS EHR;
- Electronic Data Interchange/Transfer from existing EHRs; or
- A Web Minimum Data Entry tool.

- **AMH Contracts and Payments System:**

AMH's current contract management system is outdated and not well supported. In the move toward integrated systems, AMH has invested in the creation of a contracts management module that will reside within the existing OWITS system. Payments will be made through the Client Employed Provider system (CEP), an existing system that currently makes payments for home care and other personal services. This new process will allow AMH to better manage and report on contracts.

Beginning in 2013, AMH will use the newly created OWITS Contracts Management module and begin paying for all flexible funding contracts with Local Mental Health Authorities through CEP.

In spring of 2013, draft County Financial Assistance Agreement (CFAA) information will be available in the OWITS system for viewing. The first payments using the new system and process will be made in July 2013. OWITS will house the contract financial information including amendments, and also the payment information from CEP. This will allow the LMHAs to track amendments to their CFAAs and to know what funding is included in each payment they receive²¹.

After the contract management module is completely implemented, COMPASS project staff will begin the design and implementation of additional modules. Personal Service Contracts and other contracts will eventually move into the OWITS contract management module with an estimated timeline of January 2014.

Prevalence

Prevalence of Serious Emotional Disorders

AMH uses the Federal definition of Serious Emotional Disorder, which includes children and youth from birth to age 18 who currently, or at any time during the past year:

²¹ This will assist in monitoring MHBG and SAPTBG program integrity.

- Have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),
- That resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

A substance use disorder or developmental disorder alone does not constitute a serious emotional disorder although one or more of these disorders may coexist with a serious emotional disorder. This definition is used in determining prevalence, need and access.

In 2012, the estimated number of Oregon children with serious emotional disorders is 103,861. The public mental health system serves 30 percent of these children.

For adults, AMH uses prevalence rates from SAMHSA's National Survey on Drug Use and Health and apply these prevalence rates to population estimates by the Portland State University Population Research Center.

Prevalence of Serious Mental Illness

Pursuant to section 1912 (c) of the Public Health Services Act, adults with serious mental illness are defined as:

- Age 18 and over;
- Currently have, or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent; and
- That results in functional impairment, which substantially interferes with or limits one or more major life activities. The definition is used in determining prevalence, need and access.

The current estimate of adults (age 18 and older) with a serious mental illness living in Oregon is 156,962. Of them, 46 percent are served in the public mental health system.

Prevalence of Substance Use Disorders

Addiction treatment needs are estimated using prevalence rates from the latest released state and regional specific data from the National Survey on Drug Use and Health. The Population Research Center at Portland State University publishes annual population estimates for Oregon. Population estimates were based on 2009 data. State race and/or ethnic estimates were obtained from the 2008 American Community Survey and 2007 poverty rates were used. The numbers of illicit drug related crimes are obtained from the 2008 Oregon State Police annual report of criminal offenses, including DUII arrests. The Oregon State Police data system is being replaced and replacement has taken over two years. Once the replacement is complete, missing data will be reported. Reported cases of communicable diseases (HIV/AIDS, hepatitis B - acute and chronic, and tuberculosis) are obtained from the State Communicable

Disease Reporting and Monitoring Program under the Public Health Division for the 2009 calendar year.

State Epidemiological Outcomes Workgroup

A number of OHA programs are represented on the State Epidemiological Outcomes Workgroup (SEOW) including:

- Addictions Prevention;
- Children's Mental Health;
- Oregon Department of Education;
- Association of Oregon Community Mental Health Programs;
- Oregon Research Institute;
- Lines for Life (formerly Oregon Partnership);
- County Prevention Coordinators; and
- From the OHA Public Health Division:
 - Center for Health Statistics;
 - Adolescent Health;
 - Tobacco Prevention & Education;
 - Fetal Alcohol Syndrome Program; and
 - Youth Suicide Prevention Program.

The SEOW is responsible for compiling information, analyzing, and reporting substance use and mental health incidence, prevalence, trend data and NOMs. These data are available for use in the development of county Biennial Implementation Plans submitted to AMH. In addition, data are used by AMH to assess, plan, and implement state prevention policy and programs. The SEOW tracks progress of population level data at the state and county level, but these data are not used for evaluation of activities.

The SEOW has been primarily focused on assessing consequence and consumption data to determine the level of state and community needs for substance abuse and mental illness prevention. In September, 2011 the SEOW decided to identify mental health epidemiological information focused on mental health promotion that would be tracked through 2020. Currently, the SEOW is compiling a list of evidence-based, validated mental health promotion indicators. The SEOW plans to pilot test these indicators on an "at-risk" population through a pre-test post-test study. Once the pilot study confirms that the chosen indicator list is measuring mental health promotion, the SEOW will work on integrating these indicators along with the other substance use and mental health indicators that are currently being tracked.

The SEOW has the following key criteria for data indicator selection for each substance use and mental health measure:

1. The indicators should be an accurate reflection of change in public health.
2. Chosen indicators should be derived from peer reviewed research.

Oregon's 2014-2015 State Plan for Behavioral Health Services

3. The data should be reliable and valid and collected for at least three years.
4. There should be an infrastructure in place to ensure continued data collection.

The SEOW employs a number of strategies for tracking data and reporting significant changes:

1. Fifty state-level measures are tracked and reported on the internet. Each measure is updated as the data become available.
2. There are 36 counties in Oregon; a county report inclusive of 40 measures is generated for each county every other year. Single-page, double-sided fact sheets are produced on specific priority topics.
3. Reports are also updated on the Oregon Health Authority website for public access.
4. Presentations are made to key stakeholders and training is provided for county prevention coordinators.
5. The AMH Communications Officer coordinates the release of information about notable findings to the public.

DRAFT

STEP THREE

Improve the lifelong health of all Oregonians.

Improving the lifelong health of all Oregonians is part of Oregon's Triple Aim under Health System Transformation increasing the quality, reliability and availability of care for all Oregonians and lowering or containing the cost of care so it is affordable for everyone. With solid systems in place to identify the factors that lead to chronic disease and focus on early signs and symptoms, the state can provide services and supports much earlier. Access points to better health care should start within locations where Oregonians live every day and should be built on a foundation of community awareness, behavioral health promotion, prevention, early identification, early intervention, access to treatment services and supports, and recovery management.

Improve the quality of life for the people served.

A key component of both Health System Transformation and AMH System Change is the use of flexible funds to meet the needs of the individuals served. Flexible funds will allow service providers to more effectively meet the holistic health needs of people with behavioral health disorders to improve their quality of life. AMH is committed to continuous quality improvement, and will continue to assess and take steps to improve consumer and family member satisfaction in areas such as housing stability, educational and vocational opportunities, social connectedness, and treatment outcomes.

Increase the availability, utilization and quality of community-based, integrated health care services.

CCOs are replacing a fragmented system of care that relied on different groups to provide physical health, dental health and mental health and addictions services and supports. CCOs are set up to emphasize person-centered care, where all care providers are coordinating efforts to make sure treatment plans complement each other. CCOs also work to increase health equity, to ensure that everyone in Oregon has the care they need to stay healthy. AMH and the Division of Medical Assistance Programs have and will continue to collaborate to ensure that individuals in need of behavioral health services have access to high-quality services regardless of health coverage.

Reduce overall health care and societal costs through appropriate investments.

Health System Transformation and the AMH System Change are focused on prevention and helping people manage chronic conditions. This reduces unnecessary emergency room visits and gives people support to be healthy. Better care brings:

- lower costs;
- more preventive care;
- better coordination of care to limit unnecessary tests and medications;
- Integrating physical and mental health and addictions care; and

- Chronic disease management to help people avoid unnecessary hospital care.

Service providers will have the flexibility to provide these kinds of services that help people stay healthy or get healthier. Focusing on prevention and helping people manage chronic conditions assists in avoiding higher costs over the long term. Increasing behavioral health promotion, prevention and early identification/intervention services and recovery support services will aid in decreasing overall health care and societal costs.

Increase the effectiveness of the integrated health care delivery system.

Health System Transformation is the integration of physical health, dental health, mental health, addictions services and supports. AMH will implement strategies and systems emphasizing behavioral health promotion, prevention, early identification and early intervention of conditions that lead to chronic mental health and addiction disorders. AMH will implement and participate in activities supporting a continuum of care that includes:

- Person Centered Planning and Coordination;
- Community-based services;
- Early Assessment Support Alliance (EASA);
- Screening, Brief Intervention and Referral to Treatment (SBIRT); and
- Recovery Management

Increase the involvement of individuals and family members in all aspects of health care delivery and planning.

AMH recognizes that individuals and families need to be included in all aspects of the health care system. AMH providers facilitate Person Centered Planning and Coordination with individuals they serve. The goal of recovery is addressed through person-centered planning so that all planning is specific to the needs of the individual. Individuals and family members must have meaningful involvement that is supported at the system, program, and clinical levels. This includes:

- Participation on advisory councils and quality improvement and assurance committees
- Providing input on developing new services and supports;
- Providing access to peer coaching;
- Monitoring outcomes; and
- Developing policies that are responsive to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, gender, sexual orientations, age and other aspects of diversity.

Increase accountability of the health care system.

Oregon has identified over 80 potential measures of cost, quality, access, consumer experience, and health status that can be tracked over delivery settings and populations. These measures are derived from several measure sets, including the

CMS Adult Medicaid Quality Measures, Children's Health Insurance Program Reauthorization Act (CHIPRA) Measures, Oregon's key performance measures, and the incentive measures for year one selected by the Metrics and Scoring Committee that may impact incentive payments for both CCOs and LMHAs.

Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

CCOs have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services in addition to OHP medical benefits with the goal of meeting the Triple Aim.

CCOs are local. They have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs are accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

For consumers without Medicaid coverage AMH has aligned policies, payment and outcome monitoring in a similar manner to the goals of the CCOs and Health System Transformation.

Eliminate health disparities for vulnerable populations.

AMH supports equity for individuals receiving services through the publicly-funded behavioral health system. Current data show declining treatment outcomes and service gaps for seniors and individuals with disabilities, Native Americans, African Americans, and Hispanic girls ages 12-17.

AMH created the Health Equity Workgroup (HEW) to coordinate efforts directed at eliminating health disparities as a part of the AMH System Change. HEW's goal is to align health equity standards to those of the CCOs to eliminate disparities and achieve parity for all identified populations. The workgroup provides technical assistance and training to staff providing assistance with Biennial Implementation Plans and to the AMH Planning & Advisory Council. HEW develops health equity measures for the OHA Office of Equity & Inclusion for the State of Equity Report, and responds to the Secretary of State audit concerning the children's mental health system.

STEP FOUR

Improve the lifelong health of all Oregonians.

1. Priority Type (SAP, SAT, MHP, MHS): MHP

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): Other

Goal of priority area: Utilize Positive Youth Development (PYD) to decrease risk of adverse behavioral health behaviors, and encourage youth to adopt healthy behaviors to ensure healthy transition into adulthood.

Strategies to attain the goal:

- Collaborate with Adolescent and School Health Program Unit of Public Health Division to identify PYD-programs (if any) exists in schools across the state.
- Recruit additional schools to participate in Student Wellness Survey and track PYD in eighth grade students.
- Promote PYD in schools with low PYD scores and high substance use in eighth grade students, with the assistance of county prevention coordinators.

Annual Performance Indicators to measure goal success

Indicator #1: Substance use prevalence in eighth grade students

- a) Baseline measurement-** Establish baseline of substance use prevalence in eighth grade students during 2012-2013.
- b) First year target-** Identify counties with high substance use prevalence rates among eighth graders, and decrease by 1 percent in 2014.
- c) Second year target-** Decrease substance use by eighth grade students by an additional 1 percent in 2015.
- d) Data source:** Student Wellness Survey, Oregon Healthy Teens Survey, School Health Policies and Practices Survey.
- e) Description of data:** Student Wellness Survey assesses and monitors health and well-being of Oregon youth including Positive Youth Development measures. Oregon Healthy Teens Survey is a comprehensive school-based survey that assesses public health issues in Oregon teens. The School Health Policies and Practices Survey is a comprehensive assessment of school health policies and practices in the nation and is conducted at the state, district, school and classroom levels. It monitors eight components of schools' health including mental health and social services.
- f) Data issues:** One issue that could arise is the possibility that too few schools implement positive youth development enhancing programs. Data could also be affected by too few schools participating in the surveys that monitor PYD in middle school students. This can affect analysis and comparison of data while determining success of the planned strategy.

- 2. Priority Type (SAP, SAT, MHP, MHS):** MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED
Goal of the priority area: Determine a baseline for children age six and under living in any setting, receiving a mental health assessment through the public mental health system.
Strategies to attain the goal: Establish baseline, then re-evaluate for additional strategies.
Annual Performance Indicators to measure goal success
Indicator #1: Children age six and under living in any setting, receiving a mental health assessment through the public mental health system.
- a) **Baseline measurement:** Baseline of all children age six and under, living in any setting, who received a mental health assessment through the public mental health system is being established in this grant period.
 - b) **First-year target/outcomes measurement (progress to end of SFY 2014):** Exceed baseline by 1 percent
 - c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** Exceed baseline by 2 percent
 - d) **Data source:** MMIS, ORKIDS
 - e) **Description of data:** Determine number of children age 6 and under who are Medicaid eligible, and determine number of those Medicaid eligible children who have received a mental health assessment through the public mental health system. Use MMIS billing codes H0031 and H1011.
 - f) **Data issues/caveats that affect outcome measures:** Reliability and functionality of MMIS and ORKIDS (updated version of SACWIS, Statewide Automated Child Welfare Information System)
- 3. Priority Type (SAP, SAT, MHP, MHS):** MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED
Goal of the priority area: Children in Child Welfare with SED will receive a mental health assessment within 60 days of entering substitute care.
Strategies to attain the goal:
- Determine method to increase the number of completed mental health assessments
 - Utilize CW-AMH workgroup monitoring of system and child level data monitoring.
 - Facilitate collaboration between mental health programs and child welfare system
 - Communicate with child welfare caseworkers about importance of this measure
- Annual Performance Indicators to measure goal success**
Indicator #1: Children in the custody of Child Welfare with SED receiving a mental health assessment within 60 days of entering substitute care.
Baseline measurement: 56 percent (2011)
- a) **First-year target/outcomes measurement (progress to end of SFY 2014):** 65 percent

- b) **Second-year target/outcomes measurement (progress to end of SFY 2015):** 75 percent
- c) **Data source:** MMIS and OR-KIDS
- d) **Description of data:** Numerator is the number of children entering substitute care in DHS Child Welfare system who receive a mental health assessment within 60 days of entering care. Denominator is the number of children entering substitute care in DHS Child Welfare system.
- e) **Data issues/caveats that affect outcome measures:** transitional issues with ORKIDS system; lag in reporting

4. Priority Type (SAP, SAT, MHP, MHS): SAP

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): All

Goal of the priority area: To provide the infrastructure, planning and implementation of a statewide alcohol and drug prevention system

Strategies to attain the goal:

- Fund each county and tribe in the state to provide a minimum of a .50FTE Prevention Coordinator to provide prevention services with an approved plan.
- Support a statewide prevention system that includes policies, practices, and programs that serve many Oregonians.
- Coordinate a prevention training system to increase the number of Certified Prevention Specialists (CPS).

Annual Performance Indicators to measure goal success

Indicator #1: Percentage of counties and tribes with approved prevention plans

- a) **Baseline measurement:** Number of counties and tribes with an approved prevention plan for 2013-2015 biennium.
- b) **First-year target/outcomes measurement (progress to end of SFY 2014):** All counties and tribes have approved prevention goals and objectives.
- c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** Each CMHP completed a minimum of 80 percent of approved prevention goals and objectives.
- d) **Data source:** Biennial Plans, Prevention Section
- e) **Description of Data:** Each county and tribe that submits their plans will be compared against those who have approved plans to determine if the target was met.
- f) **Data issues/caveats that affect outcome measures:** Currently there is no system to collect data from the BIP or from the Prevention Workforce Training system, although data can be gathered and compiled to determine if targets were met.

Indicator #2: Oregonians that have received prevention services

- a) **Baseline measurement:** Total served in federal fiscal year July 1, 2010 - June 30, 2011 was 171,283.

- b) **First-year target/outcomes measurement (progress to end of SFY 2014):** An increase of one percent from baseline.
- c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** An increase of one percent from first year target.
- d) **Data Source:** Minimum Data Set Database
- e) **Description of Data:** Each prevention coordinator is responsible for entering prevention services in the MDS database. Examples of data are: individuals served, evidence-based practices, and the 6 CSAP strategies.
- f) **Data issues/caveats that affect outcome measures:** Logging consistency by providers.

Indicator #3: Number of qualified candidates for the national International Certification & Reciprocity Consortium (ICRC) CPS exam.

- a) **Baseline measurement:** Number of candidates that qualified in 2012.
- b) **First-year target/outcomes measurement (progress to end of SFY 2014):** Maintain current number of qualified candidates.
- c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** Maintain current number of qualified candidates from the first year.
- d) **Data Source:** Addictions Counselor Certification Board of Oregon Data
- e) **Description of data:** Number of candidates will be collected through ACCBO prevention certification data.
- f) **Data issues/caveats that affect outcome measures:** Numbers of candidates may fluctuate as cohort training occurs every other year.

Improve the quality of life for the people served.

1. **Priority Type (SAP, SAT, MHP, MHS):** MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): SED
Goal of the priority area: The population of children with SED will show improved participation in school following mental health treatment.

Strategies to attain the goal:

- Continue to support statewide provision of educational services and supports to children with SED
- Work with educational system to create effective services/programs that meet the needs of children with SED.
- Continue stigma reduction efforts.

Annual Performance Indicators to measure goal success:

Indicator #1: Children with SED showing improved participation in school following mental health treatment.

- a. **Baseline measurement:** 30 percent
- b. **First-year target/outcomes measurement (progress to end of SFY 2014):** 32 percent
- c. **Second-year target/outcomes measurement (progress to end of SFY 2015):** 33 percent

- d. **Data source:** MHSIP YSS-F Survey
- e. **Description of data:** The number of parents/guardians who report that their child's school attendance improved following the initiation of mental health treatment.
- f. **Data issues/caveats that affect outcome measures:** Survey response rate

2. Priority Type (SAP, SAT, MHP, MHS): MHP, MHS

Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): SED/SMI

Goal of the priority area: To determine the percentage of youth and young adults ages 14-25 responding agree or strongly agree to the Adult MHSIP Survey or Youth Services Survey questions as to whether they feel they are doing better in school and/or work, and better able to handle things when they go wrong, as a result of services received.

Strategies to attain the goal:

- Young adult system involvement
- Positive peer support
- Developmentally appropriate services for youth and young adults

Annual Performance Indicators to measure goal success

Indicator #1: Young adults ages 14-25 who agree that they feel they are doing better in school and/or work, and better able to handle things when they go wrong as a result of services received.

- a. **Baseline measurement (data collected prior to/during SFY 2014):** 2013 MHSIP/YSS Surveys in progress; responses to this survey will establish baseline.
- b. **First-year target/outcomes measurement (progress to end of SFY 2014):** Exceed baseline by 1percent
- c. **Second-year target/outcomes measurement (progress to end of SFY 2015):** Exceed baseline by 2 percent
- d. **Data source:** YSS and MHSIP Survey data
- e. **Description of data:** positive response (agree or strongly agree) on MHSIP survey questions inquiring whether they are doing better in school and /or work, and better able to handle things when they go wrong
- f. **Data issues/caveats that affect outcome measures:** response rate of surveys

3. Priority Type (SAP, SAT, MHP, MHS): MHP, MHS

Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): SED

Goal of the priority area: Increase housing stability for children with SED

Strategies to attain the goal:

- Targeted development of residential treatment homes and residential treatment facilities for young adult population
- Address family stability and secure housing arrangements through Child and Family Teams.

Annual Performance Indicators to measure goal success:

Indicator #1: Decrease the number of children with SED enrolled in mental health services that are homeless.

- a. **Baseline measurement (Initial data collected prior to and during SFY 2014):** Develop baseline.
- b. **First-year target/outcome measurement (Progress to end of SFY 2014):** Decrease the number of children with SED enrolled in mental health services that are homeless by 1 percent.
- c. **Second-year target/outcome measurement (Final to end of SFY 2015):** Decrease the number of children with SED enrolled in mental health services that are homeless by 2 percent.
- d. **Data source:** COMPASS and MMIS
- e. **Description of data:** See Step Two for a description of COMPASS and MMIS.
- f. **Data issues/caveats that affect outcome measures:** None identified at this time.

4. Priority Type (SAP, SAT, MHP, MHS): MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED (with juvenile justice involvement)

Goal of the priority area: Children with SED will experience a lower likelihood of arrest following initiation of mental health treatment.

Strategies to attain the goal:

- Work plan of CSAC for 2011-12: Surveys of providers, juvenile justice staff, OYA staff, families and youth to determine critical barriers to collaboration
- Improved collaboration between juvenile justice system and mental health system
- Improved quality of services for youth involved in juvenile justice system are expected to decrease likelihood of criminal activity

Annual Performance Indicators to measure goal success:

Indicator #1: Percentage of children with arrest history in year prior to treatment who are not rearrested in the year following treatment.

- a) **Baseline measurement:** 43.7 percent
- b) **First-year target/outcomes measurement (progress to end of SFY 2014):** 45 percent
- c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** 46 percent
- d) **Data source:** YSS-F Survey
- e) **Description of data:** The percentage of children, as reported by parents or guardians, who were arrested in Year 1 (year prior to mental health treatment) and not re-arrested in Year 2 (one year after starting mental health treatment).
- f) **Data issues/caveats that affect outcome measures:** None

- 5. Priority Type (SAP, SAT, MHP, MHS):** MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SMI, SED
Goal of the priority area: Increase rates of competitive employment for adults and young adults with mental health disorders.

Strategies to attain the goal:

- CCO contracts require all individuals with SMI to be assessed for participation in IPS SE, and, if it would benefit the individual, provide IPS SE services.
- CCOs and Local Mental Health Authorities providing IPS SE services must meet fidelity benchmarks identified by AMH (see Step One).
- Contract with the Oregon Supported Employment Center for Excellence to provide ongoing training, technical assistance and fidelity monitoring for IPS SE providers.
- Increase funding allocations to Local Mental Health Authorities to support the development and implementation of IPS SE.

Annual Performance Indicators to measure goal success

Indicator #1: Increase the number individuals with SED or SMI utilizing IPS SE services.

- a) Baseline measurement (Initial data collected prior to and during SFY 2014):** 1,501 unduplicated individuals have received IPS SE between July 1, 2011 and September 30, 2012.
- b) First-year target/outcome measurement (Progress to end of SFY 2014):** Increase IPS SE utilization by 5 percent.
- c) Second-year target/outcome measurement (Final to end of SFY 2015):** Increase IPS SE utilization by 5 percent.
- d) Data source:** COMPASS and MMIS
- e) Description of data:** See Step Two for a description of COMPASS and MMIS
- f) Data issues/caveats that affect outcome measures:** Increased funding to LMHAs for IPSA is contingent upon the Legislature's approval of the Governor's Balanced Budget.

- 6. Priority Type (SAP, SAT, MHP, MHS):** MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SMI
Goal of the priority area: Increase housing stability for adults with SMI.

Strategies to attain the goal:

- Targeted development of residential treatment homes and residential treatment facilities for specialty populations
- Increase in funding for LMHAs to provide scattered-site supported housing and rental assistance – increasing access to and maintenance of housing for adults with SMI
- Utilization of Projects for Assistance in Transition from Homelessness funds to provide outreach and case management to individuals with SMI who are homeless and not engaged in mainstream services.

Annual Performance Indicators to measure goal success

Indicator #1: Decrease the number of adults with SMI enrolled in mental health services that are homeless.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Due to the limitations of CPMS (see Step Two) AMH has been unable to accurately identify the number of adults with SMI enrolled in mental health services that are homeless.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Develop baseline.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Decrease the number of adults with SMI enrolled in mental health services that are homeless by 5 percent.
- d) **Data source:** COMPASS and MMIS
- e) **Description of data:** See Step Two for a description of COMPASS and MMIS.
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

Increase the availability, utilization and quality of community-based, integrated health care services.

1. **Priority Type (SAP, SAT, MHP, MHS):** MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED

Goal of the priority area: Increase access to publicly funded mental health services by children with SED and their families

Strategies to attain the goal:

- Support of statewide expansion of community based services.
- Support of CCOs in service provision to enrollees.
- Utilization of Wraparound model /SOC to further develop the community-based services array
- Monitor enrollment increases through Oregon Healthy Kids during Medicaid expansion.

Annual Performance Indicators to measure goal success

Indicator #1: Access to publicly-funded mental health services by children with SED and their families will increase.

- a) **Baseline measurement (data collected prior to/during SFY 2014):** Percentage served in the publicly funded mental health system: 34 percent
- b) **First-year target/outcomes measurement (progress to end of SFY 2014):** 35 percent
- c) **Second-year target/outcomes measurement (progress to end of SFY 2015):** 36 percent
- d) **Data source:** COMPASS, MMIS
- e) **Description of data:** Encounters and claims, indigent care under County Financial Assistance Agreement

- f) **Data issues/caveats that affect outcome measures:** Transition of reporting during Health System Transformation and CCO development

2. Priority Type (SAP, SAT, MHP, MHS): MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED

Goal of the priority area: Expand the array of community-based mental health services available to and delivered to children with SED

Strategies to attain the goal:

- Workforce development
- Technical assistance
- Sharing of strategies for expansion of services under Statewide Children's Wraparound Initiative

Annual Performance Indicators to measure goal success

Indicator #1: The percentage of children with SED receiving three or more types of community-based mental health services will steadily increase.

- Baseline measurement** 58 percent
- First-year target/outcomes measurement (progress to end of SFY 2014):** 61 percent
- Second-year target/outcomes measurement (progress to end of SFY 2015):** 65 percent
- Data source:** COMPASS, MMIS
- Description of data:** The percentage of children with SED who receive three or more types of community based mental health services over the course of a year.
- Data issues/caveats that affect outcome measures:** None at this time

3. Priority Type (SAP, SAT, MHP, MHS): MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SMI

Goal of the priority area: Increase access to publicly-funded, community-based services for eligible individuals.

Strategies to attain the goal:

- Medicaid expansion
- Increase General Fund allocations for Local Mental Health Authorities

Annual Performance Indicators to measure goal success

Indicator #1: Increase access to publicly-funded, community-based services for eligible individuals.

- Baseline measurement (Initial data collected prior to and during SFY 2014):** 73,279 adults were served in SFY 2012
- First-year target/outcome measurement (Progress to end of SFY 2014):** Increase access by 5 percent
- Second-year target/outcome measurement (Final to end of SFY 2015):** Increase access by 5 percent
- Data source:** COMPASS and MMIS

- e) **Description of data:** See Step Two for a description of COMPASS and MMIS.
- f) **Data issues/caveats that affect outcome measures:** Increased funding to LMHAs is contingent upon the Legislature's approval of the Governor's Balanced Budget.

4. Priority Type (SAP, SAT, MHP, MHS): MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SMI

Goal of the priority area: Increase access to and utilization of evidence-based Assertive Community Treatment (ACT) services.

Strategies to attain the goal:

- CCO contracts require all individuals with SMI to be assessed for participation in ACT, and, if it would benefit the individual, provide ACT services.
- CCOs and Local Mental Health Authorities providing ACT services must meet fidelity benchmarks identified by AMH (see Step One).
- Contract with a Center for Excellence to provide ongoing training, technical assistance and fidelity monitoring for ACT providers.
- Increase funding allocations to Local Mental Health Authorities to support the development and implementation of ACT.

Annual Performance Indicators to measure goal success

Indicator #1: Increase the number individuals with SED utilizing ACT services.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 611 unduplicated individuals have received ACT services in SFY 2012.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Increase ACT utilization by 5 percent.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Increase ACT utilization by 5 percent.
- d) **Data source:** COMPASS and MMIS
- e) **Description of data:** See Step Two for a description of COMPASS and MMIS
- f) **Data issues/caveats that affect outcome measures:** Increased funding to LMHAs for ACT is contingent upon the Legislature's approval of the Governor's Balanced Budget.

5. Priority Type (SAP, SAT, MHP, MHS): SAT

Population(s) (SMI, SED, PWWDC, IVDUs HIV EIS, TB, Other): Other

Goal of the priority area: Increase utilization of substance use disorder services in Oregon.

Strategies to attain the goal:

- Promote and increase the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) among primary care providers including Patient Centered Primary Care Homes.

- Provide technical assistance to Coordinated Care Organizations and network providers through partnerships with the Division of Medical Assistance Programs (Oregon's Medicaid Authority), the Northwest Addiction Technology Transfer Center (ATTC), and Oregon Health and Science University (OHSU).
- Monitor CCO performance in SBIRT, substance use disorder treatment initiation and engagement encounters.
- Monitor access performance targets for AMH contractors and report progress routinely.
- Provide technical assistance and consultation to contractors and sub-contracted providers aimed at improving access to services as needed based on performance.

Annual Performance Indicators to Measure Goal Success

Indicator #1: SBIRT Encounters among Oregon Health Plan members.

- Baseline measurement (Initial data collected prior to SFY 2014):** 0.6 per 1,000 adults seen in outpatient.
- First year target outcomes measurement (target to the end of SFY 2014):** Increase above baseline by 0.5 percent
- Second year target outcome measurement (Final to the end of 2015):** Increase above first year measurement by 0.5 percent
- Data Source:** MMIS Encounter data
- Description of data:** Medicaid encounter data submitted by Coordinated Care Organizations through the MMIS system. Available through the Office of Health Analytics.
- Data issues/caveats that affect outcome measures:** The utilization of this encounter has been very low. First year measurement comparison to baseline is difficult to forecast. However, this measure is an incentive measure for CCOs so it is likely to improve over time. There are no national comparisons for face validity checks.

Indicator #2: Initiation and Engagement in Substance Use Disorder Treatment among OHP Members.

- Baseline measurement (Initial data collected prior to SFY 2014):** Initiation and Engagement of Alcohol and Other Drug Metric – Intake Period 01/01/2011 – 11/15/2011 (Statewide)
 - Age 13-17
 - Denominator = 331
 - Numerator (Initiation) = 49
 - Numerator (Engagement) = 18
 - Age 18 and Over
 - Denominator = 5145
 - Numerator (Initiation) = 1424
 - Numerator (Engagement) = 448
- First year target outcomes measurement (target to the end of SFY 2014):** Increase by 5 percent above baseline

- c) **Second year target outcome measurement (Final to the end of 2015):** Increase by 5 percent above first year
- d) **Data Source:** MMIS encounter data
- e) **Description of data:** Medicaid encounter data submitted by Coordinated Care Organizations through the MMIS system. Available through the Office of Health Analytics.
- f) **Data issues/caveats that affect outcome measures:** The utilization of this encounter has been very low. First year measurement comparison to baseline is difficult to forecast. However, this measure is an incentive measure for CCOs so it is likely to improve over time.

Reduce overall health care and societal costs through appropriate investments.

1. **Priority Type (SAP, SAT, MHP, MHS):** SAP
Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): Other
Goal of the priority area: To reduce high risk drinking among 18-25 year olds, ultimately leading to the reduction of alcohol abuse and dependence and over time, reduce rates of chronic liver disease.
Strategies to attain the goal: Build capacity across the state to utilize and implement the Strategic Prevention Framework by funding counties with the highest alcohol consumption and consequence rates due to binge, heavy and underage drinking.
Annual Performance Indicators to measure goal success
 - Indicator #1:** Alcohol Dependence or Abuse in the Past Year among 18 to 25 year olds
 - a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 18.7 percent in 2008-2009
 - b) **First-year target/outcome measurement (Progress to end of SFY 2014):** 17.7 percent
 - c) **Second-year target/outcome measurement (Final to end of SFY 2015):** 16.7 percent
 - d) **Data Source:** National Survey on Drug Use and Health (NSDUH)
 - e) **Description of Data:** NSDUH provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.
 - f) **Data issues/caveats that affect outcome measures:** This data is challenging to collect on the age population identified.
 - Indicator #2:** Past month binge drinking among 18 to 24 year olds
 - a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 24.1 percent in 2009
 - b) **First-year target/outcome measurement (Progress to end of SFY 2014):** 23.1 percent

- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** 22.1 percent
- d) **Data Source:** Oregon Behavioral Risk Factor Surveillance System
- e) **Description of Data:** The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.
- f) **Data issues/caveats that affect outcome measures:** This data is challenging to collect on the age population identified. Data is not current and not adequate.

Indicator #3: Past Month Heavy Drinking among 18 to 24 year olds

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 5.9 percent in 2009
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** 4.9 percent
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** 3.9 percent
- d) **Data Source:** Oregon Behavioral Risk Factor Surveillance System (BRFSS)
- e) **Description of Data:** The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.
- f) **Data issues/caveats that affect outcome measures:** This data is challenging to collect on the age population identified. Data is not current and not adequate.

2. Priority Type (SAP, SAT, MHP, MHS): SAT

Population(s) (SMI, SED, PWWDC, IVDU's HIV EIS, TB, Other): Other

Goal(s) of the priority area: Preventing or reducing foster care placements by providing ongoing development and monitoring of addiction treatment services for parents who are at risk of or involved in the child welfare system.

Strategies to attain the goal:

- Provide technical assistance and promote cross-collaborations between addiction providers and child welfare.
- Provide families with recovery support services that include parenting education, child care, and transportation resources.
- Provide technical assistance to Coordinated Care Organizations in integrating residential and outpatient behavioral health services for pregnant women within physical health care.

Annual performance indicators to Measure Goal Success

Indicator #1: Percent of participants in ITRS reunited with child in DHS custody

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Number of children reunited with their parent(s) in 2012.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Maintain current number of children returned.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Increase number of children returned by 1 percent or better.
- d) **Data Source:** ORKIDS, CPMS and OWITs
- e) **Description of data:** CPMS and OWITs data systems capture treatment need and demographic information of each enrolled individual. ORKIDS system is maintained by child welfare and captures information about children who are in foster care.
- f) **Data issues/caveats that affect outcome measures:** The ORKIDS data system is updating its capacity to provide information about number of kids returned to their families from foster care.

Indicator #2: Ensure that 100 percent of counties/direct contractors meet contractual utilization requirements.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Number of counties who met utilization requirements for 2013.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** All 36 counties and 1 tribe meeting requirements
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** All 36 counties and 1 tribe meeting requirements
- d) **Data Source:** CPMS and OWIT's Data
- e) **Description of data:** CPMS and OWITs data systems capture treatment need and demographic information of each enrolled individual.
- f) **Data issues/caveats that affect outcome measures:** none

Indicator #3: Sixty percent of providers provide 90 or more days of outpatient treatment and recovery services to individuals enrolled in ITRS

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Percent of providers who met length of stay requirements for 2013.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Maintain 2013 numbers for length of stay
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Maintain 2013 numbers for length of stay
- d) **Data Source:** CPMS and OWITs
- e) **Description of Data:** CPMS and OWITs data systems capture treatment need and demographic information of each enrolled individual.
- f) **Data caveats/issues that affect outcome measures:** none

Increase the effectiveness of the integrated health care delivery system.

1. Priority Type (SAP, SAT, MHP, MHS): MHS

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED

Goal of the priority area: Decrease rates of readmission for children with SED to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) at 30 and 180 days who are in non-forensic programs.

Strategies to attain the goal:

- AMH is working with Community Mental Health Programs, Coordinated Care Organizations and Intensive Community Based Treatment Services (ICTS) providers to ensure children discharged from SCIP and SAIP have transition plans that assure successful community tenure.
- AMH monitors discharge planning at SCIP/SAIP through technical assistance; and continues to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP.
- At the SAIP, youth needing the highest level of non-forensic care are served in a separate secure program from youth requiring forensic care in addition to inpatient level mental health care. The needs of these youth are distinctly different from the youth requiring forensic care. Some youth are negatively triggered by the behavior of youth requiring forensic care.
- AMH will continue to work with community providers to ensure that they have appropriate transition plans to smooth the transition trauma that may occur.
- As described in Step One, System of Care, Wraparound Model, Supported Employment, the Early Assessment and Support Alliance, Peer Delivered Services, and Supported Housing are available to help ensure that individuals discharged from SCIP/SAIP have access to vital community-based services.

Annual Performance Indicators to measure goal success:

Indicator #1: Decrease non-forensic patients' readmission to SCIP at 30 days.

- a) Baseline measurement (Initial data collected prior to and during SFY 2014):** 0 percent
- b) First-year target/outcome measurement (Progress to end of SFY 2014):** at or below 1 percent
- c) Second-year target/outcome measurement (Final to end of SFY 2015):** Maintain 30-day readmission rates at or below 1.0 percent
- d) Data source:** MMIS, COMPASS
- e) Description of data:** See Step 2 for a description
- f) Data issues/caveats that affect outcome measures:** None identified at this time.

Indicator #2: Decrease non-forensic patients' readmission to SAIP at 30 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 2 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** at or below 2 percent (note that for 2012 this represents 1 patient)
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** at or below 2 percent
- d) **Data source:** MMIS, COMPASS
- e) **Description of data:** See Step 2 for a description
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

Indicator #3: Decrease non-forensic patients' readmission to SCIP at 180 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 17 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Maintain at or below 15 percent
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Maintain at or below 13 percent
- d) **Data source:** MMIS, COMPASS
- e) **Description of data:** See Step 2 for a description
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

Indicator #4: Decrease non-forensic patients' readmission to SAIP at 180 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 18 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Decrease readmission rates by 1 percent
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Decrease 2014 readmission rates by 1 percent
- d) **Data source:** MMIS, COMPASS
- e) **Description of data:** See Step 2 for a description
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

2. Priority Type (SAP, SAT, MHP, MHS):MHS

Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): SMI

Goal of the priority area: Decrease State psychiatric hospital readmission rates at 30 and 180 days.

Strategies to attain the goal: AMH has developed a multi-tiered process to help assure that individuals who are discharged from the state hospital are not

readmitted. The standardized discharge criteria (LOCUS) was developed and implemented in 2010. AMH will ensure that the tool is being applied appropriately and that individuals who have been determined ready to transition are reassessed periodically. Individuals who are no longer stable should stay at the hospital for the length of time it takes them to meet the criteria again.

AMH will continue to work with community providers to ensure that they have appropriate transition plans to smooth the transition trauma that may occur. AMH's psychiatrist will also be available for consultation to residential providers during the first 90 days to provide insight and suggestions about stabilizing someone in the community.

As described in Step One, expansion of Assertive Community Treatment, Supported Employment, the Early Assessment and Support Alliance, Peer Delivered Services, and Supported Housing will help to ensure that individuals discharged from the State Hospitals have access to vital community-based services.

Annual Performance Indicators to measure goal success:

Indicator #1: Decrease non-forensic (voluntary and civil-involuntary) patients' readmission to State psychiatric hospitals at 30 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 5.77 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** 5.0 percent
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Maintain 30-day readmission rates at or below 5.0 percent
- d) **Data source:** Avatar Electronic Health Record
- e) **Description of data:** See Step 2 for a description of Avatar
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

Indicator #2: Decrease non-forensic (voluntary and civil-involuntary) patients' readmission to State psychiatric hospitals at 180 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 24.15 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Decrease readmission rates by 5 percent.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Decrease 2014 readmission rates by 5 percent.
- d) **Data source:** Avatar Electronic Health Record
- e) **Description of data:** See Step 2 for a description of Avatar
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

Indicator #3: Decrease forensic patients' readmission to State psychiatric hospitals at 30 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 6.79 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** 6.0 percent
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** 5.0 percent
- d) **Data source:** Avatar Electronic Health Record
- e) **Description of data:** See Step 2 for a description of Avatar
- f) **Data issues/caveats that affect outcome measures:** The Psychiatric Security Review Board has the ability to revoke an individual's conditional release agreement and readmit the individual to the State hospital.

Indicator #4: Decrease forensic patients' readmission to State psychiatric hospitals at 180 days.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 18.78 percent
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Decrease readmission rates by 5 percent.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Decrease 2014 readmission rates by 5 percent.
- d) **Data source:** Avatar Electronic Health Record
- e) **Description of data:** See Step 2 for a description of Avatar
- f) **Data issues/caveats that affect outcome measures:** The Psychiatric Security Review Board has the ability to revoke an individual's conditional release agreement and readmit the individual to the State hospital.

3. Priority Type (SAP, SAT, MHP, MHS): SAP

Population(s) (SMI, SED, PWWDC, IVUDs, HIV EIS, TB, OTHER): All

Goal of the priority area: To provide technical assistance and training to the Drug Free Communities (DFC), a Federal grant program that provides funding to community-based coalitions that organize to prevent youth substance use, and to coalitions across the state who are actively seeking DFC funding.

Strategies to attain the goal: Support planning, capacity and community coalition-building.

Annual Performance Indicators to measure goal success

Indicator #1: Number of hours of training and technical assistance provided.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** To be established in 2013.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Maintain baseline for number of hours of training and technical assistance.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Increase the number of hours of training and technical

assistance by 5 percent from the first year target outcome measurement.

- d) **Data Source:** AMH Prevention Staff
- e) **Description of Data:** Each Prevention Coordinator is responsible for logging hours of training and technical assistance.
- f) **Data issues/caveats that affect outcome measures:** Logging consistency.

Increase the involvement of individuals and family members in all aspects of health care delivery and planning.

1. **Priority Type (SAP, SAT, MHP, MHS):** SAP, SAT, MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): All
Goal of the priority area: Ensure access to high quality peer delivered services statewide.

Strategies to attain the goal: AMH will continue to support the use and availability of peer delivered services by:

- Providing technical assistance regarding the development of peer delivered services training curricula;
- Approving peer delivered services training curricula;
- Working with the Office of Equity and Inclusion to develop competencies and training for Non-Traditional Health Workers (see Step One);
- Ensure that individuals enrolled in a Coordinated Care Organization with behavioral health disorders have access to Non-Traditional Health Workers.

Annual Performance Indicators to measure goal success:

Indicator #1: Increase utilization of peer delivered services by individuals enrolled in publicly-funded behavioral health services.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Due to the limitations of CPMS (see Step Two) AMH has been unable to accurately identify the number of individuals utilizing peer delivered services.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Establish baseline.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Increase utilization of peer delivered services by 5 percent.
- d) **Data source:** COMPASS
- e) **Description of data:** Please see Step Two for a description of COMPASS.
- f) **Data issues/caveats that affect outcome measures:** None identified at this time.

2. **Priority Type (SAP, SAT, MHP, MHS):** SAP, SAT, MHP, MHS
Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): All
Goal of the priority area: Support the participation of behavioral health service consumers and their family members on AMH advisory councils.

Strategies to attain the goal: AMH will continue to support consumer and family member participation on ongoing AMH advisory councils by:

- Ensuring a minimum of 51 percent consumers, family members and advocates make-up of the Addictions and Mental Health Planning Council (AMHPAC), family members and youth serving on AMHPAC and the Children's System Advisory Council (CSAC) and a minimum of 20 percent on other AMH advisory councils;
- Utilizing Mental Health Block Grant funds to provide reimbursement for lodging, meals, mileage, and child care expenses incurred by consumer, family members and youth serving on AMHPAC and the Children's System Advisory Council (CSAC) ²²;
- Researching the feasibility of providing stipends for consumer, family member and youth participation on AMH advisory councils;
- Providing technical assistance and training for advisory council members to ensure their ability to actively participate in council business.

Annual Performance Indicators to measure goal success:

Indicator #1: Ensure consumer and family member access and membership on AMH advisory councils.

a) Baseline measurement (Initial data collected prior to and during SFY 2014):

- 51 percent consumer, family member or advocate membership on AMHPAC
- 51 percent consumer, family member or advocate membership on CSAC
- 100 percent consumer or family member membership on OCAC

b) First-year target/outcome measurement (Progress to end of SFY 2014): Maintain consumer and family member membership on AMHPAC, CSAC and OCAC.

c) Second-year target/outcome measurement (Final to end of SFY 2015): Maintain consumer and family member membership on AMHPAC, CSAC and OCAC.

d) Data source: Advisory council membership rosters

e) Description of data: Each advisory council maintains a membership roster including the membership configuration.

f) Data issues/caveats that affect outcome measures: None identified at this time.

3. Priority Type (SAP, SAT, MHP, MHS): SAT

Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): Other

Goal of the priority area: Identify Community Advisory Council (CAC) for various CCOs across the state. The CAC includes community members to assess, design, plan and implement a strategic population health and health care

²² Oregon Revised Statute does not allow for travel/child care reimbursements for members of the Oregon Consumer Advisory Council (OCAC).

system service plan, for the community served by the CCO. Assist Community Advisory Council of CCOs in conducting a community health assessment which is one of their contractual requirements. Assist CCOs designing and updating community health improvement plan which is one of their contractual requirements.

Strategies to attain goal: Assist CCOs in:

- Identifying and analyzing available data
- Developing a preliminary identification of health disparities
- Developing plans for gathering additional information and performing analyses on identifying more accurately and completely the significant health disparities in the CCO's service area.

Annual Performance Indicators to measure goal success

Indicator #1: Use of OHA data to conduct Community Health Assessment and Community Health Improvement Plan by CCO Community Advisory Councils.

- a) Baseline measurement (Initial data collected prior to and during SFY 2014):** Use of OHA data for available community health assessments in each CCO service area.
- b) First-year target/outcome measurement (Progress to end of SFY 2014):** Use of OHA data for the CCO Community Health Assessment
- c) Second-year target/outcome measurement (Final to end of SFY 2015):** Use of OHA data for a 3 year CCO Community Health Improvement Plan
- d) Data Source:** OHP data, Oregon State County and State Epidemiological Profile, NSDUH, TEDS, N-SSATS
- e) Description of data:** various data sources that contain incidence and trend data on addiction and mental health use, consequence and treatment data.
- f) Data issues/caveats that affect outcome measures:** Delays in availability of data.

Increase accountability of the health care system.

1. Priority Type (SAP, SAT, MHP, MHS): SAT

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED

Goal of the priority area: Increase referrals by health care professionals to substance use disorder treatment for youth. Provide recovery support services to youth who are in need of addiction treatment services

Strategies to attain the goal:

- Promote and increase the use of SBIRT among pediatricians and primary care providers.
- Provide technical assistance to Oregon CCO's in assessing risk factors for youth enrolled in the Oregon Health Plan and the Children's Health Insurance Program.
- Increase referrals to treatment services.

Annual performance indicators to Measure Goal Success:

Indicator #1: Initiation and engagement in substance use disorder treatment among OHP members 13 to 17 years of age. (HEDIS-IET)

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** 14.8 percent Initiation; 5.4 percent Engagement
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Increase Initiation and Engagement by greater than 1 percent.
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** Increase Initiation and Engagement by greater than 1 percent.
- d) **Data Source:** MMIS
- e) **Description of data:** Medicaid encounter data submitted by Coordinated Care Organizations through the MMIS system. Available through the Office of Health Analytics
- f) **Data issues/caveats that affect outcome measures:** Utilization of this measure is new to Oregon's health care system. First year measurement comparison to baseline is difficult to forecast. However, this is an incentive measure for CCOs so improvement is expected as the SUD treatment and physical health systems become integrated.

Indicator #2: Percentage of youth who report using alcohol.

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Use 2013 data as baseline
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Maintain 2013 rates
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** reduction of greater than 1 percent
- d) **Data Source:** Student Wellness Survey
- e) **Description of data:** Student Wellness Surveys alcohol use information from Oregon students in grades 6, 8 and 11.
- f) **Data issues/caveats that affect outcome measures:** None

Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

1. **Priority Type (SAP, SAT, MHP, MHS):** SAP
Population(s) (SMI, SED, PWWDC, IVDU, HIV EIS, TB, OTHER): Other
Goal of the priority area: Increase data capacity through the development of a coordinated prevention data collection, analysis and distribution system
Strategies to attain the goal:
 - Develop the prevention module within the AMH data system
 - Ongoing administration of the Oregon Student Wellness Survey (SWS) and support of the Oregon Healthy Teens Survey (OHT)
 - Ongoing development, analysis and dissemination of state, county and tribal epidemiological data**Annual Performance Indicators to measure goal success**

Indicator #1: Transition from current MDS system to Prevention module developed within COMPASS system

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** COMPASS system currently does not include a prevention module
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Prevention measures developed, tested and integrated into the COMPASS system
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** All prevention providers are trained and utilizing new prevention module within the COMPASS system
- d) **Data Source:** AMH COMPASS Team
- e) **Description of data:** Data will describe the development and transition from MDS to COMPASS for all prevention data.
- f) **Data issues/caveats that affect outcome measures:** Workload of AMH COMPASS Team and ability of contractor to meet timelines.

Indicator #2: Availability of state, county and tribal data

- a) **Baseline measurement (Initial data collected prior to and during SFY 2014):** Availability of required data measures to meet state and federal requirements in 2013.
- b) **First-year target/outcome measurement (Progress to end of SFY 2014):** Increase the availability of required Drug Free Community - Government Performance and Results Act (GPRA) data is collected through all data sources
- c) **Second-year target/outcome measurement (Final to end of SFY 2015):** All required state and federal data is reported in state, county and tribal data profiles.
- d) **Data Sources:** Student Wellness Survey, Oregon Healthy Teens Survey, Oregon Vital Statistics, Uniform Crime Reports, National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factors Surveillance System (BRFSS), Treatment Episode Data Set (TEDS), Vista PHW, a software package that allows the public health community in Oregon to access and analyze population-based health data on the county or state level.
- e) **Description of the data:** Various data sources that capture addiction and mental health related consumption, consequence, treatment and trend data.
- f) **Data issues/caveats that affect outcome measures:** OHT and SWS are administered on a rotating basis. Data not always updated on a timely basis.

Eliminate health disparities for vulnerable populations.

1. Priority Type (SAP, SAT, MHP, MHS): SAT

Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): Other

Goal of the priority area: Reduce treatment outcome disparities for special populations (initiation, engagement, retention, completion and reduced use).

Strategies to attain the goal:

- Use a standardized method for analyzing addictions treatment data to identify specific populations in need of better addictions treatment outcomes
- Identify and address the specific populations of greatest need for improvement.

Annual performance indicators to Measure Goal Success:

Indicator #1: Decrease addictions treatment outcome disparities in Oregon.

- a) Baseline measurement (Initial data collected prior to and during SFY 2014):** Use 2012 data as baseline
- b) First-year target/outcome measurement (Progress to end of SFY 2014):** To be determined.
- c) Second-year target/outcome measurement (Final to end of SFY 2015):** To be determined.
- d) Data Source:** CPMS and Compass
- e) Description of data:** Rate ratios will be used to identify health disparities.
- f) Data issues/caveats that affect outcome measures:** The methodology for analyzing the data, reporting and prioritizing the results has not been finalized.

Affordable Insurance Exchanges

Access to quality, affordable health insurance coverage has become increasingly challenging for many Oregonians and businesses. An estimated 636,000 Oregonians are uninsured, and, for those with insurance, premium costs are rising. The Oregon Health Insurance Exchange (Cover Oregon) will improve access to coverage by providing a central marketplace where individuals and small employers can shop for health coverage options and may receive help paying for coverage. Beginning October 1, 2013, Oregonians will be able to easily compare plans, find out if they are eligible for tax credits and other financial assistance, and enroll for health coverage through the Cover Oregon website. They also will be able to enroll by calling a toll-free number and working with community-based navigators and insurance agents.

Oregon created a public corporation to operate the exchange in the public interest for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families, and their employees through Cover Oregon. The Cover Oregon Board of Directors consists of private citizens, with the exception of two state officials.

Cover Oregon is a key part of Oregon's current health reform efforts aimed at improving health, increasing the quality and availability of medical care, and controlling costs. Senate Bill 99, which created Cover Oregon, required the corporation to submit a board-approved formal business plan to the Oregon Legislature in February 2012.

Value of Cover Oregon

The mission of Cover Oregon is improving the health of all Oregonians by providing health coverage options, increasing access to information, and fostering quality and value in the health care system. The corporation's goal is to create a health insurance exchange that attracts all Oregonians in the individual and small group markets as well as the uninsured by providing the following services:

- **Central place to shop for insurance plans.** Cover Oregon will provide easy-to-compare information on health plan quality and price.
- **Trusted information and assistance.** Cover Oregon will provide information on how to best use health benefits to improve health as well as referrals to other resources if appropriate.
- **Focus on cost and value.** Cover Oregon can help control the underlying cost drivers in health care through the standards it sets for plans sold through Cover Oregon. This work will be done in concert with Oregon's other efforts to improve health care and reduce costs.
- **Seamless eligibility and enrollment process.** With a single application, Oregonians can find and enroll in the health plan that best meets their needs.
- **Help paying for health coverage.** Federal tax credits and other assistance available through Cover Oregon will make health care coverage more affordable.
- **Innovative plan options and simplified plan administration for small employers.** Small employers can allow their employees to choose an insurance company and plan through a defined contribution model.

- **Community-based assistance.** Cover Oregon will include a network of specially trained customer service staff, navigators, insurance agents, and other community-based organizations that will help guide Oregonians in all parts of the state through applying to Cover Oregon and enrolling in coverage.
- **More accessible health coverage.** Through its easy-to-use website, community outreach, and financial assistance, Cover Oregon will make health coverage accessible to more Oregonians.

Cover Oregon will go live with these core services and start open enrollment October 1, 2013, for coverage effective on January 1, 2014. After a successful initial launch, the corporation will begin Phase 2, in which it will build additional capacity to better serve individuals and small employers.

Road to Cover Oregon

Oregon has been exploring the concept of a health insurance exchange for the past decade. A series of legislative acts, starting in 2007, culminated in the passage of Senate Bill 99, signed into law on June 22, 2011. The Patient Protection and Affordable Care Act, signed into law in March 2010, requires all states to operate a health insurance exchange by January 1, 2014. States developing exchanges must receive readiness certification from the federal government in January 2013. If states do not operate their own exchanges, the federal government will implement an exchange for them. By developing its own exchange, Oregon can ensure it meets the unique needs of the state's individuals, employers, and health insurance market. It also gives Oregon the ability to be innovative in the design of plans offered through Cover Oregon, so it can better contribute to broader state health reforms underway.

Cover Oregon is funded by federal grants through 2014. To pay for operations beyond 2014, Senate Bill 99 established an administrative fee, which is a percentage of premiums for lives enrolled in Cover Oregon, charged to insurance companies. There is no state funding for start-up or ongoing operations of the exchange. Given the various federal and state reforms under way, Oregon's insurance market will be significantly different when Cover Oregon launches in 2014. This requires the corporation to be innovative and nimble as it develops its website and programs.

For Individuals

Plan comparison and selection

Plans offered through Cover Oregon offer two distinct advantages to individuals. One, each plan will meet specific requirements set by Cover Oregon. Cover Oregon will use the federal minimum standard requirements as a baseline, potentially adding other requirements that ensure quality health plans are available across the state and that the types of plans available support other health system reforms in Oregon. Second, Cover Oregon will grade each plan in areas like quality, care coordination, and network adequacy. Individuals will know that plans in Cover Oregon have been independently and objectively judged based on quality and value. Health plans available through Cover Oregon will be categorized by the following levels of coverage.

Oregon's 2014-2015 State Plan for Behavioral Health Services

- *Bronze plan* – represents minimum creditable coverage. Bronze plans will pay, on average, 60 percent of an individual's health care expenses. Enrollees would then pay 40 percent through cost sharing.
- *Silver plan* – covers an average of 70 percent of health care expenses.
- *Gold plan* – covers an average of 80 percent of health care expenses.
- *Platinum plan* – covers an average of 90 percent of health care expenses.

Individuals under the age of 30 also can buy a “catastrophic” plan through Cover Oregon. These plans offer a minimum level of coverage and some preventive care.

Individuals will be able to find out if they are eligible for federal tax credits to help pay premiums or if they are eligible for the Oregon Health Plan (Medicaid) or Healthy Kids (CHIP) program. Eligibility requirements are below:

- *Individual commercial plans* – Children and adults who do not have access to affordable coverage through an employer
- *Federal tax credits* – Children and adults up to 400 percent of federal poverty level (\$89,000 for a family of four in 2011)
- *Oregon Health Plan or Healthy Kids* – Children up to 300 percent of federal poverty level
- *Oregon Health Plan* – Adults up to 138 percent of federal poverty level

The Cover Oregon website will be able to pull from other state and federal data sources, cutting down the amount of paperwork that has to be sent in and processed. Individuals eligible for commercial plans through Cover Oregon can choose a plan and enroll using the Cover Oregon website. Behind the scenes, Cover Oregon will forward information and the first month's premium payment securely to the insurance company. At that point, the insurance company will issue insurance cards and begin billing the customer directly and coverage will begin. For individuals eligible for the Oregon Health Plan or the Healthy Kids program, Cover Oregon will transfer the enrollment information to the OHA, who will complete the enrollment process. This process will be seamless to the customer.

Tax credits

Starting in 2014, many Oregonians will receive assistance paying their monthly premium using a federal tax credit for health plans offered through Cover Oregon. Based on income, some will also get additional help with cost-sharing expenses, such as co-pays and deductibles. To be eligible for the tax credits, Oregonians must be U.S. citizens or legal immigrants and must not have affordable coverage available through their employer. The federal government will determine the definition of “affordable coverage.”

The tax credit is determined during the application process and is on a sliding scale based on income and the insurance plan chosen. Once a person is determined eligible for the tax credit, they can choose to have it as an advance payment or receive the credit when they file their taxes. The advance payment lowers the premium a person pays each month and is paid by the federal Department of the Treasury directly to the

insurance company. Cover Oregon will have a simple-to-use premium calculator to help Oregonians estimate their monthly premium bill.

For Small Employers

Offering health insurance to their employees is becoming increasingly challenging for Oregon's small employers, which account for more than 50 percent of the private sector jobs in the state, according to the Small Business Administration. Only about 34 percent of private-sector firms with fewer than 10 employees offer health insurance to workers, according to the Medical Expenditure Panel Survey. The Oregon Health Insurance Cover Oregon Corporation is exploring a defined contribution model, which will make it easier for employers to offer insurance to their employees. The model will provide expanded choices for employees and administrative efficiencies for employers.

In Oregon, the Cover Oregon Corporation has explored offering four major plan options for small employers (up to 50 employees), including:

1. *Traditional.* The employer chooses one insurance company and plan that their employees must enroll in.
2. *Plan bundling.* The employer chooses one insurance company, but allows employees to select from all plans offered by that company.
3. *Multiple companies/one plan.* The employer selects a benefit plan level – such as bronze, silver, gold, and platinum, explained on page 9 – and the employees can select a plan from all companies.
4. *Full choice.* Employees can select from all companies and all plans.

The fourth option, full choice, has resonated with the small business community and meets Cover Oregon's goal of providing innovative health insurance options to Oregonians. Known as a defined contribution model, option four will allow employers to pay a certain percentage of premiums or a set dollar amount and give their employees as much choice as they want. Cover Oregon will continue to work with the insurance community and small employers on designing the defined contribution model.

Administrative efficiencies for employers

Instead of having to research multiple insurance companies, small employers will be able to visit the Cover Oregon website to offer insurance choices to their employees. After employers decide how much they will contribute to premiums, their employees will go to the Cover Oregon to enroll. If employers choose to give their employees the ability to select from a range of carriers, the employers will only have to pay one bill to the Cover Oregon, and the Cover Oregon will remit the premiums to the participating insurance companies. In Phase 2, the Cover Oregon plans to expand its services to employers, including administering health savings accounts which allow employees in high deductible plans to use pre-tax dollars to pay for medical expenses.

Tax credits

Cover Oregon also will provide information to help small employers determine whether they are eligible for a federal tax credit to help cover the cost of coverage. The credit is designed to encourage small employers to offer health insurance coverage for the first

time or maintain coverage they already have. While Cover Oregon will perform a preliminary calculation to determine whether employers may be eligible for the tax credit, the credit will be administered by the IRS. Cover Oregon will encourage employers to contact their tax advisor to take advantage of the credit. To qualify for the tax credit, small employers must:

- Provide health insurance to employees and cover at least 50 percent of the cost of coverage;
- Employ up to the equivalent of 25 full-time workers ;
- Pay average annual wages below \$50,000; and
- Employers can be for-profit or tax-exempt.

In 2014, the tax credit is worth up to 50 percent of a small employer's premium costs (35 percent for tax-exempt employers). The tax credit gradually phases out for firms that have average wages between \$25,000 and \$50,000, and for firms that have the equivalent of between 10 and 25 full-time workers.

Links to Better Health

Having insurance is a first step toward better health, but it is important to use health care services wisely. Working with insurance companies and other organizations, Cover Oregon will provide Oregonians with links to information and tools they need to help meet the state's goals of improving the lifelong health of Oregonians, increasing the quality, reliability, and availability of care, and lowering or containing the cost of care.

Cover Oregon will connect people with the best resources available for health information, such as: exercise and nutrition, managing chronic health conditions, immunizations, and talking to your doctor.

Cover Oregon will also link Oregonians with helpful services offered by their health plans, such as nurse advice lines and preventive wellness programs. Cover Oregon will help consumers learn the difference between co-pays and co-insurance, know what a deductible is, and understand their benefits so they can use them effectively. In Phase 2, Cover Oregon plans to expand on its role as a source of trusted information by providing consumers with information about the cost and quality of medical services so they can make better choices.

As part of its educational efforts, Cover Oregon will develop culturally appropriate materials in multiple languages using a variety of mediums, such as brochures, web pages, short informational videos, and social media (like Facebook or Twitter). Cover Oregon will partner with community-based organizations to ensure the information is accessible to all Oregonians, including those in rural areas and hard-to-reach populations. Cover Oregon will also provide referrals to health care and health insurance resources in local communities through the website and the customer call center.

Cover Oregon Plan Requirements and Grading

Cover Oregon will establish quality standards for plans sold in the exchange. In addition to certifying plans, Cover Oregon will grade plans on a variety of criteria and publish those grades so that people can make meaningful comparisons.

Certification of plans

The Affordable Care Act lays out general standards for “Qualified Health Plans (QHPs)” that will be certified by the state exchanges. To be certified as a QHP, plans will have to provide essential health benefits, follow established limits on cost-sharing (like deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements.

The Affordable Care Act requires all plans in the individual and small group markets to offer “essential health benefits.” Each state will design its own essential benefits package using a benchmark plan currently offered in the market. Because the essential benefit requirement is for all individual and small group plans, inside and outside of the exchange, the Department of Consumer and Business Services Insurance Division will take the lead role for Oregon. Cover Oregon plans to work closely with the Insurance Division as well as the Governor’s Office and the Oregon Health Authority in this effort.

Cover Oregon is working with its Individual and Small Employer Consumer Advisory Committee and technical workgroups to determine other requirements for qualified health plans. Besides the bronze, silver, gold, and platinum qualified health plans individuals under the age of 30 can buy a “catastrophic” plan. These plans will only be available in the exchange and will provide a minimum level of coverage including some upfront preventive care.

Beginning in 2014, all insurance companies in the individual and small group markets in Oregon must provide a bronze plan and a silver plan. To be certified to sell in the exchange, insurance companies also must agree to offer at least one gold plan. In Addition, insurers must be licensed and in good standing with the state, agree to charge the same premium for the same plan inside and outside of the exchange, and meet other requirements as determined by federal rule or the corporation to participate in the exchange. In Phase 2, Cover Oregon will focus on incorporating lessons learned from other state health reform efforts and offering plans with more innovative benefit design that can help curb costs and improve health.

Grading of plans

Cover Oregon will publish grades for qualified health plans, to help people choose the plan that best meets their needs. The Cover Oregon will grade plans on a variety of measures, including quality, care coordination, provider network adequacy, customer service, and price. Cover Oregon is working with Quality Corporation, the Oregon Health Authority, the Insurance Division, and stakeholder groups to establish consistent quality indicators while awaiting federal government regulations. The corporation will work with the Insurance Division and the Oregon Health Authority to collect necessary information from insurance companies for certification and grading, so that companies

submit information only once. Because the plans offered in the exchange will be new in 2014, only limited information on quality may be available. Phase 2 will include more complete information on quality, including customer service ratings.

Customer Service and Outreach

In developing Cover Oregon, the corporation is centering its efforts around its two major customer groups: individuals and small employers. To ensure it can best serve those groups, the corporation is developing a robust customer service program as well as a broad communication and outreach plan to reach all Oregonians.

Customer Service

Cover Oregon will be a central place where Oregonians can turn for health coverage information and assistance. The corporation is developing an extensive customer service program, including a call center with highly trained customer service staff, community-based “navigators,” and insurance agents. Customers will be able to turn to Cover Oregon not only for help enrolling, but for referrals to other entities if necessary. Through its customer service program, Cover Oregon will provide the following:

- Expertise in eligibility, enrollment, and program specifications.
- Public education activities to raise awareness about the exchange.
- Fair, accurate, and impartial information.
- Help enrolling in Cover Oregon plans.
- Help for consumers with complaints about their plans.
- Information in appropriate languages.
- Accessible information for those with disabilities.

Oregon's navigator program will provide resources to community-based organizations to assist Oregonians throughout the state. In creating its navigator program, Oregon is looking to build off the success of similar local, grassroots assistance programs, such as the Senior Health Insurance Benefits Assistance (SHIBA) program and the Healthy Kids program. The SHIBA program uses community-based organizations and a network of volunteers throughout the state to help Medicare beneficiaries and their families. The Healthy Kids program partnered with community organizations to help enroll more than 100,000 children.

The corporation also views insurance agents as key to Cover Oregon's success. The corporation will develop a certification program for licensed agents who sell plans in the exchange and a referral service for consumers who request to work with an agent. In addition, the corporation is exploring ways to give agents the ability to sell all plans in the exchange – from a variety of insurance companies – and work on behalf of consumers.

Some people in particularly challenging or unique situations may need a higher level of assistance. Cover Oregon will have specially trained staff and partners throughout the state to help those Oregonians.

Communications and Outreach Plan

Cover Oregon is approaching communications and outreach in five steps, beginning with engaging stakeholders and developing partnerships, leading to a broader effort to educate individuals and small employers about Cover Oregon so they are prepared to begin enrolling by 2014. Cover Oregon will reach all Oregonians, particularly those in rural areas and hard-to-reach populations.

Enrollment and Financial Projections

Given the uncertainties of the economy and the unknown impacts of health insurance market reforms, it is difficult to project how many Oregonians will enroll in Cover Oregon. Likewise, in a start-up organization like Cover Oregon, projecting operating expenses over the next several years is challenging. That said, Cover Oregon has worked with state and national experts to develop enrollment projections and a budget for both the start-up phase and the first two years of operations.

Enrollment Projections

The corporation's enrollment projections are based on national economic models developed by MIT economist Jonathan Gruber and adjusted by Wakely Consulting Group. The projections reflect Oregon's insurance market and the impact of federal health reforms taking effect in 2014, including Cover Oregon, the individual mandate, and tax credits and cost-sharing subsidies. The scope and intensity of outreach and communications efforts will also impact enrollment.

Oregon Health Insurance Enrollment²³, 2010

Oregon Population²⁴		3,749,000
Commercial Health Insurance²⁵		
Individual	174,000	4.6%
Portability	19,000	0.5%
Small Group 2-50	210,000	5.6%
Oregon Medical Insurance Pool	14,000	0.4%
Large Group Over 50 Fully Insured	634,000	16.9%
Associations and Trusts	178,000	4.7%
Total Covered Under State Regulation	1,229,000	32.8%
Large Group Self-Insured²⁶	576,000	15.4%
Federal Health Care Programs		
Medicare	621,000	16.6%
Medicaid	550,000	14.7%
Total Covered Under Federal Regulation	1,171,000	31.2%
Uninsured²⁷	636,000	17.0%

²³ These enrollment estimates do not total 100 percent of Oregon's population because the numbers are rounded to the nearest thousand and come from several sources.

²⁴ Office for Oregon Health Policy & Research. Figures for civilian non-institutionalized population are used.

²⁵ Oregon Insurance Division quarterly enrollment data and data from the Oregon Medical Insurance Pool.

²⁶ Oregon Insurance Division quarterly enrollment data. In 2010, self-insured enrollment was reported by insurance companies, special districts, and third-party administrators.

²⁷ Centers for Medicare and Medicaid Services.

Program Integrity

SAPTBG

Each quarter, expenditures are compiled and matched against the approved SAPT grant budget to assure that spending stays in-line with the approved plan. Additionally, expenditures are reviewed for reasonableness to assure that grant dollars are being spent on qualifying services.

AMH certifies substance abuse and problem gambling prevention, and residential and outpatient treatment programs that have met requirements set by the Oregon Administrative Rules. The OARs require that individuals providing problem gambling and addiction prevention and treatment services be certified and board licensed. The Quality Improvement and Certification Unit at AMH is responsible for conducting site reviews to monitor compliance of LMHAs and treatment service providers with state regulations. AMH develops quarterly performance measures at the county and provider levels. These indicators are designed to assess access to services, retention, and treatment outcomes relative to levels of need for services. Observations are shared quarterly with local committees and contractors. Contractors with a less than satisfactory performance are requested to take corrective action and will receive technical assistance as needed.

AMH provides funding to Community Mental Health Providers (CMHPs) and the Tribes specifically for uninsured and underinsured individuals. Through the Biennial Implementation Plans, LMHAs and one Tribe describe how block grant resources and other agency funding are used to pay for non-covered services. Currently, OWITS is the Contracts Management and optional electronic health records system that monitors payor sources and encounter data to determine who accesses publicly funded services. In the future, payor source and encounter data will be collected through MOTS (Measures and Outcomes Tracking System) which is the data collection system being developed. MOTS also provides an electronic health record system as an option for providers to use. The client's primary health insurance will be identifiable by entries for payor source.

MHBG

Approximately 70 percent of the Mental Health Block Grant funds awarded to the state are disbursed to the Local Mental Health Authorities (LMHAs), or the LMHA's designee, to provide outpatient mental health services for uninsured adults with serious mental illness and children with serious emotional disorders and their family members. These funds are included in the flexible funding awarded to each LMHA. LMHAs will have increased flexibility in the allocation and use of these funds²⁸ to address the specific needs of their local community.

²⁸ Restrictions on the use of Mental Health Block Grant funds are included in the County Financial Assistance Agreements as well as the amount of MHBG funds awarded to the LMHA. The CFAA requires the LMHA to comply with all Federal Regulations related to the acceptance and use of those funds.

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With increased flexibility and local control of resources, LMHAs will also be accountable for their performance on outcomes. LMHAs are required by Oregon law to submit biennial implementation plans (BIPs) to AMH²⁹. These BIPs are an essential part of the AMH System Change efforts enabling service providers to better serve individuals in their communities who need behavioral health services.

Revisions to the BIP preparation and submission process for the 2013-2015 contract period creates a mechanism for the LMHAs to articulate the service needs of their communities and plans to meet those needs. Additionally, the BIPs will provide invaluable information and data for statewide service planning efforts³⁰ (see Step 2 for further information on BIPs). This process will also produce meaningful plans designed to help the LMHAs achieve the desired outcomes and appropriately track their flexible funds.

When an LMHA's BIP has been approved by AMH, it is included as an attachment to the County Financial Assistance Agreement (CFAA). The CFAA also requires the submission of semi-annual financial reporting by funding source.

Encounter data, gathered through COMPASS (see Step Two), will capture insurance coverage data for each individual enrolled in publicly-funded behavioral health services. This will allow AMH to identify client level service data (e.g. service type, units of service, etc.) by insurance coverage type. This will also allow for AMH to identify the number of individuals without insurance that were served as well as the types of services provided and the number of service units provided. Service utilization reported in COMPASS will be compared to the semi-annual financial reporting required through the CFAAs discussed above to ensure alignment between service utilization for individuals without insurance coverage and the expenditures reported by funding source.

AMH staff will work closely with Office of Health Analytics staff to analyze data collected through COMPASS to ensure alignment between the LMHAs' biennial implementation plans and actual service utilization and expenditures. AMH staff will be available to provide training and technical assistance to LMHAs and private, non-profit providers to address service needs and gaps.

The approximately 30 percent of Mental Health Block Grant funds remaining are termed "discretionary funds". These funds are split between the adult and children's mental health system 65/35 respectively. Discretionary funds are currently used to support innovative practices and peer delivered services. The program staff responsible for these projects ensure program integrity through expenditure and utilization reports as well as site reviews.

²⁹ Except for Central Oregon counties subject to the Regional Health Improvement Plan (RHIP) as identified in Oregon Laws 2011, SB204, Sections 13-20. The components of the RHIP are identified in OAR 309-014-0320.

³⁰ The Addictions and Mental Health Planning and Advisory Council (AMHPAC) will utilize the BIPs to fulfill their duty to assess the adequacy and allocation of [behavioral] health services statewide.

Use of Evidence in Purchasing Decisions

AMH is committed to the use of evidence-based and promising practices. In the 2003 Oregon Legislative Session, Senate Bill 267 passed which required a stepped approach to implementing and purchasing evidence-based services for specific populations: individuals with substance use disorders who are involved in the criminal justice system; individuals who have been court-committed for treatment due to mental illness; and children and adolescents with severe emotional disorders receiving intensive, integrated community services. Seventy-five percent of public funds used to support these populations were required to be spent on evidence-based practices.

AMH defines evidence-based practices as programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence and the values of the people receiving the services. These programs or practices will have consistent scientific evidence showing improved outcomes for clients, participants or communities. Evidence-based practices may include individual clinical interventions, population-based interventions, or administrative and system-level practices or programs.

Population-based services are programs or services that work at the community level with civic, religious, law enforcement, and other government organizations to reduce risk factors for mental health and substance abuse problems. Substance abuse prevention programs that enhance anti-drug norms and pro-social behaviors are an example. Fidelity to the evidence-based structure, content and delivery of population-based programs will result in specific, intended, and measurable outcomes, such as reduction in drug abuse in the targeted population.

Administrative or service delivery system practices are clearly defined organizational models that, in combination with clinical interventions, produce specific, intended, and measurable outcomes. The type of scientific evidence applicable to these distinct categories may vary and AMH will apply the following evidence continuum to identify and promote evidence-based practices and programs in all the categories described above.

The research basis for clinical, administrative and population-based practices can be placed on an evidence continuum ranging from multiple studies using randomized assignment of patients in clinical settings to no evidence that supports the efficacy or efficiency of the practice. The following describes the levels of evidence that can be considered benchmarks along such a continuum. Each level defines the degree of evidence that a practice needs to be placed on the continuum.

Evidence-Based Practice Levels:

- I. A prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both clinically controlled and real world settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and

effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice.

- II. A treatment or prevention service that is sufficiently documented through research studies (randomized controlled studies or rigorously conducted and designed evaluations). It is not necessary that research has been conducted in both a controlled setting and a routine care setting. The elements of the practice are standardized and have been demonstrated to be replicable and effective within given settings and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool or some other means, such as a quality review based on a manual definition of the practice that defines the essential elements of the practice.
- III. A practice or prevention service based on elements derived from Level I or II practices. The practice has been modified or adapted for a population or setting that is different from the one in which it was formally developed and documented. Based on the results of the outcomes, elements of the service are continually adapted or modified to achieve outcomes similar to those derived from the original practice. Practices difficult to study in rigorously controlled studies for cultural or other practical reasons but have been standardized, replicated, and achieved consistent positive outcomes will also be considered for Level III. Given these conditions, research published in an appropriate peer reviewed journal is still required.

Non Evidence-Based Practice Levels:

- IV. A treatment or prevention service or practice not yet sufficiently documented and/or replicated through scientifically sound research procedures. However, the practice is building evidence through documentation of procedures and outcomes, and it fills a gap in the service system. The practice is not yet sufficiently researched for the development of a fidelity tool.
- V. A treatment or prevention service based solely on clinical opinion and/or non-controlled studies without comparison groups. Such a service has not produced a standardized set of procedures or elements that allow for replication of the service. The service has not produced consistently positive measured outcomes.
- VI. A treatment or prevention service which research evidence points to having demonstrable and consistently poor outcomes for a particular population.

Operational Matrix for Levels of Evidence (see information in matrix; changes are under research and fidelity scale):

	Level	Transparency	Standardization	Replication	Research	Meaningful Outcome	Fidelity Scale
Evidence-Based Practices	I	Yes	Yes	Yes	>=2 studies in peer reviewed journal. Minimum of one study should be based on a randomized control trial.	Yes	Yes
	II	Yes	Yes	Yes	>=2 studies in peer reviewed journal. Studies should be at least quasi-experimental.	Yes*	Developing or No
	III	Yes	Yes	Yes	>=2 studies in peer reviewed journals. Less rigorously controlled studies will be considered.	Yes*	No
Non Evidence-Based Practices	IV	Yes	No	No	0-1 studies	Yes	No
	V	No	No	No	None	No	No
	VI	Yes	Yes	Yes	None	No	No

*Prevention services that can be described as environmental and/or community-based process strategies are waived from the need to demonstrate client level outcomes, as long as research is available to support the process as an effective way to plan for the implementation of specific prevention strategies in the community.

The following is a list of evidence-based practices employed by providers funded through the County Financial Assistance Agreements. For further description of some of these services, please see Step One.

- 12-step Facilitation
- Acceptance and Commitment Therapy
- Across Ages
- Active Parenting of Teens
- AI's Pals: Kids Making Healthy Choices
- All Stars
- American Indian Life Skills Development
- American Society of Addiction Medicine Patient Placement Criteria 2nd Edition Revised (ASAM PPC-2R)
- Applied Suicide Intervention Skills Training (ASIST)
- ATLAS (Athletes Training and Learning to Avoid Steroids)
- Assertive Community Treatment (ACT)

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- Behavioral Couples (Marital) Therapy
- Behavioral Therapy for Adolescents
- Behavioral Therapy/Nicotine Replacement Therapy
- Beyond Trauma/Helping Women Recover
- Big Brothers/Big Sisters of America
- Border Binge-Drinking Reduction Program
- Brief Alcohol Screening and Interventions for College Students (BASICS)
- Brief Strategic Family Therapy (BSFT)
- Buprenorphine
- California Smoker's Helpline
- Cannabis Youth Treatment
- CASA START
- Cognitive Behavioral Therapy (CBT)
- CBT for Childhood Anxiety Disorder
- CBT for Cocaine Abusers
- CBT for Depression in Adolescents
- CBT for Schizophrenia and Other Psychotic Disorders
- CBT for Substance Abuse
- CBT - Project Match
- CBT - Trauma Focused
- CBT-CSA - Cognitive Behavioral Therapy for Child Sexual Abuse
- Challenging College Alcohol Abuse
- Child Development Project (CDP)
- Child-Parent Psychotherapy
- Child-Parent Relationship Therapy/Filial Therapy
- Children in the Middle
- Children of Divorce Intervention Program (CODIP)
- Class Action
- Cognitive Retraining/Remediation/Rehabilitation
- Collaborative Problem Solving (CPS)
- Commit to Quit
- Common Sense Parenting
- Communities Mobilizing for Change on Alcohol (CMCA)
- Community Reinforcement Approach (Adolescents)
- Community Reinforcement Approach with Vouchers
- Community Trials Intervention to Reduce High-Risk Drinking (RHRD)
- Communities That Care
- Consumer Run Drop-in Centers
- Contingency Management (w/o community reinforcement)
- Coping Power
- Coping with Work and Family Stress
- Creating Lasting Family Connections (CLFC)
- DARE to Be You (DTBY)
- Dialectical Behavioral Therapy (DBT)

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- DBT for Adolescents
- DBT for Adults
- DBT for Substance Abuse
- Drug Court
- Early Assessment and Support Alliance (EASA)
- Early Risers: Skills for Success
- East Texas Experimental Learning Center
- Enough Snuff
- Eye Movement Desensitization and Reprocessing (EMDR)
- Families and Schools Together (FAST)
- Families That Care: Guiding Good Choices (GGC)
- Family Advocacy Network Club (FAN)
- Family Development Research Project
- Family Effectiveness Training (FET)
- Family Matters
- Family Psychoeducation
- First Steps to Success
- Friendly PEERsuasion
- Functional Adaptation Skills Training (FAST)
- Global Appraisal of Individual Needs
- Good Behavior Game
- Greater Access to EAPS (GATE)
- Healthy Workplace
- Helping Women Recover/Beyond Trauma
- High-Scope Perry Preschool Program
- Home-Based Behavioral Systems Family Therapy
- Houston Parent-Child Development Program
- Illness Management and Recovery
- Impact of Drinking Age Law
- Improving Mood Promoting Access to Collaborative Treatment (IMPACT)
- Incredible Years
- Individual Drug Counseling
- Individual Placement and Support (IPS) Supported Employment
- Integrated Dual Diagnosis Treatment
- International Center for Clubhouse Development
- JOBS Program
- Keep a Clear Mind (KACM)
- Keepin' it real
- Kentucky Adolescent Tobacco Prevention Project
- Leadership and Resiliency Program (LRP)
- Legal Blood Alcohol Level (effects of Maine's .05% limit)
- Life Skills (Botvin)
- Lions-Quest Skills for Adolescence
- Loving Touch, Parent-Infant Massage Program

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- Matrix Model
- Medication Management
- Message Framing
- Moral Reconciliation Therapy
- Motivational Enhancement Therapy (MET)
- Motivational Interviewing (MI)
- Multidimensional Family Therapy
- Multidimensional Treatment Foster Care
- Music Therapy- Dementia and Geriatrics
- Non-violent Crisis Intervention Training Program
- Not on Tobacco
- Nurse-Family Partnership Program
- Olweus Bullying Prevention
- Oregon Social Learning Center Treatment Foster Care
- Outcome-informed Psychotherapy
- Outpatient Treatment with Synthetic Opioid Replacement Therapy (Methadone)
- Parent-Child Interaction Therapy (PCIT)
- Parenting Wisely
- Parent Management Training
- Partnership for Health
- PATHS: Promoting Alternative Thinking Strategies
- Pathways to Change
- Permanent Supported Housing
- Physicians Counseling Smokers
- Positive Action (PA)
- Prepare/Enrich Program
- Project ACHIEVE
- Project ALERT
- Project EX
- Project Northland
- Project STAR: Students Taught Awareness and Resistance
- Project SUCCESS
- Project Toward No Drug Abuse (TND)
- Projects Toward No Tobacco Use (TNT)
- Project Venture
- Protecting You/Protecting Me
- Reconnecting Youth (RY)
- Relapse Prevention
- Residential Student Assistance Program (RSAP)
- Resolving Conflict Creatively Program (RCCP)
- Responding in Peaceful and Positive Ways - RiPP
- Rural Educational Achievement Project
- SAFE Children: Schools and Families Educating Children
- Safe Dates

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- School Violence Prevention Demonstration Program
- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Second Step
- Seeking Safety
- Sembrand
- Salud
- Seven Challenges
- Skills, Opportunities and Recognition (SOAR)
- SMART Leaders
- SMART Team: Students Managing Anger and Resolution Together Team
- Smoking Prevention Mass Media Intervention
- Social Competence Promotion Program for Young Adolescents (SCPP-YA)
- Solution-Focused Brief Therapy
- SSI/SSDI Outreach, Access and Recovery (SOAR)
- Start Taking Alcohol Risks Seriously (STARS) for Families
- Stopping Teenage Addiction to Tobacco (STAT)
- Strengthening Families Program (SFP)
- Strengths Model of Case Management
- Supported Education
- Support for at-Risk Children
- Teaching Students to Be Peacemakers
- Team Awareness (for the Workplace)
- Therapeutic Communities
- Tobacco Policy and Prevention (TPP)
- Too Good for Drugs (TGFD)
- Too Good for Violence
- UCLA Social and Independent Living Skills Modules
- Wellness Outreach at Work
- Wraparound

The following is a list of currently approved Tribal Best Practices.

- Adventure Based
- Basketball Against Alcohol and Drugs (B.A.A.D.)
- Canoe Journey/Family
- Ceremonies and Rituals
- Cradle Boards
- Cultural Cam
- Domestic Violence Group Treatment for Men
- Family Unity
- Healthy Relationship Curriculum
- Horse Program
- Native American Community Mobilization
- Native American Story Telling
- Positive-Indian Parenting

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- Pow-wow
- Round Dance
- Sweat Lodge
- Talking Circle
- Tribal Crafts
- Tribal Family Activities
- Tribal Youth Conference

Additional information can be found on the Addictions and Mental Health web site at <http://www.oregon.gov/oha/amh/pages/ebp/main.aspx>.

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Quality

Oregon is focusing on indicators (see Attachment #2 for state funded services under the CFAA, and Attachment #3 for Medicaid funded services under the Coordinated Care Organizations) in 3 priority areas:

1. Access- Number of individuals served
2. Treatment Service Engagement- receipt of two or more services within 30 days of initiation date of services out of the number of individuals with an index service state (no services in prior 60 days)
3. Facility-based care follow-up, measuring the percentage of individuals with follow-up visits within 7 days after 1) hospitalization for mental illness; or 2) any facility-based service defined as residential.

Coordinated Care Organization quality measures are attached, and also look at follow-up care after hospitalization, and for children prescribed ADHD medications, screening using SBIRT, and screening for clinical depression/follow-up plan. Additional measures are listed on the attached accountability metrics.

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Trauma

Oregon has had a trauma policy in place since 2006 (Attachment #4). Recent recommendations from the Children's System Advisory Committee include an updated revision of this policy which is in progress. Until recent amendment, the Integrated Services and Supports Rule required trauma screening at the time of initial assessment. While no longer required, trauma screening is an essential part of good clinical assessment for both mental health and addictions treatment.

The Children's System Advisory Committee had Trauma Informed Services and Supports as a major workgroup focus during 2012 and an Issue Brief was approved by the Committee in February, 2013. The Issue Brief is included as Attachment #5 and has extensive recommendations for the Addictions and Mental Health Division for the implementation of a trauma informed service system. Recent budget constraints have been a significant barrier to moving forward with trauma informed workforce development, and support for evidence based trauma specific intervention training for providers. The Issue Brief outlines several suggestions that would remediate this, including use of online training resources, dissemination of regional resources for training, and suggestions for a marketing campaign to increase awareness overall of the impact of trauma on social services clients across agencies, and to begin to address gaps in knowledge and services.

Additionally, the Division has been working across systems and agencies to address trauma approaches systemically, including use of The Adverse Childhood Experiences Study research in guiding a trauma-informed health care system, and working within the Children's Health Care Policy Team to move trauma informed services and supports to the forefront of health care innovation under health system transformation.

The Youth Services Survey for Families and the Adult Consumer Survey have been amended to inquire of consumers/families as to whether or not they/their child were screened for trauma, and if there had been trauma, whether it was adequately addressed in treatment.

Oregon is also focusing extensively on pediatric psychotropic medication prescribing practices for children in child welfare foster care and developmental disabilities populations to hone in on excessive, inappropriate prescribing, lack of appropriate monitoring and lack of mental health services in conjunction with psychotropic medication prescriptions. These vulnerable populations are also likely to have experienced trauma and will benefit from mental health services and more appropriate attention to prescribing and monitoring practices.

Health Disparities

Oregon's Senate Bill 2134 is being heard in the current legislative session. The bill requires Department of Human Services (DHS) and the Oregon Health Authority (OHA) to establish uniform standards in the collection of Race, Ethnicity, and Language data. The data collection standards used by state agencies are inconsistent and insufficient to adequately assess the status and needs of Oregon's communities of color, and immigrant and refugee communities. Inadequate data collection standards make it difficult to analyze how race, ethnicity and language impact individual and community health, making services more expensive and less effective in addressing community needs. Improved data collection supports more effective interventions to address persistent disparities and protects public entities from liabilities arising from violation of civil rights laws. Improvements in data collection standards are needed to ensure state of the art, efficient, uniform and consistent data collection by race, ethnicity and preferred language.

Currently, AMH collects race, ethnicity, and language data available through CPMS and OWITS. This data is used to inform current efforts to assure health equity within AMH. Please see Step 1 for detail in how AMH has shared the data with its communities of color.

The AMH Behavioral Health Equity Workgroup has a plan that targets the following areas of work that meet the goal to eliminate health disparities among vulnerable subpopulations:

- Provide support and technical assistance for the AMH System Change for Biennial Implementation Plan in reviewing county plans and outcomes data.
- Provide AMH measures to the Office of Equity and Inclusion for the State of Equity Report III reflecting behavioral health services regarding the need for services, access to services and programs, customer service quality and related outcomes by race, ethnicity and language.
- Provide technical assistance and support in responding to the Secretary of State Audit of the Children's Mental Health System.
- Provide technical assistance and support to the AMH Planning and Advisory Council (AMHPAC).
- Provide technical assistance in the development of policies, procedures and rules related to health equity.
- Support technical assistance to CCO Innovator for individuals receiving behavioral health services.

Deliverables will include:

- Produce Cultural Health Promotion FACT Sheet;
- Produce survey that measures agency engagement in cultural health promotion; and
- Produce metrics for the State of Equity Report III

AMH will use the Biennial Implementation Plan (BIP) to inform agency processes responsible for statewide planning. The BIP is the reporting tool used to inform AMH regarding how block grant funds are spent in providing services. Counties, contractors, and tribes must provide AMH with a description of their system, planning process, strengths and needs assessment, core accountability measures, transformation/transparency measures and budget information that address access, retention, and outcomes for specialty and vulnerable populations. The plan must give specific examples on how these populations are prioritized and the role of the Local Mental Health Authority and any sub-contractors in the delivery of addictions and mental health services.

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Consultation with Tribes

AMH has dedicated staff that serve as Tribal Liaisons to the nine federally recognized tribes. Tribal liaisons are present for tribal functions to continue building understanding and rapport with Native American communities. The liaisons listen for concerns, answer questions; assist in removing barriers, and look for opportunities to provide improved or additional services to the tribes. AMH staff solicits assistance and guidance from the liaisons to ensure that cultural considerations and tribal voices are included in planning efforts around substance abuse and problem gambling prevention, addictions treatment, and mental health.

Senate Bill 770, passed by the Oregon Legislature in 2001 enacted a Government-to-Government relationship between the State of Oregon and each of the nine Tribal Governments. AMH meets this statute by consulting with the nine tribes on a quarterly basis at the SB 770 Health Services Cluster, participating in an annual Tribal Relations cultural training, and communicating with tribal staff on a regular basis.

Federally recognized tribes in Oregon are Sovereign nations, and therefore not required to go through the local community mental health authority in order to access mental health services off the reservation. Adjustments have been made in the Oregon Administrative Rules (OARs), and contract language has been modified to ensure direct access to treatment and to better meet the cultural needs of Oregon tribes.

Regarding alcohol and drug services, Tribal Governments are not required to get their biennial plan approved by an LADPC (Local Alcohol and Drug Planning Committee); these plans are approved by the Tribal Council, the Tribal Health Department, or through an entity authorized by the Tribal Council.

The Addictions and Mental Health Division is committed to providing culturally appropriate services to Native Americans in Oregon, and therefore supportive of Tribal Best Practices. Tribal Best Practices are cultural and traditional practices that have been reviewed and approved by a panel of scientific researchers, prevention and treatment practitioners and program managers across the state

Data and Information Technology

Client-level Data

AMH envisions a comprehensive behavioral health electronic data system to improve care, control cost and share information. The data system improvement project is called COMPASS and allows AMH to collect unique client-level data to comply with the Treatment Episode Data Set (TEDS) and National Outcome Measures (NOM) requirements.

The new system will allow AMH to meet business needs and requirements and will provide data that more readily supports the ability to track:

- Performance outcomes associated with services;
- Who accesses services, what services are provided, where and when; and
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

The components of the COMPASS project include:

- AMH's OWITS Behavioral Electronic Health Records (EHR): OWITS is available to all publicly funded behavioral health providers or required reporters (ex: DUII, methadone or detox providers) free of charge. The advantage of using the OWITS EHR is that agencies will no longer need to submit CPMS data to AMH. AMH will automatically pull all required data from the system and ensure that all data requirements are included within the system. Timeline: Currently implementing.
- Electronic Data Capture: This is the electronic exchange of data with AMH. There will be three methods for data submission: OWITS EHR; Electronic Data Interchange/Transfer from existing EHRs; or a Web Minimum Data Entry tool. All the data will be stored in an operational data store called the Measures and Outcomes Tracking System (MOTS). Timeline: Begin accepting data July 2013.
- AMH Contracts and Payments System: This new system and processes will streamline contracts and billing by moving to a web-based electronic process. AMH will better track funding streams and reduce the number of contract amendments. Timeline: Implement July 2013.

Information Technology Systems

Data on persons with behavioral health disorders and the services they receive are collected and stored in three primary databases:

1. The **Medicaid Management Information System (MMIS)** provides information on individuals who receive health insurance benefits under Oregon Health Plan (OHP) and other Medicaid services. In December 2008, Oregon replaced its MMIS system with a new MMIS system to collect Medicaid services data. After experiencing some problems in implementation, the new MMIS is functioning and providing appropriate data for Medicaid covered services.
2. The **Client Process Monitoring System (CPMS)** contains episodic records of care in community mental health programs and intensive treatment programs. It

is the source of many of the NOMs and TEDS data providing information such as: basic demographics, length of stay, reduced use, successful treatment completion and basic utilization of services. CPMS is submitted on various standardized electronic forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode. This system is due to be replaced by July 2013 with a more sophisticated system that will better meet AMH's business needs and provide better information for the analysis of individual and system outcomes and performance. This new system is called the Measures and Outcomes Tracking System (MOTS).

3. The **Oregon Patient/Resident Care System (OP/RCS)** includes records for all publicly funded psychiatric inpatient care delivered in the State Hospitals and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment. This system will be replaced by Netsmart Avatar and by MOTS by the end of 2013.

Each of these systems contains unique client level identifiers. The Program Analysis and Evaluation Unit uploads data from each of the systems to a central SQL server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

Current efforts to assist providers with developing and using EHRs

WITS (Web Infrastructure for Treatment Services) is a web based open source software system that is made available to Behavioral Health Treatment providers in Oregon by AMH. The system has been tailored for use in Oregon and is called OWITS (Oregon Web Infrastructure for Treatment Services). This system is designed to meet the growing needs of capturing patient treatment data and satisfy mandatory government reporting requirements for the planning, administration, and monitoring of Behavioral Health Treatment Programs. WITS was originally developed and sponsored by a SAMHSA's Center for Substance Abuse Treatment (CSAT) project in 2001.

- There are currently 22 states currently using or implementing WITS nationwide.
- This includes more than 1,200 providers and over 20,000 users who are using the WITS system nationally.
- Close to 1 million clients are being served through the use of the WITS system.

One of the major components of OWITS is an electronic health record system (EHR). The purpose of OWITS EHR is to provide software that facilitates cooperation and collaboration across treatment providers by enabling the sharing of client treatment information (within the constraints of HIPAA and 42 CFR regulations).

Staff continues to expand and modify the OWITS EHR system to specifically meet Oregon's needs. Initially, eleven providers piloted the system in 2011- 2012. Currently,

16 additional providers are in the process of being trained and implementing the OWITS EHR. The plan is to implement in waves of eight to ten agencies at a time. Each wave will last two months.

In December 2011, WITS received the Office of the National Coordinator (ONC) Meaningful Use Certification as a "Complete EHR technology" in an ambulatory setting.

Federal health care reform will require electronic health records (EHR) to be associated with all billing for Medicaid and Medicare services by 2014. Additionally, current State legacy systems have become antiquated and lack integration among internal systems, which adversely affects AMH's ability to meet our business needs, health information technology business needs, and the goals of health system transformation. This new system will automatically submit/transfer required data elements to AMH and an agency that uses the OWITS EHR will no longer need to submit CPMS or OPRCS data.

There is no cost to use OWITS EHR other than provider's staff time for training, agency set up and business transition. This system is available to mental health and substance abuse providers who receive public funding or required reporters (such as DUII and methadone treatment providers). There is an OWUG (OWITS EHR User Group) meeting monthly to allow for an open forum discussion on the use and maintenance of the OWITS EHR.

Through the COMPASS project, AMH is developing a system that will allow providers to transfer data from their existing EHR to AMH in order for an agency to meet the AMH data submission requirements.

Identification of barriers in moving to an encounter/claims based approach to payment; and

This is handled by the DMAP MMIS staff. AMH does not pay on a fee-for-service basis via encounters/claims submitted.

Specific Technical Assistance needs: There may be a need for AMH to better understand how an evolving data system designed to capture not only the episodic data, but to also capture the transition between services can still adhere to the TEDS and NOMS requirements around admissions and discharge data sets.

Suicide Prevention

Oregon's suicide prevention efforts primarily target youth and young adults, with the formation of a comprehensive plan to address suicide as the second leading cause of death for 10-24 year olds, (please see Attachment #6 "*A Call to Action, The Oregon Plan for Youth Suicide Prevention*").

Data in Oregon and nationally shows that higher suicide rates exist in the adult population and in sub-groups such as: LGBTQI2-S, Veterans, and Native Americans/Alaska Natives. Therefore, AMH revised the Community Mental Health Program Biennial Implementation Plan to include a section that specifically targets suicide prevention. Each CMHP will develop a plan that may include: suicide prevention, early identification, referral to treatment, and follow-up.

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