

**Oregon's 2012 Combined Community
Mental Health Block Grant and
Substance Abuse Prevention and
Treatment Block Grant Application**

**Please send any comments on the application to:
Marisha Johnson, Mental Health Planner & Supportive Services Coordinator
at
Marisha.L.Johnson@state.or.us**

2012 Combined Block Grant Application

Step One:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between the child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Organizational Structure

The Addictions and Mental Health Division (AMH) of the Oregon Health Authority (OHA) serves as the single state agency for behavioral health. The state is required by Oregon Revised Statute (ORS) 430.640 to establish a contractual relationship with every Community Mental Health Program (CMHP) in each county, or Native American Tribe on request of the Tribe, to assure the provision of community mental health and addictions services. Counties have the first right of refusal to directly provide services or subcontract the services. State funds for nonresidential services are allocated to counties using a method of allocation which provides the greatest flexibility for counties or community mental health programs in managing resources to best meet the needs of county residents. AMH currently contracts with 33 counties or consortia of counties covering the 36 Oregon counties, one community mental health program and nine federally recognized tribes.

Mental health services for people who are enrolled in the Oregon Health Plan (OHP) are administered through contracts between AMH and Mental Health Organizations (MHOs). The MHOs provide a full continuum of services to children with serious emotional disorders and adults with serious mental illness who are enrolled in OHP. The MHOs are required by contract to meet the needs of these individuals for medically appropriate mental health services. The MHOs provide mental health services directly through the CMHP or a contract entity under approval of the CMHP and AMH. All other non-capitated services are administered through contracts with the counties, direct contracts with service providers for regional or statewide services and a small number of residential programs.

Fully Capitated Health Plans (FCHPs), which provide alcohol and drug treatment services (excluding residential treatment) for those eligible for Medicaid and enrolled in the Oregon Health Plan (OHP), are required by contract to mandate that providers see members in the same day for emergency care. Contractors shall comply with the following access requirements:

- OHP eligible members shall be seen:
 - the same day for emergency chemical dependency treatment care;
 - including pregnant women, within 48 hours for urgent chemical dependency care; and
 - including intravenous drug users, within 10 days or the community standard for routine chemical dependency treatment care.

2012 Combined Block Grant Application

Oregon provides services to prevent and/or treat the problems created by addictions, including problem gambling. Services include acute care treatment, outpatient treatment, residential treatment, detoxification, case management, supportive housing, supported employment and peer and family-delivered support services.

Counties are required to develop comprehensive implementation plans each biennium outlining how they will deliver services along the continuum of care for all population groups. The local mental health authority shall determine the need for local behavioral health services and adopt a comprehensive local plan for the delivery of behavioral health services for children, families, adults and older adults that describes the methods by which the local mental health authority shall provide those services. The purpose of the local plan is to create a blueprint to provide behavioral health services that are directed by and responsive to the behavioral health needs of individuals in the community served by the local plan. As part of their biennial implementation plan each CMHP documents how local beer and wine tax and other revenue sources are used to maintain a level of effort to match funding provided by AMH for prevention, treatment and recovery services. The plans result in contracts that outline specific funding amounts for each service type. Residential services are funded and paid for in terms of bed days. Should a subcontractor within a county not meet utilization criteria, counties may shift resources to other providers in order to meet utilization criteria.

The Addictions and Mental Health Division is located within the newly created OHA. OHA reports directly to the Governor and is composed of the following program areas:

- Addictions and Mental Health Division;
- Division of Medical Assistance Programs (state Medicaid agency);
- Public Health Division;
- Office of Private Health Partnerships;
- Office for Oregon Health Policy and Research;
- Oregon Educators Benefit Board;
- Public Employees Benefit Board;
- Oregon Medical Insurance Pool (high risk pool);
- Family Health Insurance Assistance Program; and
- Oregon Prescription Drug Program.

In June 2011, with the leadership of Governor Kitzhaber, the Legislature passed House Bill 3650 that will create a statewide system of Coordinated Care

2012 Combined Block Grant Application

Organizations (CCOs). These organizations will manage all of the health care for OHP members in their communities. These organizations will combine the work currently being done by the FCHPs and the MHOs and expand upon it. The CCOs will be used to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care. These new organizations will provide Medicaid recipients with physical and behavioral health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities. This health reform effort will have a dramatic impact on the delivery of behavioral health services for Oregonians.

AMH has embarked on a parallel course to change the administration of the non-OHP funded addictions, mental health and prevention system. AMH intends to develop global budgets that permit increased flexibility to deliver services that improve outcomes. Increased accountability will be achieved through contracted performance outcome measures. AMH is working on an aggressive timeline, with a target for establishing the framework for global budgeting and outcomes-based management for services not covered by the Oregon Health Plan by July 1, 2012.

A key feature of both the OHP and non-OHP systems will be a move to a more flexible and accountable budgeting structure that rewards prevention and early intervention by compensating providers based on measurable outcomes rather than the quantity of services provided.

Agency Leadership

AMH has been an instrumental leader in the design and development of the Oregon Health Authority. AMH has been an active advocate in the integration of physical health care and behavioral health care services that are consumer, family member and youth-driven.

Oregon's Integrated Services and Support Rules (Oregon Administrative Rules (OARs) 309-032-1500 through 309-032-1565) establish standards for community mental health and addictions services. The AMH Quality Improvement and Certification Unit is responsible for certification and licensure of provider organizations to assure compliance with OARs and state laws. Certificates of Approval are issued to CMHPs and sub-contracted providers, children's psychiatric day treatment, and nationally accredited psychiatric residential treatment facilities for children, inpatient psychiatric acute care programs, psychiatric hold rooms used for seclusion and restraint, and residential substance

use disorder treatment. Licenses are issued to Residential Treatment Facilities and Adult Foster Homes serving adults with mental illness.

The Mental Health Planning and Management Advisory Council

The Mental Health Planning and Management Advisory Council (MHPAMAC), which serves as the statutorily required State mental health planning council, meets bimonthly. Its responsibilities include:

- Advising AMH on mental health policies and programs for children, adolescents, adults and older adults;
- Facilitating effective cooperative working relationships among the components of the mental health system;
- Making recommendations regarding the identification, development and utilization of resources;
- Identifying problems and developing recommendations for resolution; and
- Serving as the Planning Council for purposes of monitoring, reviewing and evaluating the federally mandated state plan for mental health services.

MHPAMAC is moving towards becoming a behavioral health planning council. To ensure a smooth transition, a subcommittee has been formed to identify needed bylaw changes. The subcommittee will also develop recommendations as to the configuration of the Council. The subcommittee will begin meeting in August with the goal of having an operational behavioral health planning council within 12 months.

MHPAMAC has two working subcommittees: the Adult Services Advisory Committee (ASAC) and the Children's System Advisory Committee (CSAC). The subcommittees meet monthly and route recommendations to MHPAMAC for consideration and action.

ASAC Activities

This last year ASAC has spent considerable time on the following issues:

- **Guardianship:** ASAC has been tracking this issue since 2009. The 2009 Legislature approved the creation of a Public Guardian and Conservator Task Force. The Governor appointed a member of ASAC representing the "State Agency" category (specifically the Oregon State Hospital) to serve on the Task Force. ASAC receives regular updates of the task force meetings.

2012 Combined Block Grant Application

- **AMH Initiatives:** ASAC serves in an advisory capacity for three strategic planning initiatives which are discussed further later in this document. ASAC gives input and guidance on the following projects:
 - Integrated Services and Management Demonstration Pilots
 - Adult Mental Health Initiative (AMHI)
 - Peer Delivered Services
- **Warmline Funding:** AMH is utilizing block grant funding to support the David Romprey Oregon Warmline: a statewide peer-run resource. The Warmline uses trained peers to support callers. Currently the demand for statewide Warmline services exceeds capacity, and funding has been allocated to train more operators.

Children’s System Advisory Committee (CSAC)

The Children’s System Advisory Committee is a state level policy advisory group that is a subcommittee of MHPAMAC. Stakeholders from child welfare, education, juvenile justice, representatives from adolescent alcohol and drug treatment agencies, developmental disabilities, and other child-serving agencies, family advocacy organizations and youth/family members are integral participants in CSAC. This past year CSAC developed two Issue Briefs resulting in recommendations to AMH in addition to other activities.

The Integration of Physical and Mental Health Services Issue Brief recommended:

1. That AMH require a mechanism to involve primary care providers, school-based health clinics, pediatricians, rural health care clinics and Federally Qualified Health Centers on local and regional advisory committees.
2. That AMH encourage MHOs to discuss with their contractors the expectations that child and family team meetings incorporate the participation of physical health providers along with mental health specialists.
3. AMH is to promote health care integration for children and families with the DHS Core Integration Team and the Child Mental Health Task Force Team to ensure ongoing training in health care integration.

The Integration of Mental Health and Alcohol and Drug Services Issue Brief recommendations included:

1. AMH is to continue to support the training, education and peer delivered services that encourage the use of evidence-based programs with young adults as co-trainers supporting “harm reduction”.

2012 Combined Block Grant Application

2. AMH is to utilize existing alcohol and drug and mental health professionals and peers who have been trained in prevention curricula to disseminate accurate information and to train others within their communities. This will increase early identification and intervention, as well as increase capacity for referrals in schools and other community partners.
3. AMH is to establish and disseminate a set of core competencies necessary to deliver co-occurring treatment.

Substance Use Disorder Treatment Services

Substance use disorder treatment services also have a clear process for certification. All addiction treatment providers must receive a Letter of Approval from AMH certifying that they have met Oregon Administrative Rules. These include standards for: Outpatient Synthetic Opiate Treatment Programs, Alcohol Detoxification Centers, Outpatient and Residential Alcohol and Drug Treatment Programs, Recovery Homes, and Driving Under the Influence of Intoxicants (DUI) Information and Rehabilitation Programs. Within these standards are minimum requirements for assessment which assure compliance with the American Society of Addiction Medicine Patient Placement Criteria- 2nd edition revised (ASAM PPC-2R), treatment planning, changes in level of care, documentation and aftercare.

AMH requires that individuals be certified alcohol drug counselors (CADC) in order to provide addiction treatment. CADC certification is primarily provided by the Addiction Counselor Certification Board of Oregon and provides three levels of certification based on education, experience, and standardized testing. Prevention providers who receive Substance Abuse Prevention and Treatment (SAPT) Block Grant Prevention set-aside funds are required to comply with the OARs for the services. The OARs specify the requirements for the prevention provider to have a Certified Prevention Specialist (CPS) as the County or Tribal Prevention Coordinator. In 2011 AMH revised the OARs to expand the requirement for prevention staff primarily responsible for the delivery of prevention services to also have CPS accreditation. County and tribal programs have an on-site review every three years by an AMH Prevention Specialist to assure compliance with the OARs.

Quality Improvement staff conduct site reviews of mental health and addictions programs to ensure compliance with contract conditions and state regulations. This unit also approves individuals in the state to conduct investigations and examinations for civil commitment proceedings and for individual clinicians to authorize the use of seclusion or restraint for children in approved facilities. The

2012 Combined Block Grant Application

MHOs that are contracted to manage the mental health benefit of the Oregon Health Plan are also reviewed quarterly by the AMH Medicaid Policy Unit for contract compliance.

Each biennium AMH evaluates the addiction and mental health training needs in the state. AMH develops a plan to provide the training necessary to prepare the mental health and addictions workforce to deliver the services needed to carry out the statewide addictions and mental health initiatives. The AMH Prevention unit provides annual Substance Abuse Prevention (SAP) training for county and Tribal Coordinators and other prevention specialists. Approximately 30 to 40 prevention professionals participate in the SAP training annually. In addition to the SAP training, the AMH prevention unit, through a Center for Substance Abuse Prevention (CSAP) Technical Assistance award, is in the process of developing a comprehensive workforce development plan. The plan will include prevention workforce competencies and knowledge and skill sets necessary for the field. The CSAP assistance is being guided by a diverse senior prevention member task force. The technical assistance will result in a comprehensive plan for advancing the prevention workforce and determine if Certified Prevention Specialist graduated levels (CPS I, CPS II and CPS III) would be beneficial.

Children's Mental Health Workforce Development

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

AMH Children's Mental Health Services unit also partners with Oregon Family Support Network in developing 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, ChildTrauma Academy, and Parent Child Interaction Therapy workforce development projects.

Cultural Competency

The majority of the population in Oregon is Caucasian, with the remaining population being African American, Hispanic, Native American, Asian and other ethnic groups. OARs state that community mental health and addictions programs are to provide culturally competent services. AMH requires that information be provided to potential consumers, family members and allied agencies regarding the availability of materials in a multi-lingual format.

At the direction of the AMH management team, the AMH Cultural Competency Work Group was created and developed recommendations for the AMH Cultural Competency Plan (ACCP). The ACCP was developed in response to the Department of Human Services (DHS) Standards and Guidelines for Cultural Competency and Gender Specific Services, which were approved by the DHS Cabinet in September of 2003.

The purpose of the plan is to establish cultural competence standards, values, and policy requirements for AMH and all organizations and agencies that receive grant funds from, or that are under contract with AMH. This includes county social services organizations and their vendors or contractors, managed care organizations and their provider networks and community-based organizations. The intent for the plan is to serve as a planning document to assist AMH, County governments, and provider networks to develop and implement an individualized cultural competence plan as addressed in each County's biennial implementation plan, with its goal to enhance treatment outcomes for all consumers.

AMH has worked to promote access to culturally appropriate and responsive services for the needs of diverse racial, ethnic and sexual minorities. AMH routinely requires CMHPs to address cultural factors in organizational planning. To improve access to appropriate services, the Integrated Services and Supports Rule (ISSR) requires cultural factors be included as one of the domains of comprehensive clinical assessments for all persons enrolled in state-funded mental health treatment services. Further, MHOs and other Medicaid providers are required to provide appropriate translation services for adults, children and families who require them.

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. Oregon Health and Sciences University's (OHSU) Afro-Centric Program provides a mental health infrastructure and system of care that is culturally appropriate to

2012 Combined Block Grant Application

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 disorders within the African and African-American community. The Miracles Club, an African-American recovery housing project, supports individuals recovering from addictions. In addition, AMH collaborates regularly with all nine federally recognized tribes through contract to provide substance abuse prevention and addiction treatment services.

Parent-Child Interaction Therapy (PCIT)

In 2008, four counties were selected to develop the infrastructure for implementing Parent Child Interaction Therapy. 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; 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 the development of a local and statewide training program in PCIT.

As of midyear 2011, 16 therapists trained in PCIT are bi-lingual and/or bi-cultural. The total number of therapists trained to date in PCIT numbers 52. Sites provide outreach to multiple child and family serving agencies, including those that serve Hispanic/Latino families. Each county with the PCIT program has one or more “promotores”, community health workers, linking with the Hispanic community.

Between April 1, 2010 and March 31, 2011 the overall number of children and families served was 244. Of those served, 63 percent were boys. One site served boys and girls almost equally, possibly reflecting the increased identification of girls by therapists providing on-site mental health assessments for children involved in the child welfare system.

Three of the four sites met or exceeded their target proportion of children and families from the Hispanic/Latino population. 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 28 percent of the referrals.

The AMH Prevention unit has a dedicated specialist who develops and sustains working relationships with the nine federally recognized tribes in Oregon. The

2012 Combined Block Grant Application

specialist meets at least quarterly in a joint meeting with all nine tribes. The specialist also participates in Government-to-Government meetings. Of special note is the work of the nine tribes with the support of the AMH Prevention unit in developing Tribal Best Practices (TBP).

In 2003, based on legislation, Oregon adopted an Evidence Based Practice (EBP) requirement. Senate Bill 267 required that 75 percent of the funds to sub-grantees be spent on Evidence Based Practices. Many Native American practices did not meet the requirements of EBPs, therefore the AMH Tribal Liaison, Native American stakeholders (including researchers and providers) created Tribal Best Practices (TBPs). TBPs are cultural and traditional Native American practices that have been culturally validated over many generations. Many of these practices are also being scientifically validated with the help of CSAP's Service to Science Program, Native American Center for Excellence, OHSU, and many other organizations. This work respects and values differences among consumers, shares responsibility for addressing these differences, and measures the success in addressing cultural differences.

Gender Specific Services

AMH continues to revise and monitor administrative rules and contract provisions to assure gender responsive services. Oregon Administrative Rules 309-032-1500 through 1565 for Integrated Services and Supports include standards for gender considerations and require each county to have policies in place that provide for gender specific services.

AMH supports a network of women's residential addiction treatment programs; many also provide parenting training for women in treatment with their dependent children on-site to foster healthy attachment and bonding. AMH convenes annual meetings for these providers for training, networking and sharing innovation and ideas among the providers.

The evidence-based prevention program *Friendly PEERsuasion* is being utilized in six Oregon counties and is geared toward female adolescents. This effort is focused on reducing under age drinking rates for girls, especially middle school age youth.

Tribal Liaisons

AMH has dedicated two staff serving as Tribal Liaisons to the nine federally recognized tribes. Tribal liaisons are present for all tribal functions to continue building understanding and rapport with Native American communities. The liaisons listen for concerns, answer questions, problem solve barriers, and look for

2012 Combined Block Grant Application

opportunities to provide improved or additional services to the tribes. AMH staff solicit assistance and guidance from the liaisons to ensure that cultural considerations and tribal voice are included in planning efforts. Oregon Senate Bill 770 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, participating in an annual Tribal Relations cultural training, and communicating with tribal staff on a regular basis.

The Children's Mental Health Tribal Liaison has attended the System of Care conferences for two years as a partner with the Native American Rehabilitation Association (NARA) Nak-Nu-Wit grantee site. NARA provides services primarily to Urban Native American populations. Training opportunities in children's mental health have been provided to several tribes including their participation in Oregon's work with The ChildTrauma Academy. Access to residential mental health services has been modified to better meet the needs of Oregon's tribes. AMH is partnering and providing a resource for NARA in developing and actualizing their System of Care grant.

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 OARs and contract language has been modified to ensure direct access to treatment and to better meet the cultural needs of Oregon tribes.

Outpatient Adult Mental Health Services

Clients are provided with an array of outpatient services, including assessment and evaluation, individual and group therapy, medication management, case management, and daily support and skills training. Services for individuals experiencing acute psychiatric conditions include 24-hour crisis assistance, community-based respite care, sub-acute psychiatric care, and inpatient services. An innovative feature of the Oregon Health Plan is the flexibility providers have to develop individualized treatment and intervention strategies. Allowable treatments for covered mental health conditions include both traditional treatments and alternative services suggested by contractors, allowing for less costly, and more effective service delivery when appropriate. These services, coupled with residential placements where needed and other supportive services such as peer supports, supportive housing and supported employment and supported education, aid individuals with mental illness in maintaining their tenure and stability in the community.

Case Management and Rehabilitation Services

Case Management and Rehabilitation services in the state of Oregon have been part of the care available to adults with serious mental illness. In the past services have relied on traditional models of care. Research literature suggests that the traditional models have limited success in moving people to recovery and increased independence. In recent years, Oregon has promoted wellness and recovery models, and implementation of evidence-based practices (EBPs) as a more effective method of service delivery that results in improved progress for consumers and greater system accountability and performance. Rehabilitation services and case management services continue to be influenced by both EBPs and recovery modalities. There are many aspects to the case management process, as outlined in the OARs that have a focus on client participation and agreement as means to attain goals leading to recovery. Case Managers assist clients in:

- Resource acquisition (Social Security, food stamps, housing assistance, personal care services);
- Symptom management and recovery;
- Supported Employment and Vocational Rehabilitation Services;
- Development of personal crisis plans and Declarations for Mental Health Treatment;
- Active discharge planning in the event of a hospitalization; and
- Monitoring of health and safety needs relative to their housing environment.

Crisis services

Crisis services are provided by Qualified Mental Health Professionals and are available in all 33 CMHP regions, 24 hours a day, seven days a week. These services determined by the CMHPs include: staffed hotlines; crisis intervention; mobile crisis teams; drop in centers; and brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization.

Acute Psychiatric Inpatient Services

Oregon provides all acute psychiatric inpatient services in local community hospitals rather than in the state hospitals. The goal is to provide appropriate services to stabilize and treat the individual so that they can return to their community as quickly as possible. Inpatient psychiatric services are intended to provide intensive psychiatric services for individuals posing a danger to the health and safety of the individual or others. Oregon currently has approximately 280 acute beds for adults throughout the state. There are two units in the Portland metropolitan region serving children and adolescents comprising 41 beds.

Post Acute, Intermediate Treatment Services Programs (PAITS)

The PAITS program is a community-based, transitional, 16-bed secure residential program for adults. It was developed to offer individuals receiving acute psychiatric care the opportunity for continued rehabilitative services without an admission to a state hospital. Individuals who enter a PAITS program must have a discharge plan and their stay is typically limited to 90 days.

Psychiatric Hospitalization

Oregon has two state psychiatric hospitals; Blue Mountain Recovery Center (BMRC) located in Pendleton, Oregon, and the Oregon State Hospital (OSH) which has campuses in Salem and Portland. These hospitals serve as a vital part of the continuum of care for individual adults who need longer intensive treatment that can not be provided in acute care community hospitals.

Residential Services

Oregon has an array of adult residential services for individuals who are not able to be served in their own homes. Through five licensing designations and a wide variety of program designs, AMH serves almost 2,000 individuals in licensed community settings.

Enhanced Care Services (ECS)

ECS are a unique integrated treatment component of the residential system that are designed to meet the needs of adult individuals who are elderly or have a physical disability with a co-occurring mental illness. Individuals who have difficulty maintaining placements in traditional facilities or who are at risk of multiple transitions between facilities due to symptoms of their mental illness are eligible for ECS. Mental health professionals provide intensive rehabilitative mental health services while the individual lives in a community-based care facility licensed by DHS Seniors and People with Disabilities (SPD).

Assertive Community Treatment (ACT)

Oregon supports ACT services through Medicaid and through contracts with the CMHPs. Providers bill the State directly as a fee-for-service activity outside of the managed care benefit package provided by the MHOs. Oregon has 11 authorized providers of high fidelity ACT services. AMH has received claims or encounters for 437 people since January 1, 2008. The Adult Mental Health Initiative provided funding to the MHOs to support ACT services for individuals who are transitioning out of the state hospitals or licensed community settings.

2012 Combined Block Grant Application

Local CMHPs, through their contract with AMH, may provide, or contract for, ACT services. The service array available through the CMHPs is a local decision, made through a public planning process. This planning process prioritizes populations to be served (within statutorily required prioritization) and designs the local service continuum.

Supported Housing

AMH currently has 749 supportive housing units¹, of which 120 (16%) are scattered sites. AMH continues to invest in supportive housing units. However, rather than continuing to develop residential programs, AMH is providing resources to support individuals in their own homes. Oregon is in the process of working with Centers for Medicare and Medicaid Services on a 1915(i) Medicaid State Plan Amendment. Oregon's 1915(i) is designed to foster recovery for individuals receiving services; achieves administrative simplification for providers; and supports a more complete system of care. The 1915(i) option will allow Oregon to reimburse more directly for a wraparound model.

Olmstead Plan

Oregon's Olmstead plan seeks to improve the lives of Oregonians who experience severe and profound mental illness by improving the availability and quality of community-based mental health services.

Although 98 percent of Oregonians with mental health service and support needs are served outside the residential system, Oregon's Olmstead efforts are aimed at achieving the greatest amount of independence and integration for the greatest number of consumers. Recent efforts at achieving these goals have included the Adult Mental Health Initiative, which, in Phase I, transitioned nearly 500 consumers to lower levels of care, with 40 percent transitioning to their own homes, some for the first time in their adult lives. Other initiatives, such as the Division's Co-management policy, the Integrated Services and Supports Rule, adoption of a new residential rate setting methodology, and other efforts, have begun producing results toward the State's goal of providing consumers "with a key to their own front door".

The work toward achieving these goals is monitored by the Olmstead Implementation Committee, comprised of AMH staff and external partners such as MHOs, CMHPs, advocacy groups and consumers. This committee is responsible for assessing the mental health system in regards to integration and independence,

¹ AMH housing appraisal as of June 30, 2011

and making recommendations to AMH management regarding needed actions and policies necessary to achieve the intent of the 1999 Supreme Court Olmstead decision.

Supported Employment and Supported Education

Supported Employment:

AMH is committed to implementing evidence-based practices in mental health and addictions services, and has spent increasing shares of public dollars on evidence-based practices. Oregon has implemented high fidelity Individual Placement and Support (IPS) Supported Employment in 16 programs serving 16 of Oregon's 36 counties. Three additional programs serving another three counties are working to reach the high fidelity benchmark.

In collaboration with the Oregon Supported Employment Center for Excellence, AMH is working with the MHOs to expand IPS Supported Employment throughout the State. Another area of expansion that AMH is exploring is increasing IPS Supported Employment services to young adults in transition. Services are currently available to young adults age 18-25 within the adult mental health system. AMH has an enormous interest in expanding these services to young adults age 14-18 within the child labor laws. A significant accomplishment in this area is the start of an IPS component in the Early Assessment and Support Team's (EAST) Marion County program. EAST provides services to young adults in transition experiencing their first psychotic episode. EAST hopes to replicate the success of the IPS component in the other counties it serves.

Funding for implementing new IPS Supported Employment programs is a challenge, but Oregon is working to resolve this issue in innovative ways. First, Oregon allows high fidelity IPS Supported Employment programs to bill Medicaid on a fee-for-service basis. Oregon also allocated approximately \$917,000 in general funds for the 2011-2012 contract period for 13 of the existing IPS Supported Employment programs to provide services to indigent clients. In addition, the Office of Vocational Rehabilitation Services (OVRs) has developed contracts allowing providers of high fidelity IPS Supported Employment to bill OVRs for job development, job supports, and certain milestone payments including Ticket-To-Work payments.

In the 2009-2011 biennium, IPS Supported Employment services were provided to 1,551 individuals with an average employment rate of 39.5 percent. While the average age of IPS Supported Employment consumers was 40.8 years old, 9.6 percent of consumers were young adults in transition age 14-25 years old.

2012 Combined Block Grant Application

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. In the 2009-2011 biennium 218 persons with serious mental illness received Supported Education services allowing them the supports they needed to enter General Education Development (GED), Adult High School Diploma, or post-secondary educational settings. Approximately 16 percent of consumers accessing Supported Education were young adults in transition age 18-25 within the adult mental health care setting; however, AMH recognizes the importance of providing the supports necessary for young adults under the age of 18 to remain in or return to school.

Funding sources and implementation possibilities are currently being explored to provide expanded Supported Education services to young adults in transition and adults.

Peer Delivered Services

Peer delivered services, including but not limited to peer support, are a Medicaid covered service. The MHOs may use two funding streams to provide services delivered by peers; first through encounters delivered by a peer who has been trained in a certified program, and second through prevention, education and outreach funding. Services delivered by peers are usually focused on skills training and activity therapy. Traditionally, the MHOs only provide peer delivered services to clients who are enrolled in their plan. While not available in all areas of the state, there are 25² community-based consumer survivor organizations in Oregon offering an array of services including: support groups, recreation, peer counseling, peer advocacy, employment and educational supports, social activities, information and referral, system advocacy and training. Under the Adult Mental Health Initiative (AMHI), the MHOs are able to use peer delivered services to meet the needs of the individuals who meet the definition of the targeted population for AMHI.

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) Training and Curriculum Development Director is closely affiliated with the

² AMH Peer-Delivered Services Survey, November 2010

2012 Combined Block Grant Application

Federation of Families for Children's Mental Health National Certification standards and process, resulting in increasing requests from other states for information regarding OFSN's peer delivered service training program. The restructured Peer Delivered Service Foundations curriculum for young adults and family members is being offered quarterly which includes training on: strengths, needs, culture, dreams and discovery, safety planning and goal setting. This past year 38 family members and 24 young adults were trained.

Future goals include continued development of the *Online Training Center* and to expand some of the PDS Foundations into a webinar format. The updated version of the PDS Foundations and support group training are being merged with the Advanced Family Navigator training.

Peer Delivered Services Curriculum

In 2007, a large group of adult mental health, children and family mental health and addictions peers met to provide advice and guidance to AMH regarding peer delivered services. One of the products produced was identification of the criteria for the curricula required by individuals to complete before they served as peer specialists in their respective areas. In addition they identified the process by which those reviews would be completed.

In 2008, AMH notified the public of the process, including the application form with curricula criteria. AMH started reviewing curricula in 2008 and has approved the following; seven adult mental health curricula, two mental health children and family curricula including one to prepare transition age youth to serve as peers and seven addiction curricula. The curricula are delivered throughout the state and include parenting support, senior's advocacy and African American focused services. The list of those training programs, brief descriptions and contact information are posted on the AMH website³.

Older Adults

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

³ <http://www.oregon.gov/OHA/addiction/peer.shtml#amh>

2012 Combined Block Grant Application

Several counties use multidisciplinary teams (MDTs) to address the gap in mental health services for older adult populations. MDTs range in size and complexity across Oregon counties. MDTs generally consist of representatives from the CMHP, local aging and disabilities services, law enforcement, adult protective services and private not-for-profit mental health services providers. The primary focus of the MDT is to link vulnerable older adults with necessary mental health and other social services.

Some counties or their subcontractors have developed and maintained age specific services such as senior peer counseling services or have piloted unique approaches to the provision of mental health services to older adults. For example, one county employs a psychiatric nurse practitioner to provide mental health and behavioral health consultation as well as psychotropic medication recommendations to older adults coping with dementia or some other axis I condition.⁴ This service is provided to individuals living in DHS SPD long-term care and Home and Community Based Care waived programs. Multiple counties also referenced the use of the *Age Wise, Age Well* peer counseling program as a strategy or use other senior peer counseling approaches providing a range of supportive individual, group and psychoeducational counseling services incorporating successful aging, physical health, spiritual and behavioral health approaches.

Pre-Admission Screening and Annual Resident Review (PASRR)

Oregon maintains a PASRR program consistent with federal regulations in partnership with SPD. In most counties, CMHPs are contracted to provide PASRR level II services and are expected to link individuals determined to have 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 possible.

The Psychiatric Security Review Board (PSRB)

The 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 a determination of their appropriate placement.

⁴ This Service is distinct from Pre-Admission Screening and Resident Review (PASRR).

2012 Combined Block Grant Application

The PSRB maintains jurisdiction for individuals adjudicated as GEI. As of May 1, 2011 there were 736 individuals⁵ under the jurisdiction of the PSRB in the State of Oregon. Approximately 44 percent of the PSRB population resides at the Oregon State Hospital (OSH) in Salem. The remainder of the PSRB 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 of persons for the PSRB and the court to determine if treatment in the community is appropriate. Determination of the supervision requirements of each placement, and treatment for persons conditionally released into the community is also provided. Individualized community placements include: evaluation, supervision, case management, psychotherapy, residential supports, supported employment and education services, alcohol and drug treatment, and medication management.

Newly approved 2011 legislation includes House Bill 3100 which creates standardized mental health evaluations for people who have been accused of crimes and may have a mental illness. It also requires AMH to create a certification program for the mental health professionals who conduct those evaluations. This bill also removes misdemeanants from the jurisdiction of the PSRB, but still provides a provision for commitment for involuntary treatment if warranted. Under this new 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. Senate Bill 420 places people found GEI of non-Measure 11 crimes under the jurisdiction of the Oregon Health Authority rather than the PSRB, during the time they are committed to the state hospital. Measure 11 crimes require mandatory minimum sentences and are more serious. The law gives OHA the responsibility for determining when these patients are ready to leave the state hospital. Once they do leave the hospital, PSRB will be responsible for their supervision in the community.

The PSRB 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 develop necessary residential placements that will provide the necessary supports for this population to transition to the community. An

⁵ Per monthly reports from the PSRB database.

2012 Combined Block Grant Application

additional ten community placements will be opened during the 2011-2013 biennium.

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 (REI).

As of July 1, 2011, there were 16 youth under the jurisdiction of the JPSRB; eight under Developmental Disabilities supervision and eight under AMH supervision. All 16 youth are male. Of the eight youth supervised by AMH, four 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. Two are in the community under conditional release plans that provide for supervision, treatment and support. Two others will be placed in community settings under conditional release plans within the month of July, 2011. 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 to the JPSRB on a monthly basis.

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.

Other Health Services

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and substance use disorder treatment providers. Thus, enrollment in an MHO provides coordination between medically appropriate treatment services for adults eligible for Medicaid and with many of the social supports necessary to assist adults with serious mental illness to remain in their community. The OHP benefit package includes a full array of services incorporating preventive services, diagnostic services, medical and surgical care, dental services, recovery support services and outpatient substance use disorder services.

Services for Co-Occurring Mental Health and Substance Use Disorders (COD)

People struggling with both mental illness and substance use disorders have unique issues that need to be addressed simultaneously. Oregon initiatives to address and expand COD services are progressing in both mental health and substance use disorder treatment programs. In April 2010⁶ AMH sent out a voluntary COD survey to all mental health and substance use disorder treatment providers. This survey allowed for the creation of a directory⁷ which provides the most current information by county to facilitate referrals and increase access to treatment services. There were 138 COD treatment provider programs that responded to the survey, representing 34 of Oregon's 36 counties.

For the past two years, AMH has worked with a stakeholder committee to develop core competencies for clinical staff working with individuals with co-occurring disorders. The competencies outline a frame work for supervision and employee development planning by focusing on minimum criteria for beginning, intermediate and advanced competence in the area of treating people with COD. These tools are ready for implementation by provider volunteers with guidance from the Division and will be put to great use after a key position is filled at AMH who will be responsible for carrying out the implementation.

Dual Diagnosis of Oregon, Incorporated (DDA)⁸ is a peer support group based on an authorized version of the 12 Steps of Alcoholics Anonymous plus an additional five steps that focus on dual diagnosis (mental health and substance use disorders). DDA's unique 12 step plus five model offers hope for achieving the promise of recovery. According to DDA's central office, the program holds 765 statewide meetings per month, reaching approximately 3,500 contacts in the prison system, hospitals and treatment facilities and local communities.⁹

Community Treatment Services for Addictions

AMH continues to use county and tribal financial assistance agreements to support a continuum of substance use disorder treatment and recovery services statewide in 2011-2013. Block grant funds continue to support outpatient, intensive outpatient, case management, wraparound social supports, medication assisted treatment, social detoxification and residential treatment services throughout the state for individuals without health care eligibility. Children and adults of all ages who have

⁶ <http://dhsforms.hr.state.or.us/Forms/Served/DE9778.pdf>

⁷ <https://apps.state.or.us/Forms/Served/de9778.pdf>

⁸ www.ddaoforegon.com

⁹ 06/09/2011.

2012 Combined Block Grant Application

a diagnosed substance use disorder continue to be eligible for services. Any person eligible for OHP or the State Children's Health Program (SCHIP) has access to the OHP chemical dependency benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services purchased by block grant funds. There are specialized services to meet the needs of women, parents with children, minorities and adolescents.

During 2011-2012, AMH plans to consolidate the service definitions and performance criteria for prevention, treatment and recovery services into a single service element. This effort is aimed at reducing administrative burden and providing greater flexibility and accountability to specific outcomes. To protect the integrity of block grant requirements, language building in performance and utilization requirements aligned with block grant priority areas will be included in the single service element. 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 will continue shifting investments to support strategies and services that are not included in public or private health benefit packages under OHP and for people not covered by Medicaid, including prevention, early intervention and recovery support services such as peer mentoring.

AMH will promote 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.

Addiction Treatment Services

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

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

Specialty addiction treatment services continue to be delivered by CMHPs, tribes, nonprofit programs and statewide contractors in outpatient programs and

2012 Combined Block Grant Application

residential treatment programs throughout Oregon. Varied options help individuals to recover from their addictions. Some need residential services, while others may need outpatient; both are needed for some individuals to successfully recover and manage their disease. Outpatient services include specialized programs that use synthetic medications such as methadone as an alternative to chronic opioid addiction. Education and treatment are available for people who are diverted or convicted after being arrested and charged for driving under the influence of intoxicants.

In addition to funding programs for specialty populations, block grant funds are used to fund capacity for dependent children's beds whereby children accompany their parent to residential treatment. As a supplement to block grant 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 the DHS Children, Adults and Families (CAF) Division, 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.

Increased outpatient capacity was built in each county, and residential capacity increased for approximately 120 adults and 80 dependent children. More than 18 additional recovery homes have been developed for families with addiction issues who are at risk of becoming homeless and need a supportive recovery environment. AMH will continue to work closely with CAF to implement and monitor these services during the 2011-2013 biennium. Analysis to date based on administrative data matched between AMH and CAF reveals that an estimated 1,000 children have been returned to their families. These families have either completed treatment or are still engaged in treatment through ITRS. The return of children to their families represents a cost-offset to the foster care system of \$1.7 million per month.

AMH will continue to collaborate with work groups such as the Prescription Opioid Overdose Prevention (POP), the Recovery Community Advisory Group and Oregon Medication Assisted Treatment providers to address issues related to prescription opioid poisoning. Technical assistance and training is used to increase awareness of and promote implementation of medication assisted treatment in

2012 Combined Block Grant Application

Oregon 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 block grant 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 (NOMs). During 2010, AMH worked with two regional integration demonstration projects, one in Central Oregon and one in Northeast Oregon, to integrate financing, management and clinical structures in primary and behavioral health. Addiction services, including Screening, Brief Intervention, Referral and Treatment (SBIRT) practices, are under development in these projects. It is anticipated that in the coming months, additional focus will be added to specialty addiction services, particularly as it relates to reducing emergency room utilization in Central Oregon. The AMH integration demonstration projects launched after the 2009 legislative session are guided by the following principles:

- The goal of treatment and recovery is to provide services and opportunities for individuals to become self-sufficient.
- The array of treatment and recovery services must address the therapeutic needs of people in a holistic fashion. To the extent possible, services need to be delivered in a seamless and integrated manner. Services include a continuum of core health, mental health and addiction services, as well as wraparound services for housing and employment/education assistance.
- The service delivery system must be managed in the most cost-effective and individually focused manner.
- Funding for services should follow the shortest line from the state to community provider. The management structure used will consolidate Medicaid and non-Medicaid funds to pay for the array of core and wraparound services being provided.
- The service payment process will focus on achievement of measurable outcomes whenever possible.
- Core mental health and addictions services must be geographically located to encourage access as close to individuals' homes as possible. To avoid management and program duplication, services should be provided in a regional manner where possible.

The primary and behavioral health integration project represents another major system change initiative for AMH and continues as a major focus in 2011. The SBIRT model relates to the integration project and holds promise in expanding the

2012 Combined Block Grant Application

continuum of addiction services beyond specialty addiction services. AMH continues to explore the SBIRT model with partners in primary care: FCHPs, primary care providers, Oregon Health and Science University and others. AMH monitors the Substance Abuse and Mental Health Services Administration's (SAMHSA) discretionary grant programs web site for release of the SBIRT announcements and maintains formal and informal contacts with stakeholders who have expressed an interest in partnering with AMH on this opportunity.

Recovery Support Services

AMH promotes resilience and recovery for people of all ages who experience or are at risk for mental health and/or substance use disorders. The principles of resilience and recovery guide services supported by AMH. Recovery must be the common outcome of services. AMH develops and supports policies consistent with the principles of resilience and recovery. Policies governing service delivery systems will be age and gender appropriate, culturally competent, evidence-based and trauma informed and will attend to other factors known to impact individuals' resilience and recovery.

Housing

A safe, affordable, alcohol- and drug-free place to live is essential to recovery from substance use disorders. When people are uncertain about where they will live or are forced to live in dangerous environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system are living in adverse environments.

As a result of the cost of housing and common problems associated with mental health or substance use disorders, more than 6,000 people each year with these disorders are homeless. This represents nearly one-third of homeless individuals identified in the 2010 Point in Time Count¹⁰. The State has undertaken several initiatives to address housing for people with addiction disorders.

Alcohol and Drug Free housing development funds are used to create Alcohol and Drug (ADF) housing to support people in recovery from serious addictions. For 2009-2011 four projects were funded. These projects total \$691,661 and provide 24 units of affordable alcohol and drug free housing. Current market conditions and limited amounts of other funding have impacted the number of applications being received.

¹⁰ http://www.oregon.gov/OHCS/CSS_2010_One_Night_Shelter_Counts.shtml

2012 Combined Block Grant Application

Oregon contracts with a private non-profit, Recovery Association Project (RAP), to administer a Revolving Loan Fund to provide start-up loans for self-supporting, democratically-run, alcohol and drug free housing. Oregon also contracts with RAP to provide on-going technical assistance and training to these houses. There are currently 121 houses for men and men with children, and 48 houses for women and women with children. This represents a total of 1,388 beds of alcohol and drug free housing.

Access to Recovery

Access to Recovery (ATR) is a four year \$3.3 million per year competitive grant that was secured by AMH in 2011. 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 services linkages to include faith-based and community-based organizations who receive payment for services through an electronic voucher management system.

ATR is currently piloted in five counties: Umatilla, Multnomah, Lane, Douglas and Jackson. Two additional counties (Washington and Clackamas) are expected to participate in early September 2011. Any individual 18 years or older who lives in the pilot counties and seeks supportive services to help them enter or maintain the recovery is eligible for the program. Oregon is prioritizing 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.

Substance Abuse Prevention for Youth Younger than 21

Oregon has exceeded the national average for 8th grade youth alcohol use in the past 30 days. All 36 counties and nine tribes have prioritized underage drinking (UAD) in their biennial plans. In 2008 the Governor charged a cross discipline group to develop a comprehensive plan to address UAD. That plan was approved by the Governor and continues to guide the work of AMH in addressing UAD. The plan calls for a community-based initiative involving local coalitions and leaders, public education which has been achieved through town hall meetings and other outlets, prevention curriculum for students in schools and for families, and support of enforcement and adjudication.

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 a Budget Note in the 2005 Legislative session the Children's System Change Initiative (CSCI) was established. The CSCI 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, there is a trend toward many more children and families being served in community-based settings with decreased reliance on facility-based care under a case management model utilizing locally placed care coordinators.

To assist in implementing the Budget Note, a uniform level of service intensity determination process was established using the Child and Adolescent Service Intensity Instrument (CASII) and each region was 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 was transferred to the Oregon Health Plan and is managed through MHOs. Care coordination, including use of child and family teams and service coordination plans became a pivotal part of the system. Family and youth voice and involvement began to increase and was also directed under policy. AMH began contracting for services previously provided at the Oregon State Hospital, with private non-profit agencies for Stabilization and Transition Services, 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, medication management, community-based services, which

2012 Combined Block Grant Application

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. Structures have been put in place to create an opportunity to conduct Wraparound to fidelity. Fidelity measurement will occur in the fall of 2011, using the Wraparound Fidelity Index-4.

AMH collects other 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. An electronic web interface makes these data available in real time, improving the ability of those in the system to use data for decision making. AMH also tracks process measures and family perception of outcomes. Oversight of data issues throughout the system is provided through the Children's System Advisory Committee, a subcommittee of the Mental Health Planning and Management Advisory Council, and through periodic reporting to stakeholders.

All MHOs are required to establish linkages with community support systems including local and/or regional allied agencies, physical health care providers and substance use disorder treatment providers. Thus, enrollment in an MHO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary, so children with serious emotional disorders can remain in their community. The OHP benefit package includes a full array of services such as preventative services, diagnostic services, medical and surgical care, dental services, and outpatient substance use disorder treatment services.

Child Welfare Collaboration

House Bill 3114 was passed in the 2009 Legislative Session and assures children in foster care receive appropriate psychotropic prescribing practices. This bill stipulates that a mental health assessment will be obtained before more than one new psychotropic prescription or any antipsychotic medication is prescribed to a child in foster care. It also requires annual reviews of psychotropic medications for children in foster care who are prescribed more than two psychotropic medications, or for any child in foster care under the age of six prescribed any psychotropic medication.

Another area of focus in AMH work with CAF centers around obtaining informed consent for psychotropic medication. The state is implementing a change in the administrative rules for this area of consent to reflect the identification of psychotropic medication prescribing as a special medical procedure.

CAF 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 receive a mental health assessment. CAF policy states that all children in substitute care will be referred for a mental health assessment within 21 days of placement. Mental health contracts require that comprehensive mental health assessments for children placed in substitute care 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.

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. AMH has further assisted with this policy by providing a grant to OHSU's Department of Child Psychiatry to develop a video conference system. This system will improve access to services for children who live in rural and frontier areas of the state.

AMH works with child welfare to co-finance and co-manage much of the out-of-home mental health treatment services provided to children served through CAF. CAF contracts with public and private child serving agencies to provide Behavioral Rehabilitation Services (BRS) for children whose primary need for out-of-home

2012 Combined Block Grant Application

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 CAF. 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 CMHP. It is a critical treatment option for children, especially in rural counties.

Oregon Psychiatric Access Line for Kids (OPAL-K)

The Child Mental Health Task Force of the Oregon Pediatric Society and the Oregon Council of Child and Adolescent Psychiatry is working 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.

One key project from this group is OPAL-K, the Oregon Psychiatric Access Line for Kids. A contract with the Oregon Pediatric Society has been developed with the goal of improving collaboration between pediatricians and child psychiatrists in two pilot areas in Oregon. Objectives include improved 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.

Health Matters

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 will be on: early identification and support; shared measurement and accountability through development of an early childhood data system, performance-based contracts and shared outcome measures; creation of an Early Childhood System Director position in the Governor's Office and an Early Learning Council to consolidate multiple existing efforts, funding streams and administrative structures.

An Early Learning Design Team (ELDT) has been established to design the basic architecture that will move these goals from concept to reality. This team represents communities across Oregon with experts in the fields of early learning,

2012 Combined Block Grant Application

health, and family support. The Design Team will provide preliminary recommendations and a detailed action plan for implementing a new, streamlined system which meets the Governor's goals by July 1, 2011.

Health Matters is one of three committees comprising the Early Childhood Matters Advisory Council appointed by the Governor. The others are Family Matters and Early Learning Matters. Health Matters and additional members responded to a charge from the ELDT to:

- Identify and inventory existing national standards or emerging national standards for prenatal, perinatal, early childhood and family risk/strength assessment tools addressing child health, psycho-social and relational domains;
- Recommend use of specific tools identified in the inventory; and
- Recommend standardized developmental and psycho-social screening, and monitoring at regular intervals.

The continuing role of Health Matters, Family Matters and Early Learning Matters committees (cited in the 2011 MHBG) will depend on the leadership and goals established by the Early Learning Council and the Early Childhood System Director.

The ChildTrauma Academy

AMH entered into a contract with The ChildTrauma Academy (CTA) in June of 2010 with the goal of statewide implementation of improved services for traumatized children. Dr. Bruce Perry has been providing materials and training to nine multidisciplinary sites in Oregon, covering 22 of Oregon's 36 counties in the first year. The CTA uses a Neurosequential Model of Therapeutics© that assists clinicians to provide assessment and neuro-developmentally appropriate interventions for early childhood, childhood and adolescent populations. The goal of this project is to develop a cadre of clinicians that are qualified to identify and work with children who have been traumatized through neglect or abuse.

Early Assessment and Support Alliance

In 2007 the Oregon legislature funded the Early Psychosis and the Early Assessment and Support Alliance (EASA) to bring the most current, evidence-based treatment to young adults having their first experience with psychosis. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective and prevents the long term morbidity associated with chronic psychotic illness. Early intervention and treatment of adult psychosis assists individuals in becoming independent, healthy and safe. The restoration of normal functioning will help

2012 Combined Block Grant Application

individuals maintain employment and to support themselves and their families. The utilization of this model has resulted in dramatic change in areas such as decreased hospitalization rates, and the model is cost-effective in the short term and results in cost-savings in the long term.

Currently, EASA/EAST services cover 60 percent of Oregon's population in a total of 16 counties. This leaves over 1,500,000 Oregonians unable to access EASA services and does not cover some of Oregon's geographically largest communities. This has resulted in many young adults losing care from the EASA system when they have left the area of coverage, often resulting in a re-emergence or decompensation of their psychotic symptoms.

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 wellness. Expanding care in this way addresses discrepancies in the traditional model and allows full integration of services under the Oregon Health Authority.

Collaborative Problem Solving

The statewide implementation of the Collaborative Problem Solving (CPS) model is well into its fourth year. With the inception of this project there were three programs using this model in Oregon. Through a system of care team building approach, this implementation project has resulted in well over 100 sites across the state using CPS.

The sites include an array of child serving providers including hospitals, psychiatric residential, psychiatric day treatment, education, juvenile justice, foster care providers and an extensive parent-to-parent book club network. Qualitative data reported from this project shows positive trends in reduction in the use of seclusion and restraint and improved job satisfaction for staff. Children and adolescents who are being served by the CPS model report they feel their concerns are listened to fairly and they have a voice in decision making processes. Families report benefiting from a model of care that is easily transferable to home and community settings.

AMH Initiatives

AMH adopted the tools of continuous improvement in pursuit of becoming world-class in health and human services delivery. Transforming the work of AMH is critical to improving access to high quality, cost effective services that will assist Oregonians with addiction and mental health disorders to achieve optimum

physical, mental and social well being. AMH prioritized 14 initiatives to improve the behavioral health system in Oregon. AMH is beginning to see positive results from the work of several of these initiatives.

Streamlining Transitions through the Addictions and Mental Health System

This initiative has focused on transitioning individuals to more appropriate levels of care that meet their specific service and treatment needs. In the initiative, AMH has adopted a standardized level of care assessment tool that is now being used within the state hospitals, the residential system and assisting individuals when they transition to community services and supports. AMH has also developed and adopted standardized “ready-to-transition” criteria for Oregon State Hospital (OSH). The state and county programs have agreed to a standardized method to hold counties accountable for the timely discharge of their residents from OSH. These changes are expected to reduce the time that people who are ready for transition from the hospital must wait for admission to community-based treatment. These changes will also reduce both the number of people and the wait time for admission to the state hospital.

Vacancy Exceptions

AMH has completed work on the vacancy exception initiative with the adoption of an Oregon Administrative Rule (OAR 309-011-0105 through 309-011-0115) and new procedures to support the payment for vacant beds. As a result, AMH spends fewer dollars in holding beds vacant, processes fewer vacancy payment requests and expects improvement in utilization of existing capacity. Since June 2010 approximately \$507,464¹¹ has been saved as the result of this change.

Adult Mental Health Initiative (AMHI)

AMHI became effective on September 1, 2010. On this date AMH transferred responsibility for managing access to and from facility-based residential services to the MHOs. The AMHI initiative is a multi-phase project designed to restructure the adult mental health system, by infusing person-centered planning, improving utilization of restrictive settings and standardizing criteria across all levels of care. Statewide data shows that individuals remain in highly controlled licensed settings such as residential treatment facilities for a longer time than needed. Initially, AMH had projected that 331 individuals would be transitioned to more appropriate levels of care in the first 10 months. The MHOs were able to transition more than 464 individuals in the first 10 months.

¹¹ As of June 1, 2011, Data supplied by AMH Operations and Policy Unit Database

2012 Combined Block Grant Application

A core goal of AMHI is to help individuals be successful and as independent as possible. AMHI will ensure that individuals can leave residential services when they are ready and that expensive resources are utilized by those that need them. AMHI uses performance-based contracting to provide incentives and drive better outcomes for individuals. AMH has provided the MHOs with flexible funding to provide community-based services such as supported housing, rental assistance, IPS Supported Employment, and Assertive Community Treatment.

New Person-centered Alternatives to Hospitalization (NewPATH)

The goal of this initiative is to develop a plan for community-based care and stabilization/treatment programs that promote policies of self direction and person-centered care, as well as access to necessary medical, nursing and licensed specialists, peer support and care coordination in a community setting for people who need both long term care due to disabilities of aging or brain injuries and mental health care. The NewPATH Core Team completed the project and issued a final report. The report recommends community-based services and programs that will:

- meet the needs of individuals with complex medical and behavioral health issues in the community, rather than admit them to the Oregon State Hospital (diversion); and
- discharge those individuals more rapidly who have reached maximum benefit from treatment at OSH Geropsychiatric Treatment Services (GTS) units, but have not been able to return to or stay in the community because of a lack of suitable community services and supports.

The four project objectives have been met: (1) Analyze the current census of OSH GTS to identify the NewPATH population; (2) Complete a community assessment to identify gaps in available services and supports necessary to provide for the community stabilization and community-based long-term care needs for individuals with geropsychiatric/behavioral issues and complex medical conditions; (3) Identify possible internal discharge barriers that hinder or prevent timely discharge of stabilized GTS patients; and (4) Review relevant literature related to geropsychiatric services for the population, in particular the reports and studies of workgroups convened in Oregon in the past two decades to address the needs of this population.

As Oregon faces a major shift in the way health care is provided in the state, this work will help to inform the work of other committees now charged with integrating all health care, including mental health and long-term care, to ensure that older adults can remain in their homes while receiving the care they need.

Integrated Services and Management Demonstration Pilots

AMH recommended to the 2009 Legislature a system change effort focused on an integrated management and service model including health, mental health and addictions services. The legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services.

AMH is working with two regions of the state to fully integrate physical health, mental health and addiction services. Both sites have a broad-based coalition including the public and private providers in their regions. Coalition work is resulting in changes in governance, contracting, service management and coordination. The new service coordination model will begin with an agreed-upon group of individuals who have extensive service histories with limited success across all components of the system. It is anticipated that integrated treatment and management will improve the outcomes for these clients and decrease the costs to the system.

The Central Oregon Health Council's Integration project is having significant results. In the first quarter of 2011, there were 256 emergency department visits. Comparing this quarter data with first quarter 2010 data shows a 57 percent downward trend in emergency department utilization. More than 50 percent of the individuals identified and enrolled in the emergency room diversion project continue to stay engaged with the special services and supports provided by the project. The majority of those who have exited the project have transitioned to appropriate community-based services and supports.

The demonstration projects are guided by the following principles:

- The goal of treatment and recovery is to provide services and opportunities for individuals to become self-sufficient.
- The array of treatment and recovery services must address the therapeutic needs of people in a holistic fashion. To the extent possible, services need to be delivered in a seamless and integrated manner. Services include a continuum of core health, mental health and addiction services, as well as wraparound services for housing and employment/education assistance.
- The service delivery system must be managed in the most cost-effective and individually focused manner.
- Funding for services should follow the shortest line from the state to community provider. The management structure used will consolidate Medicaid and non-Medicaid funds to pay for the array of core and wraparound services being provided.

2012 Combined Block Grant Application

- The service payment process will focus on achievement of measurable outcomes whenever possible.
- Core mental health and addictions services must be geographically located to encourage access as close to individuals' homes as possible. To avoid management and program duplication, services should be provided in a regional manner where possible.

State Hospital Improvements

The construction of the first new psychiatric treatment and recovery facility in more than 50 years was funded in the 2009-11 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. The first 90 patients moved into Harbors, the admission and intense treatment program for forensic patients in January 2011. In August 2011, 175 patients in psychosocial rehabilitation services will move into Trails with six housing units, treatment mall, and exercise and relaxation spaces.

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 will live on a unit, they will 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, increase skills in symptom management and improved quality of life.

In December 2010 AMH contracted with the consulting firm Kaufman Global to spur culture change and improvements at OSH. After seven months of work with OSH, the final report from Kaufman Global, "documented the many achievements

2012 Combined Block Grant Application

and efforts of individuals and work teams to implement purposeful change and drive the organization forward on a day-to-day basis. The result has been a significant advance toward the ultimate...goal of hospital excellence.”¹²

Wellness

AMH has engaged consumers, providers, counties and other stakeholders in the development of consumer-driven efforts to improve the health and well being of people with mental illness and substance use disorders. The early focus of this work is Tobacco Freedom, an initiative to provide people with the treatment, skills and resources they need to achieve a tobacco-free life and environment. The emphasis on wellness will improve the overall health outcomes for people with mental illness and substance use disorders, who die 25 years earlier than the average Oregonian. AMH released a Tobacco Freedom Policy earlier in 2011 to take effect in contracted residential addictions and mental health facilities January 1, 2012.

Young Adults in Transition (YAT)

The Young Adults in Transition Initiative focused on young adults ages 14 to 25. This initiative has promoted access to a system of services and supports that are young adult directed and developmentally appropriate. The initiative has effectively bridged adolescent and adult systems, thereby providing young adults with opportunities to realize their full potential and have healthy, productive lives. This project successfully completed on June 30, 2011, whereby AMH has now developed specific programming at various levels of care targeting YAT.

In addition to the development of multiple statewide residential programs and supported housing specifically designed to meet this group’s needs, the initiative also identified the need for developmentally appropriate services to be offered within the State Hospital system.

A new project has targeted a standardized transition process that will include the cross training of hospital and provider staff, the development of on site programming, and the development of a young adult transitional cottage, that has been tailored to meet the specific needs of this population is now under way.

Peer Delivered Services (PDS) and Peer Run Services

Peer-run and peer-delivered services demonstrate and exemplify hope, recovery, resilience and independence. AMH has identified the continued development as

¹² Oregon State Hospital Excellence Project, Kaufman Global (2011)

2012 Combined Block Grant Application

one of the key policy initiatives. AMH takes a broad policy approach to peer-delivered services that include the child and adult mental health systems and the addictions systems with the three policy administrators leading an internal steering committee, which works through several Oregon Health Authority/AMH stakeholder advisory groups.

Oregon is home to a wide array of peer-delivered programs; some operate within the mental health and addictions systems, and others provide alternative services. Most are community-based and all are delivered by people with mental health and/or substance use disorders or family members of adults or children with serious emotional disorders.

Peer-delivered and peer-run services are essential to reducing the significant health disparity of those living with behavioral health concerns. PDS will be instrumental in reforming the health care system to support recovery and wellness. As such, the three components of AMH's Peer Delivered Services Initiative are focused on those efforts:

1. Lead in Oregon's Health Care Transformation to ensure "whole health and full recovery" for those with behavioral health concerns by providing services including the following:
 - Peer Delivered Services focused on holistic support for mental health recovery.
 - Peer Wellness Services focused on a "whole health" support for wellness including smoking cessation and nutrition information
 - Peer Advocate Services focused on support for trauma-informed, patient centered/driven care, navigation of the healthcare system and non-traditional service and service settings
2. Lead in Oregon's Health Care Transformation to ensure the goals of improving health, increasing the quality, reliability, availability and continuity of care, reducing the cost of care, eliminating health disparities and increasing customer satisfaction by participating in policy development at all levels including: financing strategies, outcome identification, evaluation and research, elimination of health disparities and reduction of stigma and discrimination.
3. Lead in Oregon's Health Care Transformation to ensure the availability of diverse, competent peer and non-peer leaders, advocates, policy makers, service agencies, service providers and businesses to provide the services and policy development identified previously by providing "workforce"/ resource development as follows:

2012 Combined Block Grant Application

- AMH will develop “the criteria and descriptions of peer wellness specialists and their education and training requirements” (As directed by HB 3650 consumers have a right to “access competent advocates (including qualified peer wellness specialists where appropriate...)”)
- In addition to “peer wellness specialists” encourage the development of a variety of peer-run services to serve local communities
- Draw upon inherent community leadership to further develop leadership
- Provide technical assistance as identified by peers

Lean Initiative Using the Network for the Improvement of Addiction Treatment (NIATx)

To benefit from addiction treatment, people need to stay past the first session. Furthermore, treatment research confirms that people who stay involved for at least 90 days have significantly better clinical and recovery outcomes. People who access residential treatment need to experience effective and timely transitions and continuation of care, by accessing community-based outpatient or recovery support services to maintain gains made during the residential episode and successfully reintegrate to community living and recovery.

The Network for the Improvement of Addiction Treatment (NIATx) is a nationally recognized, proven approach to improving processes applied at the addiction treatment provider level that directly improve retention and continuation of care. Oregon participated in NIATx 200, a randomized clinical trial funded by the National Institute on Drug Abuse throughout 2008 and 2009, assisting 36 providers in Oregon to implement continuous process improvements to increase admissions, increase retention, decrease no shows and decrease wait times. These programs showed successful improvements in those areas.

Health System Transformation and AMH System Change

In addition to the initiatives above, AMH has embarked on major health reform to improve the health and well-being of Oregonians. One task is the integration of physical and behavioral health care for individuals served through the Oregon Health Plan. This is the Health System Transformation work set forth by House Bill 3650 that includes the development of CCOs. CCOs will manage care for OHP clients by taking the best thinking in Oregon and creating local organizations focused on one thing: reducing the barriers that stand between patients and good health. Because each community is different, there may be different models for a CCO. The criteria for how CCOs will operate is being developed with input from clients, providers, stakeholders and the public. AMH staff are working to ensure

2012 Combined Block Grant Application

that CCOs would provide greater access to integrated health, addictions and mental health services.

In addition to the work to develop CCOs, AMH has undertaken a parallel but separate system change effort with Oregon's publicly funded addiction and mental health system for people who are not eligible for OHP. Improvements to the system will be driven by the flexibility afforded by global budgeting, allowing counties the discretion to put resources where they are most needed to serve people in their communities. The budgeting flexibility will be balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve.

2012 Combined Block Grant Application

Step Two:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations¹³ described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, The Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disorders that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment.

¹³ Children with serious emotional disorders and their families; adults with serious mental illness; persons who are intravenous drug users; women who are pregnant and have a substance use and/or mental disorder; parents with substance use and/or mental disorders who have dependent children; individuals with tuberculosis; and persons with or at risk for HIV/AIDS and who are in treatment for substance abuse.

Management Information System

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 OHP and other Medicaid services. In December of 2008, Oregon replaced its MMIS system and implemented 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.

OHP provides coverage to people who are categorically eligible for Medicaid. The plan also provides coverage to an “expansion population” of adults who do not qualify for traditional Medicaid and are eligible by virtue of the Federal poverty level. MMIS includes information on eligibility status, services rendered and fee-for-service and encounter data for those served with capitation payments. MMIS also includes information about chemical dependency, pharmacy, dental and physical health service expenditures. MMIS data is accessed via a Decision Support Surveillance Utilization Review System (DSSURS).

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 National Outcome Measures (NOMs) and Treatment Episode Data Set (TEDS) 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 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 2012 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.

The data system that will replace CPMS is called OWITS (Oregon Web Infrastructure for Treatment Services). CPMS is a 30 plus year old data system that is antiquated, cumbersome and labor intensive to use. OWITS will allow providers to electronically enter treatment data and will replace manual data entry. It will supply a data-rich environment and will allow for

2012 Combined Block Grant Application

ad hoc reporting. The investment in this data system will save approximately 2080 hours in labor related to manual data entry per year.¹⁴ Providers not wishing to utilize OWITS will be able to use an electronic file system to transfer data. OWITS will allow AMH to access real time data in order to drive policy. AMH is currently piloting the OWITS system with a small group of 11 providers. AMH is using data gathered during the pilot phase to inform the broader implementation. The first stage of the statewide implementation will occur by July 2012.

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 by the end of 2011.

Each of these systems contains unique client level identifiers. The AMH 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.

Outcomes and performance measure data are gathered through the Mental Health Statistical Improvement Project (MHSIP) Youth Services Survey for Families (YSS-F) and the MHSIP Adult Outpatient Consumer Survey (AOCS), which are administered annually. Beginning with the 2011 survey, the Youth Services Survey (YSS) is also being administered. The YSS, YSS-F and the AOCS results are used to:

1. Provide feedback to those who are affected by AMH performance measures;
2. Identify areas in need of improvement or attention;
3. Track improvement in the well-being of children and adults served with public funds;
4. Recognize those programs that are doing well; and
5. Communicate results to the Governor, the Legislature, department contractors and the public.

Oregon uses data from four sources to make substance use disorder treatment decisions: the National Survey on Drug Use and Health (NSDUH), Client Process

¹⁴ Currently five people spend eight hours per week to key CPMS data (5x8x52=2080 hours/year).

2012 Combined Block Grant Application

Monitoring System (CPMS), the Children Adults and Families (CAF) system, the NIATX 200 study, and the AMH evaluation study.

1. The National Survey on Drug Use and Health (NSDUH) provides age-specific (ages 12-17, 18-25 and 26 or older) prevalence rates for alcohol and illicit drug abuse or dependence in Oregon. These rates are applied to age specific populations within each Oregon county. State age-specific estimates are also tallied to give an overall estimate of treatment need within Oregon. The county estimates of treatment need are used to allocate funds proportionately to each county.
2. CPMS, as described above, is the primary data system for collection of information about services clients receive through publicly funded treatment in Oregon, including residential, outpatient, medication assisted treatment, and DUII clients. It is the source of NOMs and TEDS and provides information about those services such as: basic demographics, length of stay, reduced use, successful treatment completion and transfer of care from residential treatment services to outpatient services within a defined time frame. This year questions were added to assess social connectedness at enrollment and upon discharge from services. AMH uses CPMS data to assess the services received within each county, and region. AMH policy staff use CPMS summary data to establish ongoing performance targets, identify providers' technical assistance needs, and award incentive grants to providers meeting or exceeding performance targets.
3. The Children, Adults and Families Division of DHS works in partnership with AMH to deliver targeted services in addition to the population based need. The CAF data system is used to identify their clients that are in need of alcohol and or substance abuse/dependency assessments and possible treatment.
4. AMH is currently in the final stages of documenting the findings from a longitudinal study assessing addiction treatment outcomes one year after initiation of services. For the longitudinal study voluntary participants are surveyed within two weeks of enrollment, six months past enrollment, and one year past enrollment regardless of whether they are still receiving services. The longitudinal study collects outcome data about overall substance use, disease management and attempts to access additional services, family/social connections, criminal justice, employment, child

2012 Combined Block Grant Application

reunification, and other measures in addition to the basics NOMs/TEDS measures.

Estimate of Prevalence

Adults with Serious Mental Illness (SMI)

Pursuant to section 1912 (c) of the Public Health Services Act, adults with serious mental illness are persons: (1) age 18 and over; (2) who currently have, or at any time during the past year had a diagnosable mental, behavioral or emotional disorder sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent; and (3) 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.

Serious Emotional Disorder (SED)

The State of Oregon 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, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within 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.

The 2010 prevalence estimate of the number of children living with a serious emotional disorder in Oregon is 106,124 children. Of them 31 percent are served in the public mental health system.

Adult Mental Health Service System Gaps

Services to the Senior Population

The senior population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for seniors is a critical area of improvement for Oregon's mental health system. Over the past two years, AMH has cultivated a collaborative relationship with the Seniors and People with Disabilities Division (SPD). A representative from SPD, as well as one from the Governor's

2012 Combined Block Grant Application

Commission on Senior Services, serves on the Mental Health Planning and Management Advisory Council.

Culturally Competent and Holistic Services for Young Adults in Transition (YAT)

While the children's system has taken the lead in the provision of culturally competent and holistic services for YAT, the Adult Mental Health Initiative is designed to ensure the right types of services are delivered at the right time. As AMHI develops young adults are actively involved in services and supports development.

Homelessness, Lack of Housing Subsidies and Lack of Supported Housing, Especially in Rural Areas

Due to Oregon's slow economic recovery, homelessness remains a looming issue for the state. Funding from the Projects for Transition from Homelessness (PATH) grant provides targeted services to individuals with serious mental illness who are experiencing homelessness. This funding is limited, however, and PATH services are available in only five of Oregon's counties.

In the 2009-2011 biennium AMH provided \$4.37 million in funding for 188 units of housing for persons with serious mental illness, substance use disorders and co-occurring disorders. Of these, 44 units were developed in counties meeting the U.S. Department of Housing and Urban Development's definition of a rural county. Despite continued housing development, stable affordable housing continues to be a significant need in Oregon. While some individuals are able to access rental subsidies, many others are excluded due to previous criminal history or the lack of support services to apply for and maintain those subsidies.

Barriers to Transition from OSH and Length of Stay

The Division's initiative to streamline transitions through the addictions and mental health system has directly impacted lengths of stay at OSH and provides a standardized set of criteria for discharge. The 2010 block grant assisted with funding for a Peer Bridger Program. Patterned after a national model, patients are paired with a peer in the community approximately six weeks prior to discharge to begin navigating services and supports needed to be successful upon their re-entry into community living.

Adult Respite and Appropriate Crisis Services, and the Development of Community Peer-Based Support Services

The subcommittee of the Planning Council working on this section mentioned this weakness both in terms of the adult and children's systems. The Division has made significant progress in addressing this weakness by funding a statewide Warmline and prioritizing peer-delivered services as one of their planning initiatives.

Lack of Statewide Financial and Organizational Infrastructure to Support Peer Delivered Services (PDS)

Oregon has not identified an ongoing and sustainable funding mechanism to support community-based consumer survivor organizations in their delivery of peer-delivered services. Without establishment of an ongoing funding mechanism or direct state support for local consumer-run organizations, many local programs face an unstable future and are able only to provide PDS in a random and piecemeal manner as resources become available. The state, counties, MHOs, providers and consumer survivor groups have not yet developed a comprehensive strategic plan for statewide financing and support of grassroots programs that are instrumental in assisting people to remain in their communities and helping them in their recovery process. Services provided by peers who have themselves experienced mental health challenges generally emerge organically as an expression of what is needed at the local consumer survivor level, and provide a locus for self-determination in the services and supports needed to be successful in recovery. Peer-delivered services are not consistently available in all communities in Oregon. PDS are also not consistently available to all populations who could benefit from them.

Services to Veterans

There is a need for access to, and utilization of, mental health services by returning veterans from Iraq and Afghanistan. While the federal government is working to meet the mental health needs of veterans and their families, some of those needs will undoubtedly be met through state and local resources. A report from the National Institute of Mental Health states that approximately 42 percent of National Guard and Army Reserve troops require mental health treatment and less than 10 percent actually receive treatment. Recent studies published by SAMHSA note the increased psychological stress associated with multiple tours of duty, and the stigma associated with veterans' accessing mental health services.

Collaboration with the Veteran's Administration continues to be a need as do veteran-specific services within the state hospitals.

Access to Integrated Care

Access to integrated care (mental health, physical health and chemical dependency services) is very limited. Some Oregon counties, such as Benton County, operate Federally Qualified Health Centers and are providing integrated care. National and AMH research¹⁵ indicate people with serious mental illness and/or substance use disorders are dying an average of 25 years earlier than the general population, and have health risk factors that can be mitigated.

House Bill 3650 passed in the 2011 Legislative Session addressing the creation of a statewide structure for Oregon's health care reform efforts. This bill creates Coordinated Care Organizations (CCOs) that serve as a single point of accountability for the cost of health care within a global budget. The CCOs will allow access to a coordinated system of physical health, behavioral health and oral health care services delivered to the specific population of members enrolled with the organization. The CCOs will be responsible for the health care of their members, including serving members that are dually eligible for Medicare and Medicaid. The CCOs will also be responsible for managing health care for persons in long-term care as part of an overall treatment plan.

The following gaps were identified by MHPAMAC. While Oregon does not specifically collect data on these issues; there have been national studies and white papers that substantiate them. In some cases, Oregon has or is developing plans to address these issues. Those instances are noted below:

- Trauma informed services and care are vital to an individual's recovery. Currently there is limited access to these services. AMH has adopted a Trauma Policy and has a Trauma Informed Services Action Plan¹⁶. The ISSR requires trauma screening as part of a mental health and/or substance use disorder assessment. Trauma informed services education is needed for the continuum of service providers throughout the state.
- Low utilization of culturally competent and age appropriate mental health and substance use disorder services for older adults: especially seniors in nursing homes. The 2008 Public Consulting Group Report reported that the physical manifestations of the aging process, combined with depression and poly-pharmacy use, make this population particularly vulnerable to co-occurring disorders.
- A holistic and culturally competent service delivery system for young adults in transition is needed. This system would include but not be limited to,

¹⁵ http://www.oregon.gov/OHA/addiction/publications/msur_pre_mort_6_2008.pdf

¹⁶ <http://www.oregon.gov/DHS/addiction/trauma.shtml>

2012 Combined Block Grant Application

substance use disorder treatment, medication management options, alternative therapies, wellness and education.

- There is a need for more mental health navigators to support people in recovery, especially for the population leaving the state hospital and criminal justice systems.
- There is a gap between access to, and utilization of, culturally competent services for the gay, lesbian, bisexual and transgender community. This is notably poignant for Young Adults in Transition, who may be grappling with the immediacy of these issues in their lives.
- Self-directed choice in housing services and supports is critical for successful recovery and should be provided in the most integrated setting possible based on an individual's choice.

Children's Mental Health Service System Gaps

Peer-Delivered Services for Young Adults in Transition and Family Members

There is a need to eliminate barriers for further development of peer-delivered services for young adults in transition and family navigators, thereby increasing leadership opportunities for young adults, as well as access to developmentally appropriate services and supports for young adults in transition especially in rural areas. This need has been identified by planning council input and feedback from family members/youth.

Need for Workforce Development

There is a need for improved workforce development to increase the use of an integrated neurobiological perspective, inclusive of physical health, prenatal exposure to drugs and alcohol, and effects of trauma in treatment facilities with specific trauma-informed treatment approaches that are appropriate to the population based on developmental considerations. This need has been identified through planning council input and anecdotally. There is a need for more extensive training for providers of early childhood mental health services. This has become apparent through an early childhood mental health provider survey administered by AMH. There is a need for additional tools/models/skills for behavior support in psychiatric residential and day treatment facilities in order to reduce the use of seclusion and restraint based on data reported by facilities.

Need for Continued Expansion in Breadth and Depth of Community-Based Services

Additional intensive community-based mental health services are needed including creating family-centered and child-focused respite and crisis respite, additional

2012 Combined Block Grant Application

capacity for mentoring, skill development and training, cognitive-behavioral treatment for trauma, and appropriate services and supports for children ages up to age five. This is based on planning council input, information gathered during site reviews and a recent AMH survey of early childhood mental health providers.

There is a need for improved integration between physical and mental health and a greater emphasis on a holistic approach to service planning for families. This gap has been identified through planning council input. Having adequately trained care coordinators in every county is an important foundation for increasing linkages between primary care and behavioral health providers and improving bi-directional integration. Care coordinators are also ideally situated to identify mental health promotion and early intervention programming needs within their community.

Co-occurring disorder treatment services for adolescents, and younger children where needed, are not readily available in Oregon. A survey of providers was conducted in 2007 that revealed this need. Budgetary cutbacks and constraints are hindering the development of co-occurring disorder treatment. Adolescent substance use disorder facilities in Oregon have developed some capacity for co-occurring disorder treatment, but there is a significant lack of capacity within the mental health system for children. Changes in the administration of services and supports through CCOs that will integrate these service delivery and payment structures will impact this issue in Oregon in the coming years.

There is a need for services that reflect the cultural and linguistic characteristics of clients in non-dominant groups, including youth with special needs, and gay, lesbian, transgender, bisexual and questioning youth and young adults. This need has been identified based on an inadequate number and types of existing services/programs and anecdotal information.

Coordination and Collaboration with Juvenile Justice Agencies

There are high numbers of children with mental health needs being served in the Juvenile Justice system, both locally and at the level of the Oregon Youth Authority. Integration of services and supports in juvenile justice settings with community mental health focused settings is difficult and lacking in many cases. CSAC has made this issue a primary focus of their Work Plan for calendar year 2011. These children and youth are high risk members of their communities, both for public safety and ongoing mental health treatment needs. Many have extensive trauma histories in earlier childhood. Oregon is exploring better options for effective treatment collaboration for these children.

Expansion of System of Care Values, Principles and Practices

There is a significant discrepancy between children's and parents' OHP eligibility, which continues to have a significant negative effect on service delivery for families. There are also significant discrepancies between benefits available to Medicaid eligible children/families and non-Medicaid eligible children/families. Health care reform actions being taken within the state may begin to address some of this gap, but it will likely be several years before change is a reality at the service delivery level.

In addition to these disparities, there is a crucial need for the development of braided funding between child-serving state agencies and improvements in interagency collaboration. This is hindering the development of an efficient and purposeful System of Care for children and families in Oregon.

The ability to integrate data and information across service systems is lacking. This is critical to the ongoing development of a System of Care for children in Oregon. Service systems need to be able to "communicate" with one another to impact the child and family and provide needed services and supports that are timely and effective. Communication of assessment data, integrated services and supports plans, and time/location of child and family team meetings are critical pieces of information that can get buried in the current system or create additional work and potential inefficiencies in communication using present systems.

Monitoring Processes to Identify Critical Gaps and Highest Need for SAPT

AMH uses the following monitoring processes to assure services to communities with highest needs and to identify critical gaps within the SAPT continuum:

1. AMH develops quarterly performance measures at 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 (CMHPs). Contractors with a less than satisfactory performance are put on notice to take corrective action and will receive technical assistance if needed.
2. AMH estimates the number of adults and youth who need alcohol and other illicit drug treatment annually. Oregon has updated the need estimation methodology by improving documentation, providing reproducible estimates, and increasing potential for valid estimates using the following summarized methodology. SAMHSA funds the NSDUH survey regarding substance use, abuse and dependence across all states as well as regions

2012 Combined Block Grant Application

within each state. The Oregon specific prevalence rates for specific age groups (ages 12-17, ages 18-25 and ages 26+) are applied to the age specific populations within each Oregon County. State age-specific estimates are also tallied to give an overall estimate of treatment need within Oregon. Ages 18-25 were included because the reported rate of dependence and abuse are more than double ages 12-17 or ages 26+. Ages less than 12 are not included in the survey because the survey is for ages 12+ and less than 0.001 percent of all those in public funded treatment were less than 12 years old. If a client is less than twelve years old they still would be eligible for treatment but the population for those less than 12 are not included in the overall needs estimates.

3. AMH produces reports using data from the CPMS, quarterly Treatment Improvement Report (TIR) and shares the reports with CMHP Directors, the primary contractors delivering or sub-contracting for these services at the local level. The TIR summarizes each CMHP's performance measures including access to treatment. AMH estimates access by the number of unduplicated individuals who received treatment during the year. This number is compared for each CMHP to the annual demand for treatment services. Other performance measures that AMH shares include:
 - engagement,
 - completion of treatment,
 - retention, and
 - length of stay.
4. AMH also uses a monthly report from designated Intensive Treatment and Recovery Services (ITRS) through use of a special coding system for utilization and performance standards. ITRS is provided to parents/guardians that need treatment to either regain custody of children removed from the home in part due to parental substance abuse/dependency or for those at high risk of having their children removed. Counties and providers receive monthly updates on their utilization numbers for residential and/or intensive outpatient/outpatient treatment services. Overall performance indicators are also reported such as treatment completion rates and meeting Child Welfare service agreements.

AMH uses this performance related information to make recommendations to counties regarding Biennial Implementation Plans. If a CMHP does not address defined performance issues correctly, AMH may reject the plans or request amendments to address deficits in the plans. Based on observations,

2012 Combined Block Grant Application

AMH may also require changes that redirect funding from a specific service to another service, from one defined population to another defined population, or from one CMHP to another CMHP. AMH monitors data continuously and can make changes in funding levels or categories at any point in the biennium.

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, and from the OHA Public Health Division: the Center for Health Statistics, Adolescent Health, Tobacco Prevention & Education, Fetal Alcohol Syndrome Program and Youth Suicide Prevention Program. Participants outside of OHA include: the Oregon Department of Education, Oregon Commission on Children and Families, Association of Oregon Community Mental Health and Addictions Program Directors, Oregon Research Institute, Oregon Partnership and County Prevention Coordinators.

The SEOW is responsible for compiling information, analyzing, and reporting substance use incidence, prevalence and related addictions data and NOMs. These data are in turn used in the county Biennial Implementation Plans for AMH and for the county comprehensive planning for Oregon Commission on Children and Families. In addition, data are used by AMH to assess, plan, and implement state prevention policy and programs. The SEOW is not used for evaluation of activities, although the data is used to track progress of population level data at the state and county level.

The SEOW was initiated prior to AMH being awarded the Strategic Prevention Framework State Incentive Grant (SPF SIG) in 2009 and has been primarily focused on assessing consequence and consumption data to determine the level of state and community needs for substance abuse prevention. Beginning in September, 2011 the SEOW will identify mental health epidemiological information focused on mental health promotion that will be tracked through 2020.

The SEOW established the following key criteria for data indicator selection:

1. The indicators should be an accurate reflection of change in public health.
2. The data should be reliable and valid and collected for at least three years.
3. There should be an infrastructure in place to ensure continued data collection in the future.

2012 Combined Block Grant Application

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 web. Each measure is updated as the data becomes available.
2. There are 36 counties in Oregon; a county report is generated for each county every other year. The county reports include 40 measures.
3. Single-page, double-sided fact sheets are produced on specific priority topics.
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.

Addiction treatment needs are estimated using prevalence rates from the latest released state and regional specific data from NSDUH (state rate and age specific rates 2007/2008 were used). The Population Research Center at Portland State University publishes annual population estimates for Oregon. Year 2009 was used for the population estimates. 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. It is expected to have updated years to report soon but no date has been released yet. Reported cases of communicable related diseases (HIV/AIDS, hepatitis B -acute and chronic, and tuberculosis) are obtained from the State's Communicable Diseases Reporting and Monitoring Program under the Division of Public Health for the 2009 calendar year.

Prevalence of Substance Related Criminal Activities

AMH estimated prevalence of alcohol and illicit drug related criminal activities from the year 2008 in the Law Enforcement Data System (LEDS), which is instituted and maintained by the Oregon State Police (OSP). The OSP analyze and disseminate criminal justice information as authorized by Oregon's legislature (ORS 181.730). OSP develops standards and procedures (ORS 181.715) for reporting criminal justice data and all law enforcement agencies in Oregon are required to report criminal activities to LEDS (ORS 181.550). The database is also part of the national network in criminal justice information. The Criminal Justice Commission has posted on their website by county both drug related arrests and DUII (2008) by county at <http://www.oregon.gov/CJC/SAC.shtml>.

Incidence of Communicable Diseases

Incidence rates (number of persons per 100,000 residents within the region) of communicable diseases (HIV/AIDS, hepatitis B, and tuberculosis) are reported as indicators of communicable disease prevalence within each region. The Oregon Public Health Division collects and reports on incidents of these diseases based on rules governing the process (ORS 433.004). All licensed health professionals are required to convey any reportable disease to county public health offices. Other agencies and professionals are required to inform county public health offices including law enforcement officers (ORS 433.009), paramedics (ORS 433.085) and magistrates (ORS 433.130). County public health offices report all submitted data to the Oregon Public Health Division. The Oregon Public Health Division documents, collects, analyzes and disseminates the communicable disease information.

Data collection uses a variety of the resources described in preceding paragraphs, including the NSDUH survey statistics for Oregon. Other sources used are the 2009 Oregon census estimates, the Oregon State Police (2008 drug related arrests and DUII arrests using the Criminal Justice Commission described above for the information) and Public Health data (tuberculosis, hepatitis B, and HIV/AIDS).

Methodology

Overall

The estimated need for alcohol and drug treatment in Oregon is made using the latest information available from the National Survey on Drug Use and Health (NSDUH). This survey provides Oregon estimates of abuse and dependence for three age groups: 12 – 17, 18 – 25, and 26 plus. The Portland State University Population Research Center provides the state with annual population estimates for each county by a variety of demographics, including age groups.

AMH uses the latest population estimates and multiplies them against the prevalence estimates from the NSDUH for each county and age group. These county estimates are grouped into regions for the purpose of Block Grant reporting. This provides AMH with total estimated need by region for alcohol and drug treatment.

To estimate the gap between treatment and need, AMH totals the number of unique people served by age group and county. The information is grouped into the specified regions and compared to the treatment needs number. The result demonstrates the difference between those treated and those in need by region.

2012 Combined Block Grant Application

Intravenous drug users (IDU) and women

To estimate the treatment needs for IDU and women populations, AMH creates proportions of IDU and women served compared to all people served. This proportion is applied to the need estimates discussed earlier to come up with the estimated need among IDU and women. These estimates can be compared to the actual number that received services, similar to the methodology described earlier.

Prevalence for Hepatitis B, HIV/AIDS and Tuberculosis

This information is made available through the state's Public Health Department. The rates are at the county level and AMH uses this information to tally up rates by region.

Race and Ethnicity Estimates

Prevalence information for treatment needs among race and ethnicity groups is not available through the NSDUH. AMH uses the treatment need estimates for the general population and applies them to the population numbers for each of the race/ethnicity groups to generate estimated need for each race/ethnicity group. The information is then compared to counts of treated individuals to describe the gap between need and served, similar to previously described methods.

Substance Abuse Prevention and Treatment Service System Gaps

Heroin and Other Opioid Drugs

Since 1999, the rate of unintentional drug poisoning deaths has more than doubled, from 4.5 to 9.3 deaths per 100,000. Heroin-related deaths in Oregon are the highest they have been since 2000. Nearly 130 people across Oregon died in heroin-related deaths in 2009, more than twice the amount of all other drug-related deaths combined. Prescription opioid analgesics are increasingly implicated in drug poisoning deaths as well. Prescription drug abuse, particularly related to opioid pain medications, is a growing concern among addiction treatment providers and stakeholders in Oregon. Prescription pain relievers are Oregon's fourth most prevalent substance of abuse following alcohol, tobacco and marijuana. Compared to the rest of the nation, Oregon ranks among the top 10 states for:

- Annual abuse of prescription drugs for all ages (228,000 persons per year);
- Past year abuse of prescription drugs by youth 12 to 17 (34,000 persons per year); and,
- Past year abuse of prescription stimulants (55,000 persons per year).

2012 Combined Block Grant Application

The rate of non-medical use of pain relievers in Oregon is higher than that of the nation. The 18 to 25 year age group is of particular concern, with 15 percent reporting non-medical use of pain relievers in the past year. The rate of treatment admissions with prescription drugs as the primary substance of abuse has risen by 142 percent from 2003 to 2009. By contrast, since 2005 the rate of admissions with methamphetamine as a primary substance has declined by 20 percent. AMH intends to work to expand services to this population using evidence-based practices including the use of medications to treat addictions.

Co-occurring Mental and Physical Conditions

A growing number of individuals who enter addiction treatment have multiple and complex physical and mental health needs in addition to their substance use disorders. It is more common for individuals entering treatment to report having issues of dependence related to more than one type of substance. More individuals who enter treatment than in past years have physical health concerns or complications such as hepatitis C virus, HIV/AIDS, pregnancy, serious dental issues, chronic pain, and diabetes. While the provider system is hopeful about the impact of federal health reform on their ability to serve more Oregonians with a health benefit and to coordinate care with a growing number of physical health providers, the system is challenged in the meantime to hold on to existing capacity with reduced budgets and increased fixed costs.

In addition, according to the NSDUH 20 percent of Oregonians age 18 to 25 reported experiencing serious psychological distress in the past year and more than 10 percent experienced a major depressive episode. Unfortunately, Oregon ranks among the highest among the states for this measure. An estimated 30 to 40 percent of individuals who enter addiction treatment also have a co-occurring mental health disorder. Under the current rate structure, providers are challenged to meet the clinical and medical staffing needs that will adequately serve these populations and to provide the level of service intensity required to address complex and multiple issues facing individuals accessing treatment.

Returning Veterans

Oregon has 333,752 veterans, of whom approximately 60,000 are under age 44 (Veterans Administration, 2007). Approximately 30 percent of Iraq and Afghanistan War veterans report symptoms of Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury, Depression, or other mental illness. The addiction treatment system has insufficient capacity to serve a growing number of veterans. Due to budget reductions and constraints, workforce development initiatives have not kept pace with providing the unique skills and competencies needed to treat

2012 Combined Block Grant Application

veterans with complex needs. Family members who often care for a returning veteran also have complex needs go unmet as well.

Nearly 19 percent of the current conflict's veterans who received care through the Veteran's Administration (VA) were diagnosed with substance abuse or addiction disorders. The United States Army reports a 56 percent increase in diagnosed alcohol disorders from 2003 to 2009, leading to a need for more substance abuse counselors. From March to December 2009, 357 veterans and 28 family members of veterans contacted Oregon Partnership Helpline for substance abuse needs. However, interviews with VA staff, Oregon National Guard staff, and recently returned veterans indicate reluctance to access treatment services offered by the military. This situation is complicated by the fact that one in eight (about 13 percent) of non-elderly veterans are uninsured and about half of those are not eligible for VA health care. Their mental health and addiction needs go untreated, leading to higher incarceration rates, increased homelessness, family conflict, poor health and suicide. Not only does this service gap affect veterans it also impacts their family members.

Oregon Access to Recovery offers a choice of clinical and recovery-support services to individuals and their families seeking recovery. Veterans and their family members, particularly returning soldiers from Afghanistan and Iraq are considered a priority for this service. AMH recognizes the key relationships for access to potential Access to Recovery participants will be through local Veterans' Administration centers and other military and veterans' organizations. AMH and Oregon Department of Veterans' Affairs continue to collaborate making contacts and establishing relationships.

Re-Entry for Incarcerated Individuals

Individuals who have been incarcerated experience significant obstacles re-entering the community. Oregon currently has 13,927 incarcerated individuals, nearly double the population in 1995. Nearly 40 percent of people in jail are there on drug charges, representing 5,570 individuals (Department of Corrections, 2009). At any given time there are also some 19,000 individuals on parole and probation throughout the state (Department of Corrections, 2009). In February 2010, AMH conducted a focus group with inmates seeking input about their fears and hopes. As individuals approach parole, they grow anxious regarding housing, staying clean and sober, getting a job, developing sober support systems, and reintegrating with the broader community. They report a high need for recovery support services with little access.

Population Increase and Unmet Need

As Oregon's population grows, there will be an increase in the number of people with addiction disorders. However, funding for the basic community treatment services needed to treat these disorders has not increased in relation to the need for services. National research that looks at the need for services indicates 8.2 percent of the adult population ages 26 and older requires alcohol and drug treatment services; in Oregon that is 205,919 people. For those ages 18-25, the same research shows that 21.8 percent or 67,976 people are in need of treatment. The research also shows 8.8 percent of youth age 12-17 require treatment; in Oregon that is 27,591 youth.

In calendar year 2009, public funds provided services for 36,238 adults (18 percent of the need), 12,207 young adults (18 percent of the need) and 6,663 youth (21 percent of the need). Some of these individuals have insurance and with laws in place to ensure parity, demands for treatment will increase. However, many people with addiction disorders do not seek treatment until they have lost their jobs, insurance and families and when they seek or are mandated to treatment, they must rely on publicly funded services.

Detoxification

The current gap in detoxification capacity adversely impacts the service and availability of detoxification services which in turn increases the likelihood a person will access inappropriate or expensive care. AMH will invest block grant funds to assist currently funded Oregon detoxification programs to implement recognized standards of best practice documented in the literature and to increase capacity. The newest SAMHSA Treatment Improvement Protocol on detoxification and withdrawal management and the National Quality Forum National Voluntary Consensus Standard for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices will be used as a foundation document for building standards of care and service expectations. The service system will be supported in a shift from delivering "clinically managed" (commonly known as social) detoxification to "medically-monitored" detoxification. Additionally, Oregon lacks any stand-alone facilities for detoxification for adolescents ages 12-18.

Lack of Safe, Affordable Housing

The urban areas of Oregon are some of the most expensive for rental housing and home ownership in the country. A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addictions and mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous

2012 Combined Block Grant Application

environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most consumers of Oregon's publicly funded system live in these adverse living environments. As the economy has worsened, housing insecurity has become more pronounced for people with substance use and mental health disorders. In rural Oregon the need for safe, affordable housing is more pronounced due to the greater impact of the economic downturn. People experiencing homelessness who have mental health disorders are much less likely to use medications appropriately and continue in treatment services, thus increasing the risk of further illness, mandated treatment and greater disability.

2012 Combined Block Grant Application

Step Three:

Using the information in Step 2, States should identify specific priorities that will be included in the MHBG and SAPTBG. The priorities must include the target populations (as appropriate for each block grant) that are the Federal goals and aims of the Block Grant programs (those that are required in legislation and regulation)¹⁷ and should include other priority populations as identified by the State.

¹⁷ Children with serious emotional disorders and their families; adults with serious mental illness; persons who are intravenous drug users; women who are pregnant and have a substance use and/or mental disorder; parents with substance use and/or mental disorders who have dependent children; individuals with tuberculosis; and persons with or at risk for HIV/AIDS and who are in treatment for substance abuse.

State Priorities

1. **Health Systems Transformation** - OHA has begun implementation of House Bill 3650, the plan to integrate physical and mental health and addictions treatment managed by community-based Coordinated Care Organizations (CCOs). The Health Policy Board oversees the work of the Oregon Health Authority and the Governor appointed work groups to develop a plan to improve the health delivery system for Oregon Health Plan and Medicaid clients. The plan focuses on coordinated physical, behavioral, and eventually oral health to streamline an inefficient system, increase focus on prevention, improve the quality of care and control the cost of care. The groups are charged with presenting a draft operations plan to the February 2012 legislative session. OHA anticipates the legislatively approved plan to be fully operational on July 1, 2012. The major transformation involves development of Coordinated Care Organizations (CCOs). These organizations will serve as a single-point of accountability for the cost of health care within a global budget and for access to and quality of a coordinated system of physical health, behavioral health and oral health care services delivered to the specific population of individuals enrolled with the organization.

To improve health care OHA plans to focus on: health and preventive care, providing care for everyone and reducing waste in the health care system. OHA will be addressing these problems in both the public and private sectors. As part of the integration process OHA will incorporate SBIRT into contracts and agreements with entities using the National Quality Forum standards of care as a foundation for this work. OHA plans to build SBIRT into expectations for agreements with the CCOs. To better meet the needs of prioritized block grant populations OHA continues to partner with the Public Health Division on their Community Transformation grant application focusing on SBIRT.

2. **AMH System Change** – Community mental health and addictions programs have made innovations that prepare the system for integration, greater accountability and cost-effectiveness. Treatment outcome improvement efforts will continue to be refined for the mental health and addictions services systems as part of the outcome-based contracting process and in response to any new measures or performance domains included in the National Outcome Measures. AMH will expand utilization and performance incentives into more contract areas with local mental health authorities

2012 Combined Block Grant Application

between 2011 and 2014, building upon efforts related to the ITRS initiative. During the 2011-2013 biennium AMH intends to ensure all entities who receive SAPT block grant funds adhere to the “National Voluntary Consensus Standards for the Treatment of Substance use conditions: Evidence-Treatment Practices”.

3. **Underage Drinking Prevention** – AMH is emphasizing underage drinking (UAD) prevention. The counties and tribes have consistently placed UAD in their top three priorities. Based on the findings from the Oregon Healthy Teen Survey and the Student Wellness Survey, the past 30 day use of alcohol by 8th graders is almost twice that of the national average. UAD is so pervasive that the previous Governor appointed a task force including a wide range of agencies and disciplines. The task force developed Oregon’s Strategy to Reduce Underage Drinking. This plan contains six major initiatives including community-based leadership and coalitions to address UAD, public education, school-based curriculum, parent workshops, increased enforcement and adjudication, and improved data and evaluation infrastructure to accurately measure the outcomes of the initiative and guide future planning. The plan continues to guide the work of the counties, tribes and recipients of the United States Department of Justice Office of Juvenile Justice and Delinquency Prevention Enforcing Underage Drinking Laws funding. All Oregon counties and tribes submit biennial county or tribal plans defining how they will address the UAD problem in their area.
4. **Intensive Treatment and Recovery Services (ITRS)** – ITRS is an initiative started with funding from the 2007 Legislature addressing families experiencing a substance use disorder. The initiative is a collaborative effort between AMH and CAF. Funds were provided to increase the following services: residential treatment for parents and dependent children who go to treatment with their parent, intensive and regular outpatient treatment, child care, transportation, parenting classes, case management, peer-delivered services, alcohol and drug free housing, and other wraparound options for people in a parenting role who are in recovery from substance use disorders. AMH will continue to focus on cross division collaboration and coordination with child welfare partners. In addition, AMH will continue to monitor the contract performance standards for ITRS contractors to ensure they meet established targets. AMH maintains an assertive and close monitoring relationship with these contractors, reporting data on performance monthly to keep contractors engaged and accountable. NIATx was used as a process

2012 Combined Block Grant Application

improvement tool to promote provider/sub-contractor performance improvement in meeting the contract performance standards.

5. **Young Adults in Transition**—AMH has developed specific programming at various levels of care targeting Young Adults in Transition (YAT) aged 14-25. This development is an attempt to redress the dramatic shortfalls in services that occur once an individual turns 18 and includes, YAT specific residential development, YAT specific programming at the State Hospital, YAT specific Policy and Regulations, and YAT system integration as a part of AMH's health integration with OHA.

YouthM.O.V.E. Oregon is a statewide youth driven organization working closely with both the Oregon Family Support Network and AMH to further develop youth driven services and supports, peer delivered services for YAT and to expand youth voice in Oregon. YouthM.O.V.E Oregon is devoted to improving services and systems that support positive growth and development by uniting the voice of individuals who have lived experience in various systems, including but not limited to, mental health, juvenile justice, education and child welfare.

YouthM.O.V.E Oregon works as a diverse collective to unite the voices and causes of youth while raising awareness around youth issues. Coordinating young leaders across the state who sit on advisory committees and boards allows youth voice to be effectively heard. YouthM.O.V.E. also coordinates young adults to give service directly back to their communities.

Early intervention in psychosis is a well-researched model that is based on the observation that identifying and treating someone in the early stages of a psychosis can significantly improve their longer-term outcome. The 2007 Oregon legislature funded the Early Assessment and Support Alliance (EASA) to bring the most current, evidence-based treatment to individuals in the early stages of illness. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective, and prevents the long term morbidity associated with chronic psychotic illness. EASA is a critical program of services and supports that promote prevention and early intervention in psychosis. Expansion of this program beyond the existing 16 counties is a goal of AMH. EASA programs have demonstrated dramatic decreases in hospitalization rates and have shown to be cost effective in the short term and result in long term cost savings.

6. **Peer-Delivered Services** - AMH will continue to develop through policy guidance, funding and technical assistance, peer delivered services (PDS) as a component of a comprehensive service delivery system in both addictions and mental health. AMH recognizes the indisputable value of PDS in transforming the mental health and addiction services delivery system to one based on a recovery model. AMH will work with all service populations' stakeholder groups to develop strategies to increase the use and availability of PDS. AMH will develop the criteria and descriptions of peer wellness specialists and their education and training requirements and will encourage the development of a variety of peer-run services to serve local communities. Focused investment in this initiative is an investment in the future, an investment in the workforce, and an investment that will demonstrate significant results in transforming and redesigning the service delivery system.

7. **Co-occurring disorders** – While there is a clearly identified need for co-occurring disorder treatment capacity in the children's mental health system, few mental health clinicians are competent to deliver these services and supports. The mechanisms for such service delivery do not currently exist in the system. Some residential alcohol and drug programs are offering co-occurring disorder treatment. There is a co-occurring disorder competency checklist available for supervisors who would like to audit the skills, knowledge and abilities of their staff. AMH developed this checklist in 2009 and it is available on the AMH website:
<http://www.oregon.gov/OHA/addiction/co-occurring/main.shtml#cdcc>.

8. **Driving Under the Influence of Intoxicants (DUII) System Enhancements** - OHA/AMH plans to develop DUII system enhancements including implementing new Alcohol and Drug Evaluation and Screening Specialists (ADES) rules. Other system improvements include training for ADES and treatment providers about rule changes and the functions of the ADES. House Bill 2104 increases the fees associated with DUII Diversion Agreements and convictions. This will provide an additional \$5 million to the Intoxicated Driver Program Fund for indigent treatment, interpreter services and ignition interlock device services for those unable to pay. Additional legislation requires first-time offenders to install an ignition interlock device in their cars. AMH will administer the fund.

9. **Trauma informed services workforce development – Children’s Mental Health** – Workforce development to improve trauma informed service delivery is a crucial need in Oregon’s children’s mental health system. Preliminary efforts, through a contract with Dr. Bruce Perry and the ChildTrauma Academy, have begun to develop a cadre of clinicians qualified to identify and work with children who have been traumatized through neglect or abuse. Clinicians need to acquire a better understanding of the impact of trauma on brain development, with special attention to the developmental phase the child is in when the trauma occurs. Interventions are then tailored to the need of each child.

10. **Strategic Prevention Framework** - SAMHSA’s Center for Substance Abuse Prevention (CSAP) awarded Oregon a State Prevention Framework Grant (SPF) July 1, 2009 in the amount of \$2.1 million per year for five years. AMH submitted a statewide plan that identified the state’s data driven priorities. CSAP approved the plan in May of 2011. AMH has initiated work with 12 counties and nine federally recognized tribes. The implementation of the SPF will provide Oregon’s prevention system a common framework for assessing state and local needs and priorities based on the findings of the SEOW. The SEOW is making data-driven decisions about evidence-based programs to address the identified priorities delivered to the appropriate population and mobilizing communities and tribes in the implementation of the evidence-based programs. The SPF will also identify gaps in the prevention system infrastructure and afford AMH and the communities and tribes methods for evaluating evidence-based outcomes. The initial phase of the implementation process will install the prevention framework in 12 counties and nine federally recognized tribes. The long term plan is to implement the SPF framework throughout Oregon.

11. **Prescription Opioid Overdose Prevention Project (POP)** - Public health data show a trend of prescription opioid poisoning which has contributed to yearly increases in the number of prescription opioid related deaths and hospitalizations in Oregon. AMH and the Public Health Division formed the POP workgroup in 2010 in an effort to develop a detailed understanding of the opioid overdose death problem in Oregon. POP has been charged with assessing the state’s capacity to address the problem, and formulating strategies to impact this issue including additional data analysis and research. The POP will focus on developing methods to collect, analyze and disseminate data that track indicators over time and implement strategies

throughout community health and behavioral health networks to reduce opioid related poisoning, hospitalizations and deaths.

- 12. Increase Housing Stability for Young Adults and Adults with Serious Mental Illness and Families with Children with Serious Emotional Disorders** – Stable housing is a primary factor for facilitating recovery for people with mental health 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”¹⁸. Oregon has clearly identified housing as a key factor in recovery. Oregon’s historical focus has been on developing structured housing. More resources are being utilized to develop scattered site supported housing and independent living opportunities.
- 13. Increase Rates of Competitive Employment for Adults with Serious Mental Illness** – Oregon has successfully implemented the person-centered, evidence-based practice of IPS Supported Employment in 16 programs serving 16 counties throughout Oregon. In the 2009-2011 biennium 1,551 people with serious mental illness accessed IPS Supported Employment services. Even with the State’s high unemployment rates, the participants in the IPS Supported Employment programs have an average employment rate of 39.5%. As IPS Supported Employment services are expanded, AMH anticipates an increase in the overall employment rates for adults with serious mental illness.
- 14. Wellness** – AMH has engaged consumers, families, providers, counties and other stakeholders in the development of consumer-driven efforts to improve the health and well being of people with mental illness and substance use disorders. The early focus of this work is Tobacco Freedom, an initiative to provide people with the treatment, skills and resources they need to achieve a tobacco-free life and environment. This emphasis on wellness will improve overall health outcomes for people with mental illness and substance use disorders, who die 25 years earlier than the average Oregonian¹⁹. In June 2011, AMH released a Tobacco Freedom Policy to take effect in contracted residential addictions and mental health facilities January 1, 2012.

¹⁸ Permanent Supportive Housing Toolkit, SAMHSA, 2010

¹⁹ http://www.oregon.gov/OHA/addiction/publications/msur_pre_mort_6_2008.pdf

15. Cultural Competency – Services must be modified to become culturally sensitive and culturally competent so programs and services address cultural needs and recognize ethnic diversity. An area of great need for further development in Oregon is services and supports for individuals identifying as lesbian, gay, bisexual, transgender or questioning who have mental health and/or substance use disorder treatment needs. Additionally, Caucasians, Asians and Hispanics are under represented in the services population, while African-Americans and Native Americans are over represented relative to the numbers in the general population.

16. Increase Access to Community-Based Services – With health care reform and the expansion of Medicaid coverage, the percentage of adults with SMI accessing publicly funded services is expected to increase significantly. Individuals with SMI benefit from community mental health services that are specific to their needs and strengths. These services assist individuals in avoiding institutionalization and promote a path to recovery.

With the implementation of the Children’s System Change Initiative in 2005, Oregon saw a tremendous expansion of community-based services, in breadth, depth and intensity of available services for children and their families. However, there are still places within Oregon lacking in necessary types of services to complement a full array of community-based services for children and their families. In addition, many areas are lacking in adequate respite and crisis respite services for families that could assist in preventing residential and acute care services utilization.

17. Increase Access to Services in Rural Areas – Oregon has 36 counties of which 11 counties are considered urban. The remaining 25 counties are considered rural/frontier and approximately 23 percent of the State’s population resides in these counties. In rural areas, distances and lack of transportation can become barriers for individuals and families to access mental health and addictions services and supports. Individuals in rural areas continue to face barriers in receiving services such as psychiatric evaluation, outpatient treatment, extended care and acute care. Oregon has increasingly used teleconference technology for psychiatric evaluations and addictions treatment services and supports. Additionally, a majority of Oregon’s rural/frontier counties have received federal designation as mental health professional shortage areas to assist in recruiting psychiatrists for areas that lack coverage by physicians without regard to specialty.

- 18. Decrease criminal justice involvement for adults with SMI** – In Oregon, as in other parts of the country, police are often times called in and become the default “mental health crisis system”. This results in increasing numbers of people with serious mental illness being incarcerated when community-based mental health services may have been more appropriate. An additional layer of complexity arises when people experience difficulty accessing the help and treatment that they need, have an acute mental health episode and end up in the criminal justice system. AMH will continue to work with law enforcement, criminal justice system partners and CMHPs to develop preventive strategies and appropriate interventions.
- 19. Decrease OSH/SCIP/SAIP readmission rates at 30 and 180 days** – The Supreme Court’s Olmstead decision requires people to be treated at service levels appropriate to their needs in the most integrated setting possible. AMH has placed special emphasis on integrating state hospital and community services. It is important that adults and children discharged from OSH/SCIP/SAIP have effective transition planning on discharge. Individuals discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the individual’s needs and strengths. Better linkages need to be established between receiving programs in the community and these inpatient programs.
- 20. Increase services to older adults** – The older adult population is too often served by multiple systems that do not work collaboratively to meet the varied and specialized needs of these individuals. Improved access to quality services for older adults is a critical area of improvement for Oregon’s mental health and addictions treatment and support services systems. Over the past two years, AMH has cultivated a collaborative relationship with SPD. A representative from SPD and the Governor’s Commission on Senior Services serve on MHPAMAC. The integrated physical and mental health care for those older adults who are eligible for both Medicare and Medicaid should improve access to appropriate mental health and addictions treatment for this population.
- 21. System of Care Expansion** – The state of Oregon is committed to expanding its developing System of Care for children’s mental health. Building on successes in system reform generated from the policy changes and service delivery modifications developed in the Children’s System Change Initiative, Oregon has steadily worked to create an environment where a Wraparound model could grow and flourish as the cornerstone of

2012 Combined Block Grant Application

system development meeting the needs of children and families. Legislation passed in 2009 paved the way for a demonstration project that began to seed true System of Care development within Oregon. The Statewide Children's Wraparound Initiative will continue to contribute toward System of Care development and expansion. Integration of all system partners, with blended funding, is the goal.

22. Juvenile justice collaboration – CSAC has made collaboration with Juvenile Justice, and the integration of mental health and juvenile justice system efforts, a priority for its work plan for calendar year 2011. Better system integration as well as service integration will be essential for further expansion of the System of Care, and will be of benefit to children, young adults and their families. A needs assessment of the service gaps is currently being conducted.

2012 Combined Block Grant Application

Step Four:

For each of the priorities identified in Step Three, identify the relevant goals, strategies and performance indicators over the next two years. For each priority area, States should identify at least one goal. Each stated objective must be measurable.

For each goal, the State should describe the specific strategy that will be used to reach the goal. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, emotional health and prevention of mental illness and system improvements that will address the goal.

2012 Combined Block Grant Application

Priority Area #: 1 Health Systems Transformation

Goal:

Develop a plan to fully implement the requirements of House Bill 3650 to contract with CCOs for integrated physical health, mental health and addictions services for Legislative approval in February 2012.

Strategy:

Under the direction of the Health Policy Board work with the four workgroups established by the governor to develop a plan to implement the requirements of House Bill 3650. The plan includes requirements in four areas:

1. Criteria for selecting and contracting with CCOs.
2. Development of the global budget and method for allocating to the CCOs.
3. Development of the performance outcomes and other metrics needed to manage integrated physical health care, mental health and addictions services.
4. Development of the requirements to include people who are eligible for both Medicaid and Medicare in the services provided by the CCOs.

Performance Indicator:

The plan is approved by the February 2012 Legislative Session.

Description of Collecting and Measuring Changes in Performance Indicator:

AMH will participate in the Health System Transformation leadership committees and internal work groups producing work productions for consideration by the Health Policy Board and the four Governor appointed external work groups.

2012 Combined Block Grant Application

<i>Priority Area #:</i> 1 Health Systems Transformation
<i>Goal:</i> Increase access to publicly-funded mental health services by children and their families.
<i>Strategy:</i> Monitor enrollment increases from expansion of Medicaid program to children (Oregon Healthy Kids). Continue to support statewide expansion of community-based services and support MHOs/CCOs in service provision to enrollees. Utilize wraparound demonstration sites to further develop the array of community-based services.
<i>Performance Indicator:</i> Percentage of children with serious emotional disorders (SED) served in the publicly funded mental health system.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> Contracts, Medicaid encounters and claims (CPMS and MMIS data). Numerator – The number of children with SED receiving publicly funded mental health services. Denominator – The estimated number of children with SED.

2012 Combined Block Grant Application

Priority Area: 2 AMH System Change

Goal:

Develop a system of care for people with, or at risk of developing mental health and/or addiction disorders by improving mental health and addiction systems ensuring compatibility with the new statewide integrated health system.

Strategy:

Create a system of care that better utilizes Medicaid and non-Medicaid funds, improving services and health outcomes of those who are insured and those who are uninsured. The system change includes five main concepts:

1. A system of care that coordinates services and supports for individuals across the full spectrum of care.
2. Global budgeting for non-Medicaid funds with counties.
3. Outcome-based system management for CCOs and local mental health authorities
4. Coordination of Medicaid and non-Medicaid funds

Performance Indicator:

AMH, in conjunction with contractors and stakeholders, will develop and implement the new system change by July 1, 2012.

Description of Collecting and Measuring Changes in Performance Indicator:

AMH will meet weekly to ensure executive and sub-committees responsible for creating the new system are producing deliverables needed to implement change by July 1, 2012.

2012 Combined Block Grant Application

Priority Area: 3 Underage Drinking Prevention
Goal: Implement strategies across the State to reduce and prevent underage drinking in all 36 counties and nine federally recognized tribes.
Strategy: <ol style="list-style-type: none">1. In collaboration with the Enforcing Underage Drinking Laws Program, provide best-practice strategies for reducing underage drinking among the counties & tribes. Strategies include, but are not limited to: Statewide Positive Community Norms campaign to promote community norms regarding alcohol use by teens; Minor decoy, controlled party dispersal and shoulder tap operations.2. Collaborate with the Alcohol & Drug Policy Council to promote underage drinking prevention activities and environmental changes.3. Continue to address priority efforts developed in “Oregon’s Strategy to Reduce Underage Drinking” using block grant and other funding streams.
Performance Indicator: Decrease in the number of sales of alcohol to minors. Increase in the number of citations related to alcohol use by minors and for furnishing alcohol to minors. Decrease percentage of 8 th graders who report alcohol use in the past 30 days to 27 percent.
Description of Collecting and Measuring Changes in Performance Indicator: Oregon Liquor Control Commission data will be used to monitor compliance rates among liquor licensees during minor decoy operations. In addition, Alcohol & Drug Policy Commission activities will be monitored for changes in statutes related to underage drinking. Implementation of Student Wellness Survey in all schools throughout the state.

2012 Combined Block Grant Application

<i>Priority Area:</i> 4 Intensive Treatment and Recovery Services (ITRS)
<i>Goal:</i> Develop and implement addiction treatment and recovery services for parents who are at risk of or involved in the child welfare system, preventing or reducing out of home placements for their children.
<i>Strategy:</i> Build recovery oriented system of care in all counties.
<i>Performance Indicator:</i> Establish baseline in 2011. Ensure that 100 percent of counties/direct contractors meet contractual utilization requirements, and 60 percent provide 90 or more days of outpatient treatment and recovery services to individuals enrolled in ITRS in 2012.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> Pull and send out monthly progress reports to contractors with utilization data using CPMS and OWITS data. Identify contractors who serve 60% of individuals enrolled in ITRS for at least 90 days in treatment and recovery services using CPMS data pulled through March 31, 2012. Award incentives to those contractors who meet 60% threshold for fiscal year 2012. Use Key Performance Measure #3 (biennial), CPMS and child welfare data (annual) to measure child reunification rate for parents receiving ITRS.

2012 Combined Block Grant Application

<p>Priority Area: 4 Intensive Treatment and Recovery Services (ITRS)</p>
<p>Goal: Develop and implement addiction treatment and recovery services for parents who are at risk of or involved in the child welfare system, preventing or reducing out of home placements for their children.</p>
<p>Strategy: Provide technical assistance using a structured approach to develop cross-collaboration between addiction providers and child welfare offices and programs promoting effective community partnerships and best practices.</p>
<p>Performance Indicator: Percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment. Most current result is 43.3 %. Target for 2011 is 55 %.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: Pull and send out monthly progress reports to contractors with utilization data using CMPS and OWITS data. Identify contractors who serve 60% of individuals enrolled in ITRS for at least 90 days in treatment and recovery services using CPMS data pulled through March 31, 2012. Award incentives to those contractors who meet 60% threshold for fiscal year 2012.</p> <p>Use Key Performance Measure #3 (biennial), CPMS and child welfare data (annual) to measure child reunification rate for parents receiving ITRS.</p>

2012 Combined Block Grant Application

Priority Area #: 5 Young Adults in Transition

Goal:

To increase service coordination and delivery for persons aged 14-25 with serious emotional disorders who are transitioning into the adult community mental health service system.

Strategy:

Expansion of community treatment/housing options; technical assistance; AMH workgroup; youth system involvement.

Performance Indicator:

Establish and increase the number of young adults in transition (YAT) served in specific community placements.

Description of Collecting and Measuring Changes in Performance Indicator:

AMH funded specific community placements-annual reports.

2012 Combined Block Grant Application

<p>Priority Area: 6 Peer Delivered Services</p>
<p>Goal: Increase the use and availability of peer delivered services.</p>
<p>Strategy: Peer-delivered services are promising practices that exemplify hope, recovery, resilience and independence. Peer-delivered services reflect a national trend and these services play a role within a recovery-oriented continuum of care. Oregon is home to a wide array of peer-delivered programs; some operate within the physical and behavioral health care service delivery systems, and others provide alternative services. Most are community-based and all are delivered by people with substance use and/or mental health disorders or family members of adults or children with mental health disorders. Peer delivered services operate at the grassroots level and some of these programs have a statewide focus. AMH serves as a partner and collaborator in this effort and encourages community engagement in support and expansion of these services.</p>
<p>Performance Indicator: Develop baseline of the number of peer service providers integrated into medical, dental and behavioral health service delivery systems.</p> <p>Develop baseline and document a 5% increase in the number of peer service providers and contractors receiving technical assistance from OHA.</p>
<p>Description of Collecting and Measuring Changes in the Performance Indicator: Develop system to collect and measure changes in the number of peers service providers integrated into medical, dental and behavioral health service delivery systems.</p> <p>Develop system to collect and measure the number of peer service providers and contractors receiving technical assistance from OHA.</p>

2012 Combined Block Grant Application

Priority Area #: 6 Peer Delivered Services

Goal:

Increase the training of youth with SED and their families in mental health services planning and monitoring.

Strategy:

Training of youth and family members; Family Navigator training; Youth Navigator curriculum development; recruitment of youth and family members for advisory councils; technical assistance by family partnership specialist within AMH.

Performance Indicator:

1. Increase the number of trained family members of children with SED.
2. Increase the number of trained youth (ages 14-25) with SED who have had or who are currently receiving mental health services.

Description of Collecting and Measuring Changes in Performance Indicator:

Oregon Family Support Network Project Reports and training rosters

2012 Combined Block Grant Application

<i>Priority Area #:</i> 7 Co-occurring Disorders
<i>Goal:</i> Increase the number of adolescents receiving treatment for co-occurring disorders
<i>Strategy:</i> Share co-occurring disorders competency checklist with chemical dependency and psychiatric residential treatment facilities, understand barriers that may impede development of these services and work to eliminate barriers.
<i>Performance Indicator:</i> Obtain baseline measurement of facilities that are capable of co-occurring disorder treatment.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> Survey of facilities

2012 Combined Block Grant Application

<p>Priority Area: 8 Driving under the Influence of Intoxicants (DUII) System Enhancements</p>
<p>Goal: Increase access to DUII services for indigent populations including treatment, interpreters, and ignition interlock device installation.</p>
<p>Strategy: Develop performance-based contracting to maximize the number of indigent status individuals served. Provide ongoing monitoring and status reporting of system capacity increases to appropriate stakeholders.</p>
<p>Performance Indicator: Establish a baseline and document a 5 percent increase in indigent individuals served, and ignition interlock devices installed for indigent individuals.</p> <p>Establish a baseline and document a 5% increase of indigent individuals who complete treatment requirements.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: Analyze CPMS data and monthly vendor installation reports regarding ignition interlock devices to ensure compliance with performance indicators.</p>

2012 Combined Block Grant Application

<i>Priority Area #:</i> 9 Trauma Informed Services Workforce Development
<i>Goal:</i> Increase the number of clinicians skilled in a neurodevelopmental-based approach to treating trauma in children.
<i>Strategy:</i> Contract through the ChildTrauma Academy
<i>Performance Indicator:</i> Count number of clinicians trained
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> Establish baseline in 2012.

2012 Combined Block Grant Application

<i>Priority Area:</i> 10 Strategic Prevention Framework
<i>Goal:</i> Implement the Strategic Prevention Framework in the State of Oregon.
<i>Strategy:</i> Fund 12 counties and nine federally recognized tribes based on the State Epidemiological Outcome Workgroup and SPF Advisory Council data and funding recommendations.
<i>Performance Indicator:</i> The 12 counties will have approved plans and the nine tribes will have completed comprehensive assessments.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> All sub-recipients plans/assessments will be submitted and accepted.

2012 Combined Block Grant Application

<p>Priority Area: 11 Prescription Opioid Overdose Prevention Project (POP)</p>
<p>Goal: Prevent further increases in hospitalizations and deaths related to prescription opioids.</p>
<p>Strategy: The POP will develop a work plan that outlines specific, well-defined strategies, to reduce hospitalizations and deaths resulting from prescription methadone poisonings. The POP will use the Strategic Prevention Framework Model, outcomes data, informed decision making and the Oregon Injury and Violence Prevention plan to accomplish the work.</p>
<p>Performance Indicator: Establish a baseline as of fiscal year 2011 and maintain current rates of hospitalizations and deaths related to overdose of prescription opioids among individuals enrolled in the Oregon Health Plan.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: Analyze MMIS data to ensure maintenance of rates of hospitalizations of OHP individuals related to prescription opioid overdoses, including methadone. Analyze Oregon Vital Statistics death certificate data to ensure maintenance of rates of deaths in Oregon related to prescription opioids, including methadone.</p>

2012 Combined Block Grant Application

<i>Priority Area #:</i> 12 Increase housing stability for adults with SMI
<i>Goal:</i> Increase housing stability for adults with SMI.
<i>Strategy:</i> Oregon’s historical focus has been to develop structured housing in order to fill the gap in housing needs for people with serious mental illness. AMH is implementing new approaches to investing resources from the development of structured housing, to supporting model programs which integrate people into the community of their choice, living in their own homes, with appropriate and flexible support services.
<i>Performance Indicator:</i> As reported in the 2010 Mental Health Block Grant implementation report, 50.6 percent of adults responding to the MHSIP-AOCS reported that their housing situation had improved. A minimum of 52.6 percent of adults with SMI will report that their housing situation has improved in FY 2012.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> MHSIP Survey Results will be used to collect data and measure this performance indicator. Numerator – The percent of respondents to the MHSIP Adult Outpatient Consumer Survey that agree or strongly agree with the survey item, “My housing situation has improved.” Denominator – The number of adults responding to the MHSIP Adult Outpatient Consumer Survey that responded to the survey item, “My housing situation has improved.”

2012 Combined Block Grant Application

Priority Area #: 12 Increase housing stability for families with children with SED

Goal:

Decrease homelessness among children who receive publicly funded outpatient mental health services.

Strategy:

Increased focus on young adults in transition, and on youth involvement and youth voice, is one strategy that AMH is using to reduce the incidence of homelessness in the 14-25 year old age group. AMH also strives to work with MHOs and CMHPs to provide individualized services that strengthen families and mitigate family stress which can be helpful in decreasing the incidence of child homelessness.

Children receiving mental health services are likely to receive services from other service delivery systems prior to, during, and/or following receipt of mental health services; the services provided through these other service delivery systems could also have an impact on homelessness. Data on homelessness within the mental health service population are collected only at the beginning and at the end of an outpatient mental health service episode; changes in housing status within the service episode are not known.

Performance Indicator:

Identify the number of children who are no longer homeless at the termination of services out of the total number identified as homeless at the initiation of service.

Description of Collecting and Measuring Changes in Performance Indicator:

CPMS data

Numerator – Number of children completing an episode of outpatient mental health service that were identified as homeless upon initiation of that service episode and identified as no longer homeless upon termination of that service episode.

Denominator – Number of children completing an episode of outpatient mental health service who were identified as homeless upon initiation of that service episode.

2012 Combined Block Grant Application

<p>Priority Area #: 13 Increase rates of competitive employment for adults with SMI</p>
<p>Goal: Increase the percentage of clients who are competitively employed.</p>
<p>Strategy: Oregon is committed to implementing evidence-based practices in mental health and addictions services. To this end, AMH has spent increasing shares of public dollars on evidence-based practices. Oregon has implemented high fidelity Individual Placement and Support (IPS) Supported Employment in 16 programs serving 16 of Oregon’s 36 counties. Three additional programs serving another two counties are working to reach the fidelity benchmark.</p>
<p>Performance Indicator: Establish baseline in 2011. In 2012 a minimum of 15 percent of adults with serious mental illness will be competitively employed.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: CPMS will be used to collect data and measure this performance indicator. Numerator – Number of adult clients competitively employed full- or part time. Denominator – Number of adults competitively employed full- or part-time plus the number of persons unemployed plus the number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops, and other; excludes persons whose employment status was “not available”).</p>

2012 Combined Block Grant Application

Priority Area #: 14 Wellness
Goal: Increase the percentage of adults with SMI reporting positive outcomes on the MHSIP survey.
Strategy: With the movement to a cohesive state health authority, AMHI and the integrated services pilot sites, the goal is that more efficient and effective service delivery will lead to more positive client outcomes.
Performance Indicator: As reported in the 2010 Mental Health Block Grant implementation report, 57.2 percent of adults reported positive outcomes on the MHSIP survey. In 2012, 59.2 percent of adults with SMI will report positive outcomes on the MHSIP survey.
Description of Collecting and Measuring Changes in Performance Indicator: MHSIP Survey Results will be used to collect data and measure this performance indicator. Numerator – The number of adults reporting positive perception of outcomes. Denominator – The number of adults responding to the MHSIP Adult Outpatient Consumer Survey (AOCS).

2012 Combined Block Grant Application

<p>Priority Area #: 14 Wellness</p>
<p>Goal: Improved Functioning</p>
<p>Strategy: Two of the Addictions and Mental Health Division's (AMH) Strategic Planning Initiatives will address this performance Measure: Peer Delivered Services and Wellness. <u>Peer-delivered services</u> are promising practices that exemplify hope, recovery, resilience and independence. Peer-delivered services reflect a national trend and these services play a role within a recovery-oriented continuum of care. Oregon is home to a wide array of peer-delivered programs; some operate within the mental health and addictions systems, and others provide alternative services. Most are community-based and all are delivered by people with serious mental illness or family members of adults or children with serious emotional disorders. Peer delivered services operate at the grassroots level and some of these programs have a statewide focus. AMH serves as a partner and collaborator in this effort and encourages community engagement in support of these services. <u>AMH's Wellness Initiative</u> strengthens integration efforts already underway between physical health and behavioral health. It blends the excellent work of the AMH Wellness Task Force (established after the release of the division's 2008 <i>Measuring Premature Mortality among Oregonians</i> report²⁰), DHS Core Integration Team, the Public Health Division, OSH, mentors, consumers, family members, community stakeholder groups and providers in consultation with national experts to move from knowing about health inequities to taking immediate action steps to prevent health disparities.</p>
<p>Performance Indicator: As reported in the 2010 Mental Health Block Grant implementation report, 57 percent of adults with SMI responded positively to the functioning question on the MHSIP-AOCS. In 2012, 59 percent of adults with SMI will respond positively to the functioning question on the MHSIP-AOCS.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: MHSIP Survey Results will be used to collect data and measure this performance indicator. Numerator – The number of adults with positive responses to the functioning question on the MHSIP survey. Denominator – The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.</p>

²⁰ <http://www.oregon.gov/DHS/mentalhealth/data/main.shtml>

2012 Combined Block Grant Application

<p>Priority Area #: 14 Wellness</p>
<p>Goal: Increase reported social connectedness on the MHSIP-Adult Outpatient Consumer Survey.</p>
<p>Strategy: The Peer Delivered Services Initiative will help address this goal. Feeling supported in recovery is a key to remaining vital and healthy. Support delivered by peers who have themselves experienced the mental health system can be a powerful tool in a person’s recovery. The AMHI Initiative will also address this goal as more people are served in the community.</p>
<p>Performance Indicator: As reported in the 2010 Mental Health Block Grant implementation report, 60.1 percent of adults with SMI had positive responses to the social connectedness category in the MHSIP-AOCS. In 2012, 62.1 percent of adults with SMI will have positive responses to the social connectedness category in the MHSIP-AOCS.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: MHSIP Survey Results will be used to collect data and measure this performance indicator.</p> <p>Numerator – The number of adults with positive responses to the social connectedness category in the MHSIP Adult Outpatient Consumer Survey. Denominator – The number of adults responding to the MHSIP Adult Outpatient Consumer Survey.</p>

2012 Combined Block Grant Application

<i>Priority Area #:</i> 14 Wellness
<i>Goal:</i> Caregivers of children with SED report an increase in Social Connectedness.
<i>Strategy:</i> People need to feel that they have meaningful relationships and have a place in the community. Families of children with SED and young adults with mental health disorders are in need of a supportive community. Stigma remains a significant barrier to increased feelings of social connectedness among families and young adults with SED. Development of peer delivered services for family members and youth will significantly impact the alienation that stigma causes for families and young adults, and improve family wellness. Development of systems of care statewide will also assist in improving feelings of social connectedness.
<i>Performance Indicator:</i> The social connectedness domain of the YSS-F survey.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> YSS-F Survey, YSS survey Numerator – Number of caregivers of children with SED with positive response to the Social Connectedness questions on the YSS-F survey. Denominator – The number of caregivers of children with SED responding to the YSS-F survey.

2012 Combined Block Grant Application

Priority Area #: 15 Cultural Competency
Goal: The proportion of the ethnic/racial population received services will match or exceed the proportion of the State's children within the same ethnic population.
Strategy: Expansion of culturally competent workforce development and increased access to services for children who are ethnically or culturally diverse in their background.
Performance Indicator: The percentage share of children within ethnic categories who are receiving mental health services compared to the percentage share of children within ethnic categories for the general population.
Description of Collecting and Measuring Changes in Performance Indicator: CPMS, MMIS, Portland State University Population Research Center Numerator – Within each ethnic / racial group, the number of Medicaid-eligible children who receive publicly funded mental health services. Denominator – Within each ethnic / racial group, the number of Medicaid-eligible children.

Priority Area #: 16 Increase access to community-based services

2012 Combined Block Grant Application

Goal:

Increase the percentage of adults with serious mental illness (SMI) who have access to the publicly funded mental health system.

Strategy:

Continue education of policy makers and legislators regarding the costs savings of community-based treatment services provided in the most integrated setting. These services are appropriate to a person's needs in order to avoid much higher costs associated with institutionalization. Continue to support statewide expansion of community-based services and support MHOs/CCOs in service provision to enrollees.

Performance Indicator:

A minimum of 48.5 percent of adults with serious mental illness will access publicly funded mental health services in FY 2012.

Description of Collecting and Measuring Changes in Performance Indicator:

CPMS will be used to collect data and measure this performance indicator.

Numerator – The number of adults with SMI accessing publicly funded mental health services.

Denominator – The number of adults with SMI.

2012 Combined Block Grant Application

Priority Area #: 16 Increase access to community-based services
Goal: Increase the array of community-based mental health services available to and delivered to children with serious emotional disorders.
Strategy: Workforce development; technical assistance; Statewide Wraparound Project.
Performance Indicator: The percentage of children with SED who receive three or more types of community-based mental health services over the course of a year will match or exceed baseline, which was 38%.
Description of Collecting and Measuring Changes in Performance Indicator: Client Process Monitoring System (CPMS) and Medicaid Management Information System (MMIS) Numerator – Number of children with SED who receive three or more types of community-based mental health services. Community-based mental health services for children are defined as intensive services available in the community such as assessment, care coordination, skills training, individual therapy, group therapy, family therapy, respite, peer-delivered services and crisis intervention. Denominator – Number of children with SED.

2012 Combined Block Grant Application

Priority Area #: 17 Increase access to services in rural areas
Goal: The proportion of children receiving mental health services in rural areas will match or exceed the proportion of the State's population of children who live in rural areas.
Strategy: Formation of regional oversight committees; telemedicine; videoconferencing for interagency collaboration.
Performance Indicator: The proportion of the children receiving mental health services who live rural areas will match or exceed the proportion of the State's population of children who live in rural areas.
Description of Collecting and Measuring Changes in Performance Indicator: CPMS, OP/RCS, MMIS and public sources of data on the number of children living in various areas across the State. Numerator – a. For the proportion of children receiving mental health services who are from rural areas: The number of children receiving mental health services who live in rural areas. b. For the proportion of children living in rural areas: The number of children living in rural areas. Denominator – a. For the proportion of children receiving mental health services who are from rural areas: The number of children receiving mental health services. b. For the proportion of children living in rural areas: The number of children living in Oregon.

2012 Combined Block Grant Application

<p>Priority Area #: 18 Decrease criminal justice involvement for adults with SMI</p>
<p>Goal: Decreased criminal justice involvement by adults with SMI.</p>
<p>Strategy:</p> <ol style="list-style-type: none">1. AMH will continue to work with law enforcement, criminal justice system partners and CMHPs to develop preventive strategies and appropriate interventions.2. Through AMHI, additional community services will help to divert individuals from criminal justice involvement.3. The Early Assessment and Support Alliance will help divert individuals who are experiencing their first psychotic break from future involvement in the criminal justice system.
<p>Performance Indicator: In 2012, 70.9 percent of adults with SMI will report no arrests in the year following treatment on the MHSIP-AOCS.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: MHSIP Survey Results will be used to collect data and measure this performance indicator. Numerator – Difference between the number of adult consumers arrested in the year preceding treatment and the number of adult consumers arrested in the year following treatment. Denominator – The number of adults responding to the MHSIP Adult Outpatient Consumer Survey who indicated (1) when they initiated treatment with the most recent mental health service provider; (2) whether they were arrested in the year before initiation of the most recent mental health treatment episode; and (3) whether they were arrested in the year following initiation of the most recent mental health treatment episode.</p>

2012 Combined Block Grant Application

<p>Priority Area #: 18 Decrease criminal justice involvement for adults with SMI</p>
<p>Goal: Reduce reliance on mandated admission to OSH through the aid and assist process for adults with serious mental illness.</p>
<p>Strategy: AMH has pilot projects in four Oregon counties: Douglas, Lane, Marion and Multnomah. AMH is working with judges, defense attorneys and public defenders to divert people from being criminally committed to the state hospital. AMH provides funding to the CMHPs for case management, rental assistance, psychiatric assessments, medications and staff training. AMH also supports the counties in developing diversion agreements with county courts and jails.</p>
<p>Performance Indicator: In 2012, 298 or fewer adults with SMI will be mandated to admission to OSH through the aid and assist process.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: OP/RCS will be used to collect data and measure this performance indicator.</p> <p>Numerator – The number of aid and assist admissions. Denominator – 1</p>

2012 Combined Block Grant Application

<p>Priority Area #:19 Decrease OSH readmission rates at 30 and 180 days</p>
<p>Goal: Decrease the rate of readmission of adults with SMI to the State psychiatric hospitals within 30 days.</p>
<p>Strategy: 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 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.</p> <p>AMH will work with community providers to ensure that they have appropriate transition plans to smooth the transition trauma that may occur. AMH will implement positive behavioral supports training for residential providers. 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.</p> <p>AMH continues to work with MHOs to support individuals who transition directly to independent living. AMH will review each situation of early readmissions and use them as a training opportunity for MHOs and community providers.</p>
<p>Performance Indicator: 1.0 percent or less of adults with SMI will be readmitted within 30 days of discharge from OSH.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: OP/RCS will be used to collect data and measure this performance indicator. Numerator – The number of civilly committed adults discharged from the state psychiatric hospitals who return within 30 days. Denominator - The total number of civilly committed adults discharged from the state psychiatric hospital.</p>

2012 Combined Block Grant Application

<p>Priority Area #: 19 Decrease OSH readmission rates at 30 and 180 days</p>
<p>Goal: Decrease the rate of readmission of adults to the State psychiatric hospitals within 180 days.</p>
<p>Strategy: 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 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.</p> <p>AMH will work with community providers to ensure that they have appropriate transition plans to smooth the transition trauma that may occur. AMH will implement positive behavioral supports training for residential providers.</p> <p>AMH continues to work with MHOs to support individuals who transition directly to independent living. AMH will review each situation of early readmissions and use them as a training opportunity for MHOs and community providers.</p>
<p>Performance Indicator: 9.3 percent or less of adults with serious mental illness will be readmitted within 180 days of discharge from OSH.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: OP/RCS will be used to collect data and measure this performance indicator. Numerator – The number of civilly committed adults discharged from the state psychiatric hospital who return within 180 days. Denominator - The total number of civilly committed adults discharged from the state psychiatric hospital.</p>

2012 Combined Block Grant Application

<p>Priority Area #: 19 Decrease SCIP/SAIP Readmission Rates at 30 days</p>
<p>Goal: Reduce the rate of readmission within 30 days of children with SED to the Secure Children’s Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).</p>
<p>Strategy: Oregon is working with Community Mental Health Programs, Mental Health 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. Youth 14-17 comprise the greater part of the denominator for this indicator. AMH monitors discharge planning at SCIP/SAIP through technical assistance; AMH continues to encourage development of community-based services that will meet the needs and strengths of children being discharged from SCIP/SAIP. AMH has taken action by creating a separate secure program for youth who need the highest level of mental health (not forensic) care within a residential program.</p>
<p>Performance Indicator: Reduce the rates of readmission within 30 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: MMIS and CPMS data</p> <p>Numerator – Number of children with SED who are readmitted to the Secure Children’s Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 30 days of their first discharge of the fiscal year. Denominator – Number of children with SED who are discharged from the Secure Children’s Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year.</p>

2012 Combined Block Grant Application

<p>Priority Area #: 19 Decrease SCIP/SAIP Readmission Rates at 180 days</p>
<p>Goal: Reduce the rates of readmission within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).</p>
<p>Strategy: It is important that children with SED have effective transition planning upon discharge from the Secure Children's Inpatient Program or Secure Adolescent Inpatient Program. Children discharged from these programs must be discharged appropriately and receive follow up treatment and support services according to the child's mental health needs and strengths.</p>
<p>Performance Indicator: Reduce the rates of readmission within 180 days for children with serious emotional disorders to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP).</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: CPMS data</p> <p>Numerator – Number of children with SED who are readmitted to the Secure Children's Inpatient Program (SCIP) and the Secure Adolescent Inpatient Program (SAIP) within 180 days of their first discharge of the fiscal year.</p> <p>Denominator – Number of children with SED who are discharged from the Secure Children's Inpatient Program (SCIP) or the Secure Adolescent Inpatient Program (SAIP) over the course of the fiscal year.</p>

2012 Combined Block Grant Application

Priority Area #: 20 Increase services to older adults
Goal: Increase participation rates for Medicaid-eligible older adults in Medicaid managed MHOs.
Strategy: Work with MHOs and CCOs to increase participation rates of older adults in the Medicaid managed care plans. Develop an ongoing process to report to the MHOs and CCOs about the participation rates of older adults in all Medicaid Managed Care Plans. Develop plan specific strategies to address issues with managed care entities that are not meeting performance expectations.
Performance Indicator: Establish baseline of enrolled older adults receiving services by Medicaid Managed Mental Health Care Plans in 2011, and increase by 10 percent in 2012.
Description of Collecting and Measuring Changes in Performance Indicator: CPMS and MMIS will be used to collect data and measure this performance indicator. Numerator – The number of Medicaid-eligible older adults receiving MHO services. Denominator – The number of Medicaid-eligible older adults enrolled in MHO plans.

2012 Combined Block Grant Application

<p>Priority Area #: 21 System of Care (Family Voice)</p>
<p>Goal: Parents/guardians of children with SED will report improved functioning of their children.</p>
<p>Strategy: With the movement toward a cohesive state health authority and the continued development of a children's mental health System of Care, it is anticipated that efficient and effective service delivery will lead to positive outcomes that will be reflected in parental perception of children's functioning.</p> <p>Technical assistance with service providers to develop appropriate selection of therapies, treatment and supports for individual children and their families; workforce development.</p>
<p>Performance Indicator: Parents/guardians of children with SED will report improved functioning of their children.</p>
<p>Description of Collecting and Measuring Changes in Performance Indicator: Youth Services Survey for Families (YSS-F) and Youth Services Survey Results</p> <p>Numerator – Number of caregivers of children with SED with positive response to the Functioning questions on the YSS-F survey. Denominator – The number of caregivers of children with SED responding to the YSS-F survey.</p>

2012 Combined Block Grant Application

<i>Priority Area #:</i> 21 System of Care Expansion
<i>Goal:</i> The population of children with SED will show improved participation in school following mental health treatment.
<i>Strategy:</i> Continue to support statewide provision of educational services and supports to children with SED. Work with educational system to create services/programs that meet the needs of children with SED effectively. Continue stigma reduction efforts.
<i>Performance Indicator:</i> The number of parents/guardians who report that their child's school attendance improved following the initiation of mental health treatment will meet or exceed baseline.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> MHSIP YSS-F Survey Numerator – The number of parents/guardians who report that their child's school attendance improved following the initiation of mental health treatment. Denominator – Number of parents/guardians who provide a valid response to a survey item indicating school attendance.

2012 Combined Block Grant Application

<i>Priority Area #:</i> 21 System of Care Expansion
<i>Goal:</i> Increase the percentage of children with severe emotional disorders who receive mental health services while residing in a family-like setting.
<i>Strategy:</i> Continued implementation of the Children’s System Change Initiative and the Statewide Children’s Wraparound Initiative; Technical assistance to counties. Work together with the Children, Adults and Families Division to promote use of family and relative foster care whenever children cannot live with their natural parents, promote permanent adoption whenever feasible.
<i>Performance Indicator:</i> Percentage of children with SED receiving mental health services in an outpatient setting while residing in a family-like setting will match or exceed 89%.
<i>Description of Collecting and Measuring Changes in Performance Indicator:</i> Client Process Monitoring System (CPMS) data Numerator – Number of children receiving outpatient mental health services while residing in a family-like setting. Family-like settings include children in foster care, relative foster care, children residing with biological or adoptive parents. It excludes children living in psychiatric residential settings. Denominator – Number of children with SED receiving public mental health services.

2012 Combined Block Grant Application

Priority Area #: 21 System of Care Expansion
Goal: Children in Child Welfare with SED will receive a mental health assessment upon entry into substitute care.
Strategy: Determine method to increase number of completed mental health assessments. Utilize CAF-AMH workgroup monitoring of system and child level data monitoring. Communicate with all child welfare caseworkers about importance of this measure. Facilitate collaboration between mental health programs and child welfare system.
Performance Indicator: Increase the percentage of children entering the child welfare system who receive timely initial mental health assessments to 90 percent.
Description of Collecting and Measuring Changes in Performance Indicator: MMIS and administrative data maintained within the Division of Children, Adults and Families (CAF). Numerator – Number of children with SED entering substitute care in the DHS Child Welfare system who receive a mental health assessment within 60 days of entering care. Denominator – Number of children with SED entering substitute care in the DHS Child Welfare system.

2012 Combined Block Grant Application

Priority Area #: 21 System of Care Expansion

Goal:

To increase the number of parents/guardians of children with SED who agree or strongly agree that mental health services have been family-driven.

Strategy:

Ongoing support for meaningful family involvement; technical assistance regarding roles of family members in the child and family team, training of care coordinators and family peer specialists.

Performance Indicator:

Increase the percentage of caregivers of children with SED who agree or strongly agree with a survey item (appended to the Youth Services Survey for Families) indicating that services were family-driven.

Description of Collecting and Measuring Changes in Performance Indicator:

MHSIP YSS-F

Numerator – The number of parents/guardians that agree or strongly agree with the survey item indicating that services were family-driven.

Denominator – The total number of parents/guardians responding to the MHSIP YSS-F.

2012 Combined Block Grant Application

Priority Area #: 22 Juvenile Justice Collaboration
Goal: The population of children with serious emotional disorders (SED) will experience a lower likelihood of arrest following initiation of mental health treatment.
Strategy: Youth who come in contact with the juvenile justice system have a high occurrence of mental health needs. Oregon will seek to improve the provision of mental health services to youth involved in the juvenile justice system. Improved mental health services are expected to decrease criminal activity.
Performance Indicator: The percentage of children, as reported by parents or guardians, who were arrested in Year 1 and not re-arrested in Year 2, will increase.
Description of Collecting and Measuring Changes in Performance Indicator: MHSIP data Numerator – The number of children, as reported by parents or guardians, with no arrests for one year after starting treatment. Denominator – The number of children, as reported by parents or guardians, who were arrested within a year prior to mental health treatment.