

# *Addictions and Mental Health*

---

## *Mission*

The mission of the Oregon Health Authority is to help people in communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care. The Addictions and Mental Health Division contributes to that mission.

The mission of the Addictions and Mental Health Division (AMH) is to assist Oregonians to achieve optimum physical, mental and social well-being by providing access to health, mental health and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities.

The mission is accomplished by working in partnership with individuals and their families, other state agencies, providers, advocates and communities to accomplish the following goals.

## *Goals*

The goals of AMH are to:

Improve the lifelong health of all Oregonians;

Improve the quality of life for the people served;

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

Reduce overall health care and societal costs through appropriate investments;

Increase the effectiveness of the integrated health care delivery system;

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

Increase accountability of the health care system; and

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

## ***History***

Oregon's mental health system has been in existence for 160 years. A portion of the Oregon State Hospital facility built in 1883 remained in use throughout 2008. Prior to the mid-20th century, virtually all people with mental illness received treatment in institutional settings. In 1971 the state created the community mental health system and included both mental health and addictions treatment as part of that system. Services are financed and regulated by OHA and delivered through county-based Community Mental Health Programs (CMHP) or their subcontractors.

Mental health and addictions policy, prevention and treatment services have been combined, separated and recombined – most recently in 2001 – and now include problem gambling policy, prevention and treatment.

The emphasis on community-based treatment for these disorders grew in the 1980s based on recommendations by a series of commissions, task forces appointed by the Governor and DHS, and Executive Orders. In the mental health treatment area, more people are treated in the community than in institutions, and approximately 72 percent of public funding goes to community-based services.

Major trends include the focus on recovery-oriented and resiliency-oriented services, consumer-driven services, peer-delivered recovery services, and services for children based on strengths and input from their families and delivered in the most natural setting nearest their homes.

Since the 2003 passage of Evidence-Based Practices (EBPs) legislation, prevention and treatment services that have proved effective are provided for people with substance use disorders, problem gambling behaviors and mental health disorders.

These services are directed at people who have a propensity to commit crimes, experience emergency mental health services, or are juveniles with a propensity to commit crimes. AMH, the community mental health system and the providers have made major changes to focus on the prevention and treatment methodologies that have proved effective. During 2005-2007 the system exceeded the requirement that at least 25 percent of state and federal funds be spent on EBPs. During 2005-2007, 56 percent of addictions treatment services and 33 percent of mental health services were evidence-based. During 2007-2009 the system spent at least 50 percent on evidence-based services. For 2009-2011 the requirement is at least 75 percent. The testing for compliance with the 75 percent requirement is underway and will be completed in the fall of 2010.

The 2003 Legislature directed AMH to reform the children's mental health system to "substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive and culturally competent home- and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized."

The Children's Mental Health System Change Initiative (CSCI) ensures that youth and families receive services locally through local or regional mental health organizations with built-in accountability. CSCI created a standardized method to determine a child's and family's level of service needs, ensure care coordination, increase service flexibility and interagency collaboration, and increase accountability at the local and state levels. The CSCI system structure includes the use of child and family teams, care coordination at multiple levels, and system oversight. Meaningful family and youth involvement is emphasized at all levels of the system, from the child and family teams through the state system advisory committees. This altered system is forming the basis for the initial efforts to meet the statutory requirements for Children's Wraparound passed as HB 2144 by the 2009 Legislature.

As the mental health system has evolved in Oregon during the past 40 years, the system of local mental health services also developed. The closure of Dammasch State Hospital in 1995 was a landmark step in moving from state hospital care to community mental health services. The "deinstitutionalization" movement in Oregon paralleled a national movement. While the community mental health movement was assisted with federal incentives to local communities in many states, Oregon did not fully take advantage of the federal incentives to establish community mental health programs and services. The lack of federal investment in

setting up a comprehensive mental health system has had a profound effect on Oregon's system of community mental health services.

Oregon's system is now under stress because it has relied on creating a "mini-institutional" approach to service delivery. The development of PSRB community services has further pushed the system to rely more heavily upon community residential treatment facilities.

The service delivery system is overly reliant on the use of residential facilities, which are less flexible and more costly than a community-based system grounded in housing with supports. The system lacks the resources that keep people living in their homes rather than small or large group settings. The mental health system at present is meeting less than 50 percent of the need for public services for adults and children.

The current average length of stay in Oregon's residential treatment programs varies by the type of facility and ranges from just under 350 days in residential treatment homes to nearly 600 days in residential treatment facilities. The average length of stay in Oregon state hospitals for the civilly committed population is just over 200 days. The time many people are staying in these institutions is far too long. The length of stay can be reduced only with an investment in supportive housing resources.

Housing opportunities in the community with an array of supportive services not only enable more effective treatment for many, but provide an increase in capacity by reducing the length of stay in residential facilities through providing more permanent housing plus services. Without an investment in supportive housing, intensive outpatient and peer services, Oregon will not be able to move individuals from state or community facilities to self-sufficiency. This understanding is the driving force behind a new AMH initiative to redesign the management of adult residential services.

Many communities around the state have begun developing integrated care models. The local system combines physical health care with addictions treatment and recovery services, mental health services, employment and supportive housing into an integrated system. These integrated delivery models show much promise because individuals, regardless of the type of problems, enter the right door for service.

Better use of current mental health and addiction capacity also needs close examination. The recent changes in the children's mental health system may provide the experience and lessons needed to revise the adult mental health delivery system. Oregon will benefit from a cost-effective system that is right-sized to best serve the needs of people with mental illness and addictions.

As a result of Governor Kulongoski's 2004 Mental Health Task Force, the state entered into a process to replace the aging and unsafe buildings of Oregon State Hospital (OSH) and strengthen the community-based mental health system to support future population growth and the treatment of people requiring long-term psychiatric care nearer their homes. The 2007 Legislature approved Certificate of Participation (COP) financing to build two new state-of-the-art psychiatric treatment and recovery facilities to replace the Oregon State Hospital. The first facility with capacity to treat 620 people in programmatically unique areas with separate residential areas and centralized treatment malls will open in 2011; it is located in Salem on the grounds of the current hospital. The second facility, scheduled to open in 2013, will treat 360 people and will be located in Junction City. The new facilities will be supported by an integrated electronic hospital management system with an electronic health record at its core. The Behavioral Health (Data) Integration Project (BHIP) was approved for COP financing and will be operational before the new facility opens.

These changes will occur in a state environment that, since January 1, 2007, provides parity in the coverage of alcohol and drug and mental health treatment services by Oregon-based group insurance carriers. The services are managed based on medical necessity using similar methods as for physical health care.

In 2009, the Oregon Legislature passed statewide health reform and included addiction and mental health services as part of health care managed by the Oregon Health Authority. This framework supports the integrated treatment of people with addiction and mental disorders in order to:

- improve the health of Oregonians,
- increase the quality, reliability and availability of care, and
- lower or contain the cost of care.

The 2009 Legislature also created the Alcohol and Drug Policy Commission at the same time it abolished the Governor's Council on Alcohol and Drug Abuse (HB 3353).

The Commission structure was established in late 2009 and early 2010 and began meeting under the joint leadership of the Attorney General and the Directors of the Departments of Corrections and Human Services/Oregon Health Authority. The commission provided a preliminary report in May 2010. The report provides a blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon.

## ***Services***

AMH's services restore functioning, promote resiliency, health and recovery, and protect public safety by serving adults, children and adolescents, and their families who have substance use disorders, mental and emotional disorders, and problem gambling disorders. During 2008-2009, 120,000 adults and 40,000 children and adolescents were served.

### ***AMH:***

- Provides hospital-level care to adults with mental illness who cannot be safely or successfully treated in a lesser level of care.
- Contracts with county mental health programs, tribes, mental health organizations (MHOs), and private nonprofit agencies to provide community-based services to Oregonians who have mental illness, emotional and substance use disorders, and who are addicted to gambling.

The services available include:

- Early intervention,
- Prevention,
- Outpatient treatment,
- Day treatment and residential treatment,
- Acute psychiatric treatment in local hospital specialty units,
- Medications and medication management,
- Case management,
- Housing and supports,
- Peer supports and peer-delivered services,
- Employment and education supports,
- Psychiatric residential treatment,
- Psychiatric day treatment,
- Care coordination,
- Crisis services,
- Skill training,

- Intensive community-based treatment services, and
- Long-term active psychiatric treatment in two state hospitals on three campuses.

Services are available to people who are eligible for Medicaid and those who do not qualify for Medicaid but do not have the resources to pay for services.

### ***Programs***

AMH either provides or contracts for services that help restore people with addiction disorders, including gambling, and people with mental health disorders to a level of functioning that allows them to:

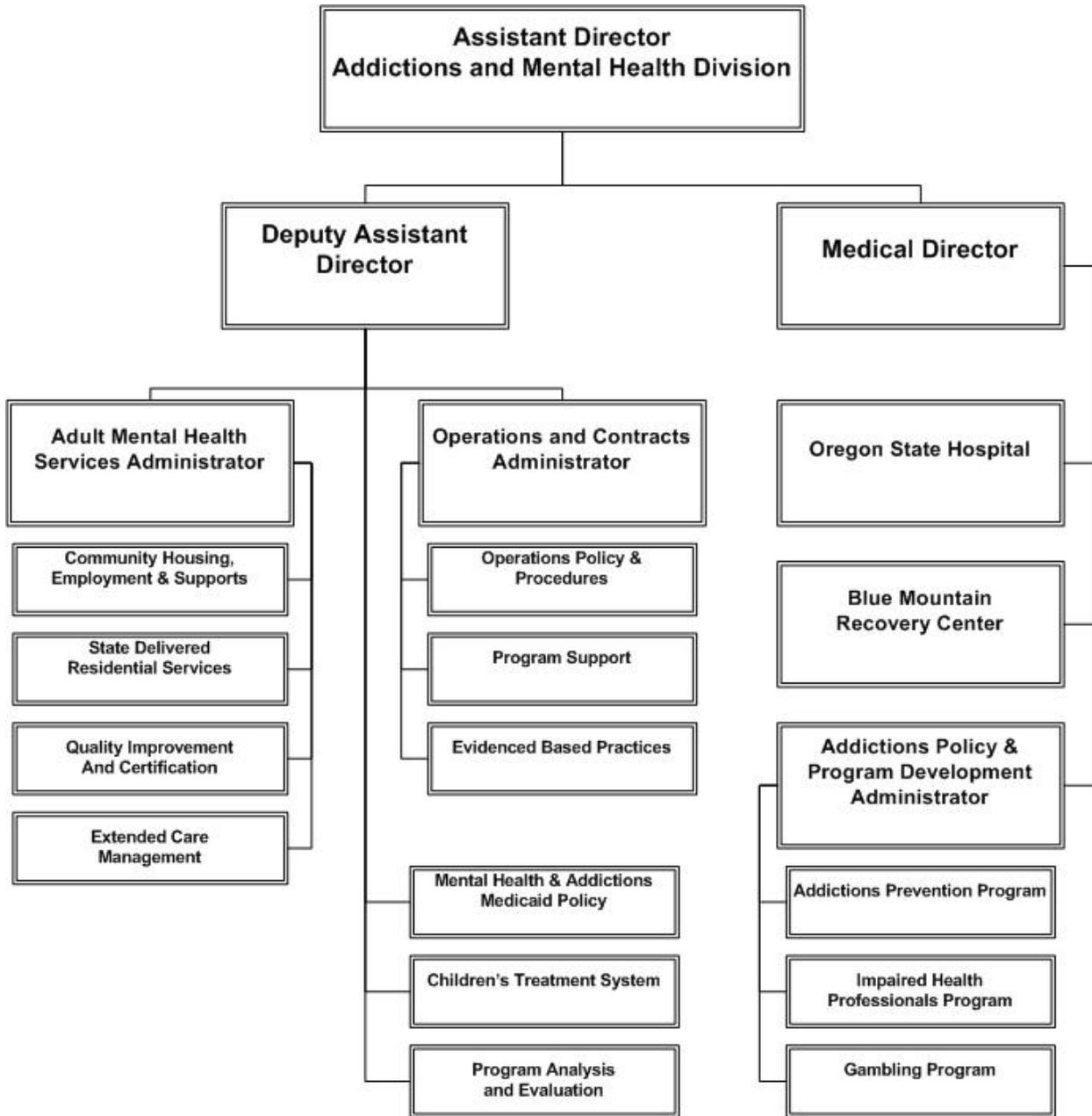
- Be successful at school and work,
- Live safely and productively in the community,
- Avoid repeated cycles of arrest and incarceration,
- Maintain stable relationships and living situations,
- Maintain or obtain appropriate parenting skills,
- Reduce their risk of infectious diseases and chronic health conditions, and
- Reduce the use of acute psychiatric hospitals for crisis stabilization.

Services are aimed at promoting health for youth by helping them avoid the use of alcohol and other drugs, and for adults by helping them enter into recovery and adopt safe and healthy lifestyles.

AMH has six primary program areas:

- Alcohol and drug prevention,
- Alcohol and drug treatment,
- Problem gambling prevention and treatment,
- Community mental health treatment,
- State-delivered secure residential treatment, and
- State hospital services at the Oregon State Hospital (OSH) and Blue Mountain Recovery Center (BMRC).

*Organizational structure*



## ***Alcohol and Drug Prevention***

---

Alcohol and drug prevention services are designed to promote healthy choices by Oregonians when presented with the opportunity to use drugs or to drink inappropriately. These are critical services for young people who are frequently presented the opportunity to drink in spite of their age. Underage drinking is dangerous and is frequently linked with binge drinking. This results in increased risk for traffic accidents, risky sexual behavior, violence and suicide. It is important that adults of all ages, especially older adults, understand the effects on their bodies from the use of alcohol and other drugs. With appropriate information people can make healthy, responsible choices.

### ***Services provided***

Prevention programs help people make smarter life choices and reduce risk factors associated with alcohol and drug abuse. AMH administers prevention services aimed at people who have not yet been diagnosed with alcohol or drug problems. These services will reduce the rate of underage drinking and the development of substance use disorder and associated social problems (e.g., drunk driving, violence and child abuse).

### ***Where service recipients are located***

Prevention services are available in every Oregon county. Community mental health programs (CMHPs), tribes and statewide contractors provide evidence-based services to prevent the problematic use of addictive substances and activities including alcohol and drugs. These services support and are integrated with the priorities set forth in each county's Comprehensive Plan as developed by the local Commission on Children and Families.

## ***Who receives services***

Services to both prevent and end use of addictive substances are available to all Oregonians, with a focus on youth. The primary audiences for prevention services are:

- The entire population through public education and awareness campaigns;
- Sub-groups of people who are at above-average risk of involvement with alcohol and other drugs through selected prevention services such as family management programs for families with youth who have poor academic performance; and
- Individuals who show minimal but detectable signs of involvement with alcohol and other drugs, but do not meet diagnostic criteria for abuse or dependence, through indicated prevention services such as substance abuse educational programs for youth who receive a Minor in Possession (MIP) violation.

More than 97,800 Oregonians were provided access to broad-based prevention information during 2008-2009. In addition, 23,287 people received selected prevention services and another 3,216 received indicated prevention services.

## ***How services are delivered***

Services are delivered by CMHPs, tribes and statewide nonprofit organizations. Evidence-based interventions are selected to meet the needs of local communities, and may be delivered to groups of individuals at risk of substance abuse or may be delivered to the population as a whole to educate them about the risks of youth substance abuse.

## ***Why these services are significant to Oregonians***

Effective prevention services reduce the incidence of underage drinking and lessen the risk of alcohol- and drug-related traffic accidents and resulting deaths. These services reduce the risk of youth violence, youth suicide and risky sexual behavior. Youth who are not involved in underage drinking or other drug use perform better

in school, are more likely to graduate, and more likely to avoid contact with the juvenile justice system.

## *Performance measures*

### **KPM 5**

#### *Eighth-graders' risk for alcohol use*

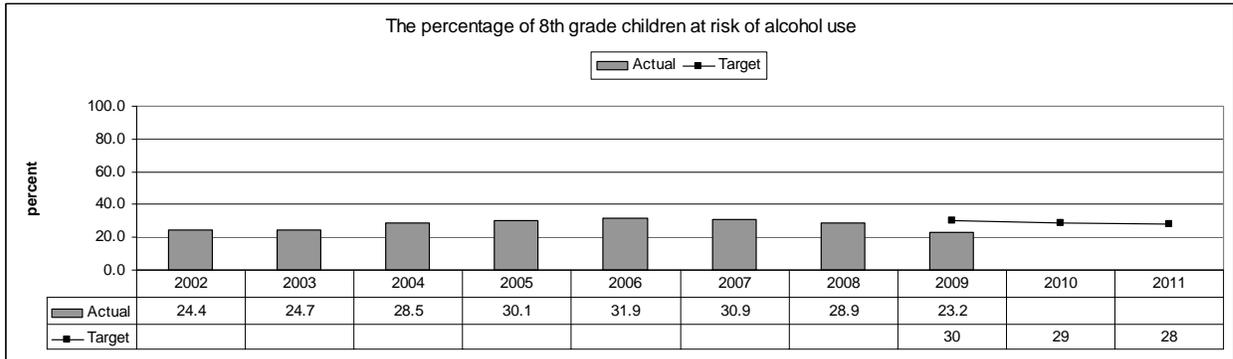
**Purpose:** AMH tracks many different measures that help assess and plan needed prevention services. Eighth-grader risk for alcohol use serves as a central indicator. Many of the prevention efforts target children and adolescents, making this indicator critical in tracking performance and directing resources. The data are collected through an annual survey called the Oregon Healthy Teens Survey. The survey is conducted with a representative sample of eighth- and 11<sup>th</sup>-graders.

**Target:** The current target for this measure is 30 percent.

**Results:** After remaining steady in the low 30 percent range for several years, this measure peaked in 2006 at 31.9 percent, but has since dropped to 23.2 percent. This is below the goal rate of 30 percent. This is despite the fact that state funding for substance abuse prevention has been reduced, the population in Oregon has grown and other prevention programs have been cut, including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. During this same period, marketing and advertising efforts promoting alcohol and tobacco have increased, particularly advertising for distilled spirits and hard liquor.

**Comment:** The 2009 Legislature approved changes to the Key Performance Measures that strengthened the measures by separating the measure for alcohol from that for drug use. This allows the state to assess the two measures separately since they show very different findings, with the overall trend for illicit drug uses decreasing while alcohol use has been on the increase. The risk associated with drug use is lower than that of alcohol use.

***How Oregon compares to other states:*** When alcohol use within the past 30 days is compared between Washington and Oregon eighth-graders, Oregon does not compare favorably – 15.4 percent versus 23.2 percent – although as noted above, Oregon has shown considerable improvement. Washington has maintained funding for its prevention efforts, and it shows.



## **KPM 6**

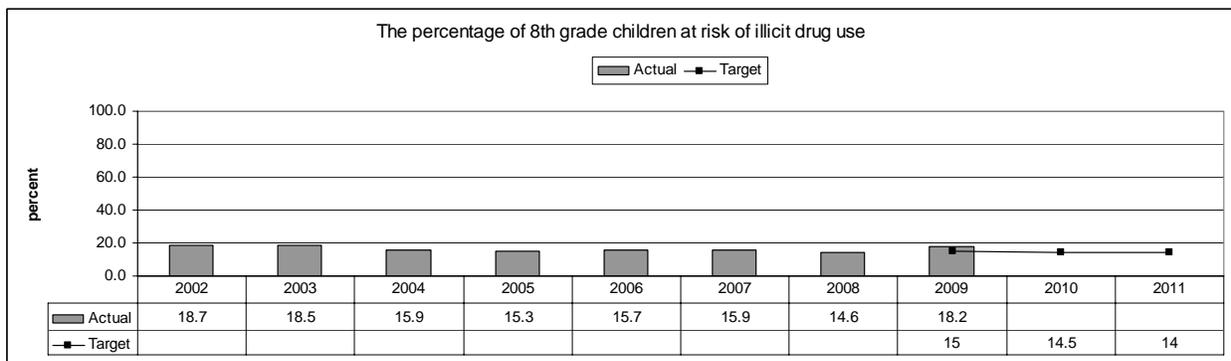
### ***Eighth-graders' risk for illicit drug use***

**Purpose:** AMH tracks many different measures that help assess and plan needed prevention services. Eighth-grader risk for illicit drug use serves as a central indicator. Many of the prevention efforts target children and adolescents, making this indicator critical in tracking performance and directing resources. The data are collected through an annual survey called the Oregon Healthy Teens Survey. The survey is conducted with a representative sample of eighth- and 11<sup>th</sup>-graders.

**Target:** The current target for this measure is 15 percent.

**Results:** After remaining steady in the high teens percentage range for several years, this measure dropped to a low of 14.2 percent in 2008, but in 2009 it showed a sharp increase to 18.2 percent. This is below the goal rate of 30 percent. As noted, state funding for substance abuse prevention has been reduced, the population in Oregon has grown and other prevention programs have been cut including the Commission on Children and Families, juvenile crime prevention programs, and school funding for programs that work to help keep youth involved in healthy and positive activities. It is too early to tell if this year's results truly mark a reverse in the direction of this indicator.

**How Oregon compares to other states:** The percentage is significantly higher than national rates of 7.6 percent for 2008, which was published in Monitoring the Future national survey results on drug use.



## *Other performance measures*

National Outcome Measures (NOMs) for prevention services include prevalence of substance use, consequences of use, and related risk and protective factors. Prevalence data tell the extent of a problem, such as the percentage of youth who drink. Consequence data provide information about the impact of use on individuals such as alcohol-related motor vehicle fatalities. Risk factors are conditions that increase the likelihood of substance use or related negative consequences; protective factors are conditions that support healthy behaviors and outcomes. In all cases the information helps AMH direct its prevention efforts.

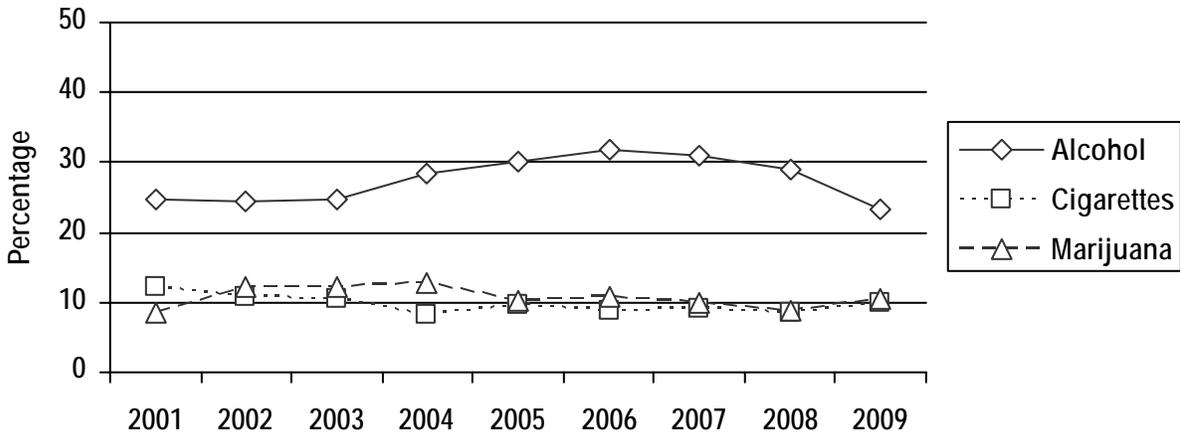
Use of alcohol, tobacco and illicit drugs impacts families, schools, workplaces and communities. It causes long-term health problems, leads to premature death, contributes to injuries, violence and abuse, and can lead to addiction that erodes an individual's ability to function normally.

Substance abuse and dependence affect Oregonians of all ages. About 9 percent of Oregon youth 12 to 17 years old abuse or are dependent on alcohol or drugs; 22 percent of young adults 18 to 25 and 8 percent of adults 26 or older abuse or are dependent on alcohol or drugs, requiring treatment.

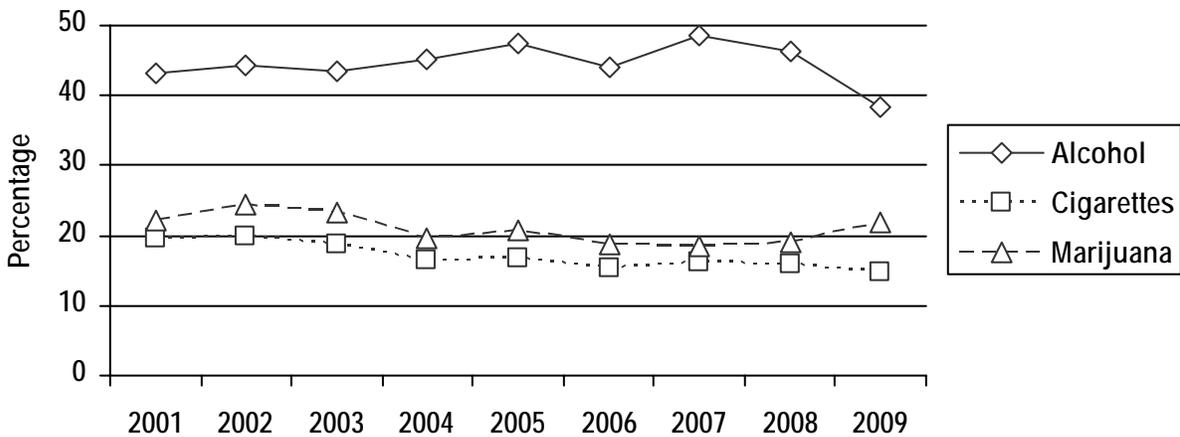
Initiation of alcohol, tobacco or marijuana use at young ages has been linked to more intense and problematic levels of use in adolescence and adulthood. The charts below show the trends in alcohol, cigarette or marijuana use by eighth and 11<sup>th</sup> grade youth. Alcohol use is clearly the largest issue among both eighth and 11<sup>th</sup> grade youth. Since 2006, alcohol use among eighth graders has declined three consecutive years. However, in 2009 nearly one in four youth reported drinking on one or more days in the past month. Marijuana and cigarette use have remained steady. In 2009, approximately 10 percent of the youth reported use in the past 30 days.

Rates of alcohol, cigarette and marijuana use increase substantially between eighth and 11<sup>th</sup> grade. Past month alcohol use among 11<sup>th</sup>-graders is 65 percent higher (23.2 percent for eighth grade versus 38.3 percent for 11<sup>th</sup>); cigarette use is 50 percent higher (9.9 percent for eighth grade versus 14.9 percent for 11<sup>th</sup>); and marijuana use is double that of eighth graders (10.6 for eighth grade versus 21.8 percent for 11<sup>th</sup>).

**Percent of 8th grade youth that used alcohol, cigarettes or marijuana in the past 30 days**



**Percent of 11th grade youth that used alcohol, cigarettes or marijuana in the past 30 days**



An American Medical Association (AMA) report shows that adolescent drinkers perform worse in school, are more likely to fall behind and have an increased risk of social problems, depression, suicidal thoughts and violence. Even occasional heavy drinking injures young brains.

Young people who consume alcohol are more likely than adults to drink heavily. Youth who binge drink are much more likely to engage in other risky behaviors such as drug use, risky sexual behavior and aggressive antisocial behavior. Oregon youth who binge drink are more likely to report attempting suicide than youth who do not.

Oregon youth begin drinking at very young ages and are more likely to start drinking before 13 years of age than to start smoking cigarettes. During 2009, 22 percent of 11th graders reported they first drank alcohol before the age of 13 versus 7 percent who first smoked a cigarette before 13.

Three factors known to influence the likelihood of underage alcohol use are: perceived risk of harm, parents' disapproval of drinking and accessibility to alcohol. Oregon eighth- and 11th-graders are more likely to report lower risk of harm and less parent disapproval for alcohol than for cigarette use. Despite the fact that sales of alcohol to minors are illegal, 42 percent of eighth-graders and 79 percent of 11th-graders say it is "sort of easy" or "very easy" to get beer, wine or hard liquor.

Alcohol is the most widely used addictive substance among adults in Oregon. Alcohol is a known carcinogen and a leading cause of chronic liver disease. It is toxic to many organ systems including the heart, stomach, pancreas and nervous system. Each year about 1,200 Oregonians die from alcohol-related causes. Deaths from alcohol-induced diseases are one of the 10 leading causes of death for men and women in Oregon.

Even moderate alcohol consumption can lead to negative consequences such as alcohol-related motor vehicle crashes, birth defects and harmful interactions with medications. Approximately two thirds of Oregon men (65 percent) and half of women (52 percent) drink alcohol each month.

By far, heavy drinking and binge drinking are most closely linked to negative health consequences and contribute to crime and violence against persons. Heavy drinking is associated with heightened levels of all-cause mortality. Heavy use of alcohol refers to alcohol consumption at levels that exceed U.S. Dietary Guidelines. Men who drink more than two drinks per day and women who drink more than one drink per day are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence. In 2009, 6 percent of Oregon adults 18 or older were heavy drinkers.

Binge drinking is strongly associated with injuries, motor vehicle crashes, violence, Fetal Alcohol Spectrum Disorder (FASD), chronic liver disease and a number of other chronic and acute conditions. Binge drinking is defined as consumption of five or more drinks by men and four or more by women in a short time span. In 2009, 19 percent of men and 11 percent of women in Oregon reported binge drinking.

## ***Key budget drivers and issues***

### ***Underage drinking***

Oregon youth are continuing to drink at rates above the national average, with eighth-grade girls drinking at higher rates than boys. These youth will continue to use and abuse alcohol and other drugs, which will increase the demand for treatment services. There will be added social costs including increased teen pregnancy, motor vehicle accidents and death, school failure, entry into the juvenile justice system, and continued high rates for adolescent suicide. It is critical to restore funding for effective, evidence-based prevention and early intervention services to reverse the trend in underage drinking and improve the associated social indicators.

### ***Prescription Drug Abuse***

Both chronic and occasional drug use can result in serious medical conditions. Youth and young adults in Oregon have higher rates of illegal use of drugs such as heroin, cocaine and methamphetamine as well as prescription drugs used (without a doctor's orders) to get high than their younger or older counterparts. Prescription drug abuse is a growing concern in Oregon. Eight percent of Oregon 11<sup>th</sup>-graders reported using prescription drugs to get high in the past 30 days according to the 2009 Oregon Healthy Teens Survey. By contrast, 5 percent of 11<sup>th</sup>-graders said they used illicit drugs other than marijuana in the past 30 days. Adolescents are more likely than young adults to become dependent on prescription drugs. National studies and published reports indicate that the intentional abuse of prescription drugs to get high is a growing concern.

## ***Alcohol and Drug Treatment***

---

Alcohol and drug treatment services assist people in recovering from addiction. People in recovery function better in society and at work, do a better job parenting their children, and stop committing crimes. Their physical health improves, which reduces medical care costs and use of emergency departments.

### ***Services provided***

Services consist of outpatient, intensive outpatient, residential and detoxification services. Different options are needed to help individuals recover from their addictions. Some individuals may need residential services, while others may need outpatient; both are needed for 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 heroin addiction. Education and treatment are available for people who are convicted of driving under the influence of intoxicants (DUII).

### ***Where service recipients are located***

Community mental health programs (CMHPs), tribes and county-designated nonprofit organizations provide treatment for alcohol and drug abuse problems in all 36 counties and in statewide and regional residential treatment programs.

### ***Who receives services***

Children and adults of all ages who have a diagnosed substance use disorder may be eligible for services. Any person eligible for the Oregon Health Plan (OHP) or the State Children's Health Insurance Program (SCHIP) has access to the OHP substance abuse benefit when medically appropriate. Pregnant women and intravenous drug users have priority for services under the federal Substance Abuse Prevention and Treatment Block Grant. There are specialized services designed to meet the needs of women, parents with children, minorities and adolescents. During 2008-2009, 36,238 adults age 26 and above were served;

12,207 young adults age 18 through 25 were served; and 5,663 adolescents age 12 through 17 were served.

### ***How services are delivered***

Services are delivered by CMHPs, tribes, nonprofit programs and statewide contractors in outpatient programs, school-based health centers and residential treatment programs throughout the state.

### ***Why these services are significant to Oregonians***

As a result of these services, fewer children are admitted to foster care due to parental substance abuse. State and local jurisdictions see reduced costs to the criminal justice system for adults and juveniles. Local hospitals experience reduced use of emergency departments.

### ***Intensive Treatment and Recovery Services***

AMH is implementing the 2007-2009 Legislatively Adopted Budget initiative to increase access to addictions treatment for parents who are involved in the child welfare system or at risk of involvement in that system. Increased outpatient capacity now exists in each county, and residential capacity has increased for approximately 120 adults and 80 dependent children who access treatment with their parents. Eighteen additional recovery homes have been developed for families with addictions issues who are at risk of becoming homeless and need a supportive recovery environment. AMH worked closely with the Children, Adults and Families Division (CAF) to implement these services and monitor systems outcomes.

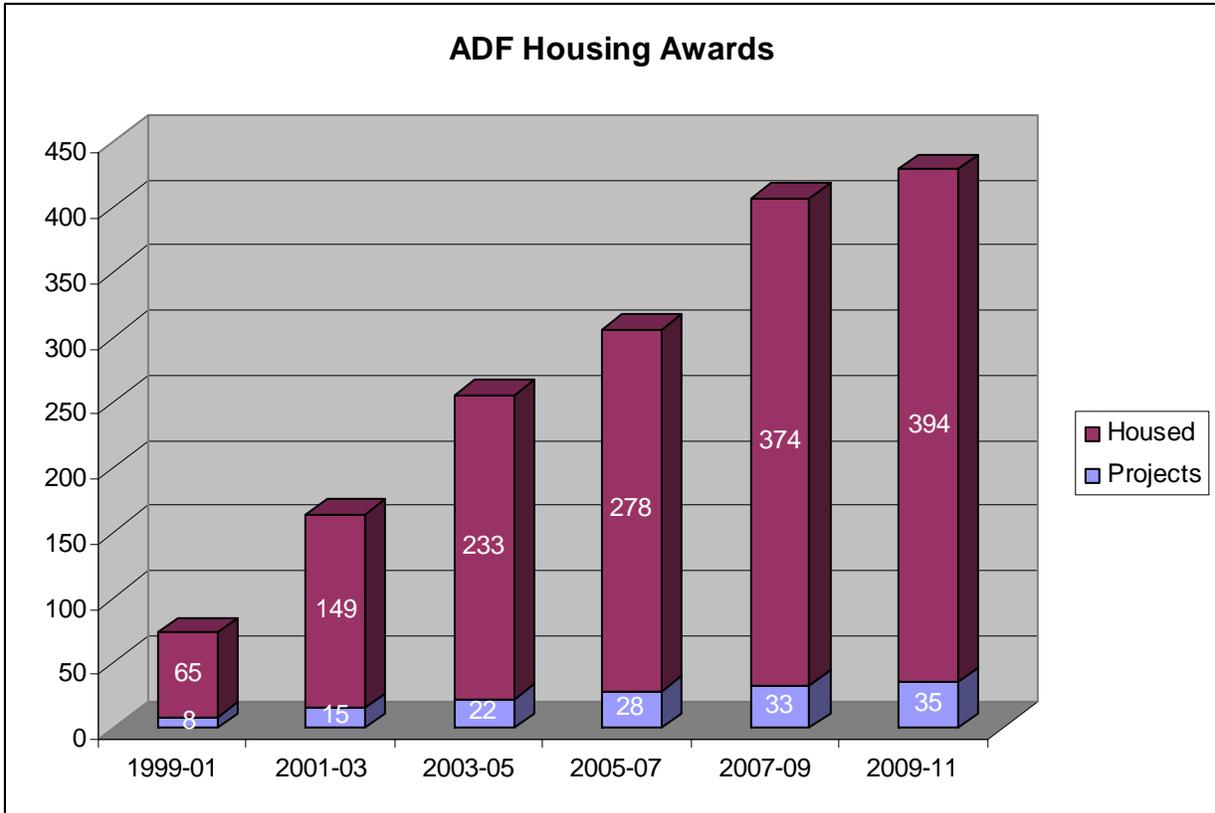
Over 900 children have been returned to their families; these are families who have either completed treatment or are still engaged in treatment through Intensive Treatment and Recovery Services (ITRS). Eighteen family-focused recovery homes have been developed (compared to a target of 14). The return of the children to their families represents a cost-offset to the foster care system of \$1.7 million per month.

## ***Housing***

A safe, affordable, alcohol- and drug-free place to live is essential to recovery from addiction 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 exactly in these adverse living environments.

As a result of the cost of housing and common problems associated with mental illness 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 Count. The state has undertaken the following initiatives to address housing for people with addiction disorders:

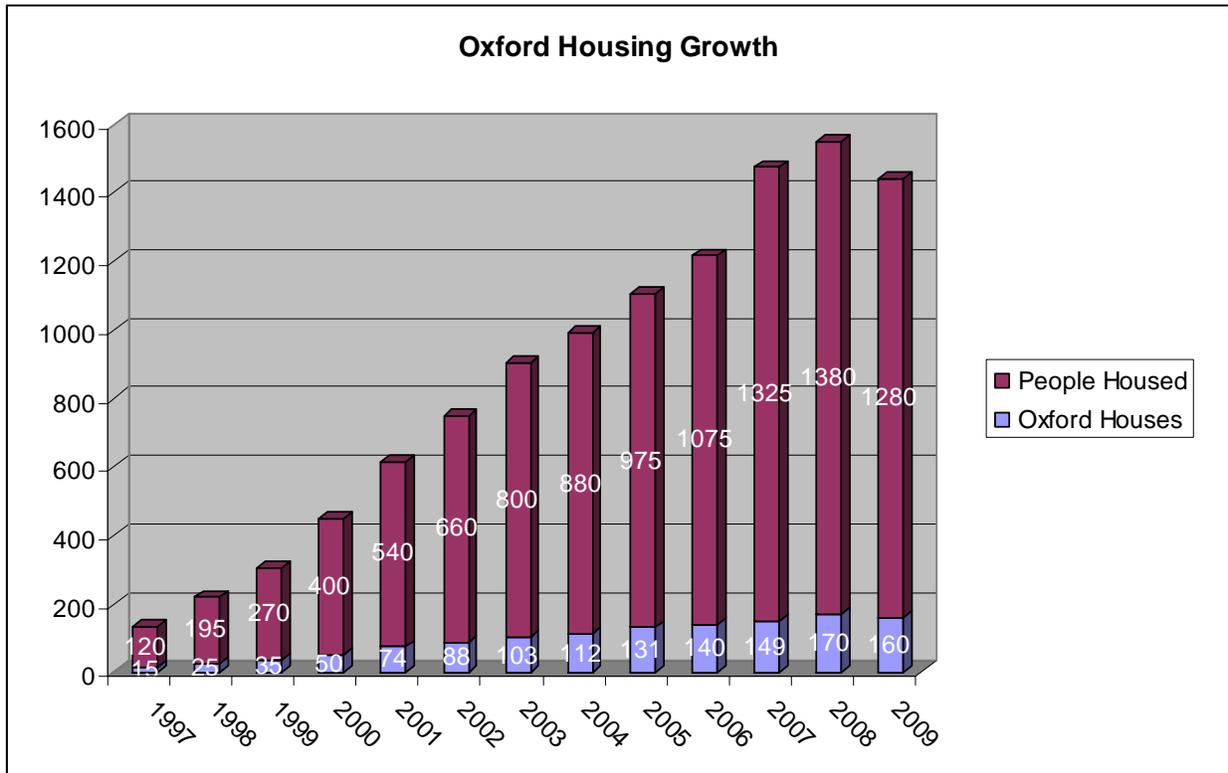
Alcohol and Drug Free (ADF) housing development: These funds are used to create Alcohol and Drug Free (ADF) housing to support people in recovery from serious addictions. For 2009-2011 two projects have been recommended for funding. These projects total \$450,000 and will provide 20 units of affordable alcohol and drug free housing. Fewer applications were submitted for funding due to the recession, changes in financial markets and timing of other funding sources. The following chart reflects AMH's accumulative distribution of ADF housing development funds through the 2009-2011 biennium.



ADF housing assistance services: AMH funds eight projects in seven counties and one tribal community to help more than 456 people each year in recovery from addictions obtain stable ADF housing as they transition to self-sufficiency.

Oregon Recovery Homes (ORH): Through the Intensive Treatment and Recovery Services Initiative approved by the 2007 Legislature, Oregon Recovery Homes were able to increase their staff outreach coordinators from two to five full-time employees. With the help of a grant from the Spirit Mountain Community Fund, ORH was able to add a sixth outreach coordinator, who works exclusively with homes serving women and the challenges of housing women with children who are in recovery. There are now 160 Oxford Homes in 16 Oregon counties accommodating approximately 1,280 people recovering from alcoholism and drug addiction. More than 300 children live in these homes. The drop in houses represents a 6 percent decrease in ORH housing from the 2007-2009 biennium. The loss of 10 houses can be attributed to the economy. Many residents rely on minimum wage or labor-related jobs, and with fewer jobs available, many houses were not able to remain viable. Several houses consolidated members, avoiding the

loss of even more beds. These homes operate on a self-governed, peer support model. The following chart shows the growth of homes and housing capacity since 2001.



***Outcomes and Impact:***

- Over 900 children have been reunited with their parents and are no longer in family foster care. Their parents have accessed addiction treatment and recovery services with ITRS providers (as reported by CAF).
- \$1.7 million a month is the cost-offset in family foster care for these children. This means that providing addiction treatment and recovery supports for this population group paid for itself within a period of six months.
- 4,440 parents have accessed addiction treatment and recovery services.

- 1,734 parents are currently engaged in treatment and recovery services.

## *Performance measures*

### **KPM 1**

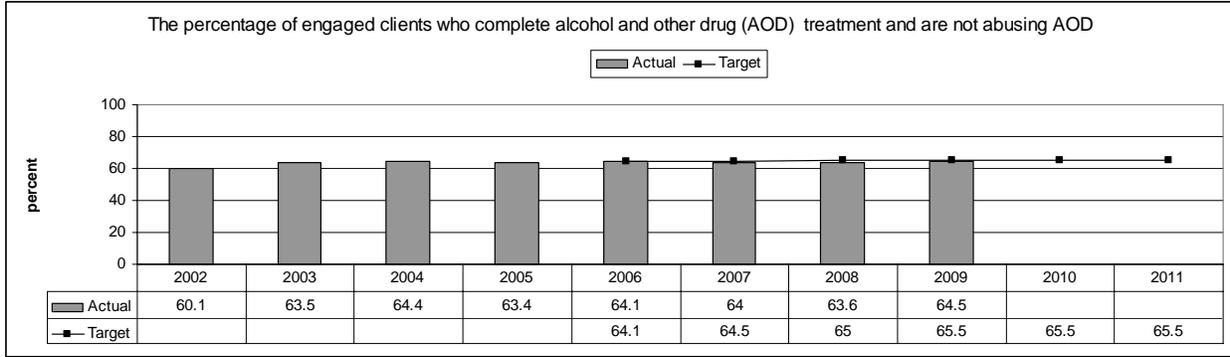
#### ***Completion of alcohol and drug treatment***

***Purpose:*** Once a client enters into alcohol and drug treatment service, the next goal is for the client to complete treatment. Clients who complete treatment have achieved at least two-thirds of their treatment plan goals and have been abstinent from drug and/or alcohol use for 30 days prior to treatment ending. Research has found evidence that treatment completion rates and other process measures are strongly related to long-term positive outcomes after treatment, such as abstinence and not being involved in criminal activities. Given this relationship and the availability of data, treatment completion is a good, practical indicator for the long-term success of services.

***Target:*** AMH's target is to push overall completion rates to 65-66 percent and beyond during the next few years.

***Results:*** For purposes of this key performance measure, completion rate is aggregated across all alcohol and drug services and has been in the low to middle 60 percent range for the past several years. It currently is 65 percent. It is expected to increase during the next few years as more providers implement evidence-based practices and implement quality improvement efforts designed to retain clients in treatment.

***How Oregon compares to other states:*** One reason the completion rate has not changed substantially during the past several years is that it already is very high, making further improvement difficult. Nationally, the completion rate for alcohol and drug treatment services is 51 percent. This is based on data submitted by states to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies.



## **KPM 2**

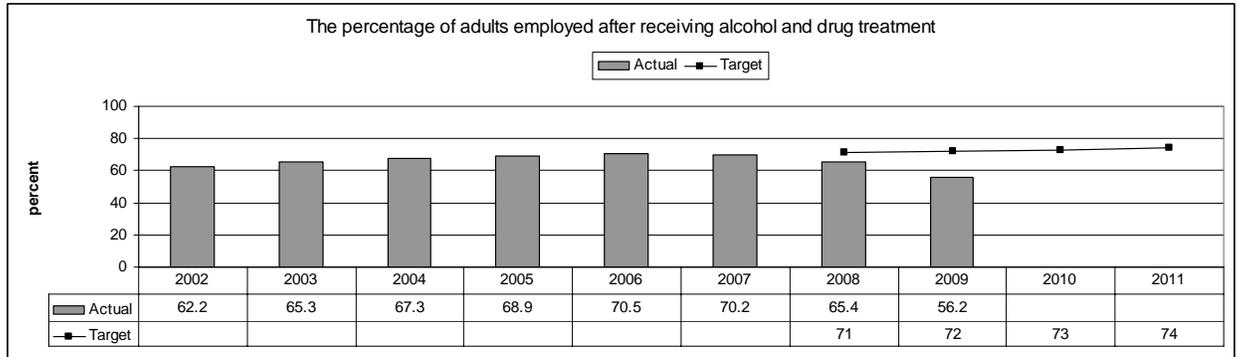
### ***Adults employed after alcohol and drug treatment***

**Purpose:** A key outcome for many clients is to maintain or gain employment as a result of their treatment. AMH’s strategy relates to the Oregon Business Plan initiative to increase access to treatment and intervention services for Oregon workers who have alcohol and drug problems but no insurance.

**Target:** AMH’s target is to push overall employment rates to 72 percent and beyond during the next few years. It will be difficult to reach this target in this economic environment.

**Results:** From 2002 through 2007 a greater percentage of clients had ended service employed. This changed in both 2008 and 2009 as actual rates of employment declined substantially in each year due in large part to the economic climate in Oregon. Starting in 2008 the percentage dropped and in 2009 was 56.2 percent after peaking at 71 percent.

**How Oregon compares to other states:** Despite the drop, Oregon’s rate of employment at discharge is higher than the national rate of 42.8 percent (2008).



### **KPM 3**

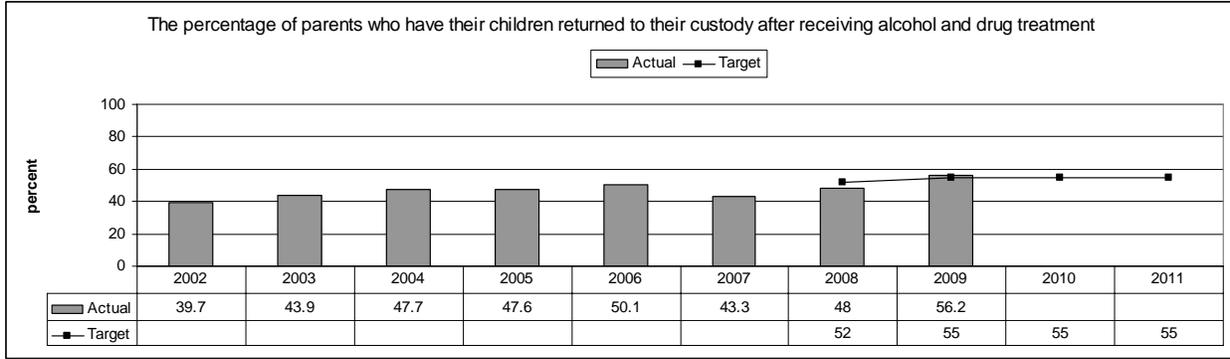
#### ***Children returned to custody after parental alcohol and drug treatment***

**Purpose:** During the past few years alcohol and drug issues have become one of the most common reasons cited for child abuse and neglect, leading to DHS taking custody of children. Alcohol and drug treatment and meeting the goals of treatment play a major role in the reunification of a child and his or her parents.

**Target:** AMH’s target is to push overall return rates to 50 percent and beyond during the next few years.

**Results:** The trend through 2009 shows that more parents each year were meeting treatment criteria that allowed reunification with their children. AMH surpassed its goal for 2009 by 1.2 percent. The implementation of Intensive and Recovery Services, funded by the 2007 Legislature as a treatment strategy focused on people at risk of or whose children were taken into state custody as a result of parental substance abuse, turned these results around; 48 percent in 2008 and 56.2 percent in 2009 of parents had their children returned following successful conclusion of substance abuse treatment. The rate in 2007 was 43 percent.

**How Oregon compares to other states:** There are no national data for comparison.



## **KPM 4**

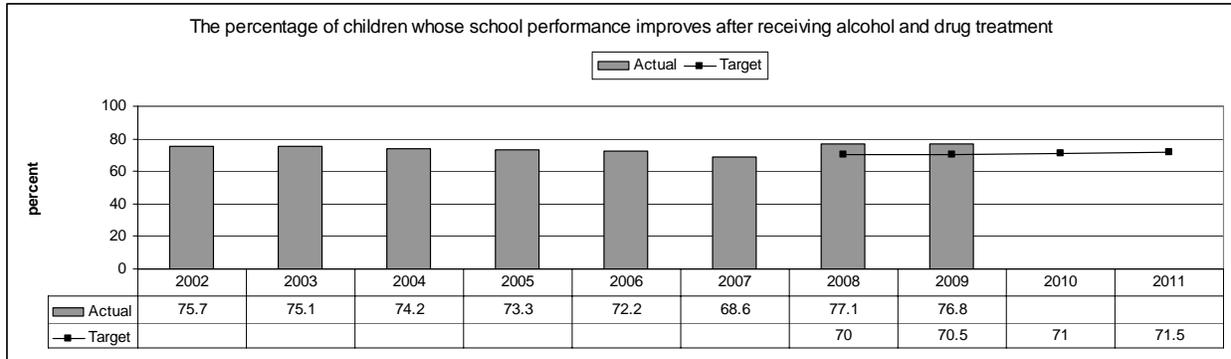
### ***Children with improved academic performance after alcohol and drug treatment***

**Purpose:** Alcohol and drug issues are a major barrier to academic achievement. Poor academic performance often is an initial flag for abuse of alcohol and drugs among teens. A goal of treatment is to help a child perform to his or her potential. Improved academic performance is definitely a step in the right direction.

**Target:** AMH's target is to push overall improvement rates to 70 percent and beyond during the next few years.

**Results:** The down trend since 2002 appears to be changing with the rate for 2008 and 2009 exceeding those of the years since 2002. In 2009, AMH showed 76.8 percent of children with improved school performance, which exceeded the goal by 6.3 percent.

**How Oregon compares to other states:** This measure looks at academic performance. Most national data track only improvement in attendance. This makes comparisons difficult.



Many of the key performance measures are part of larger set of federal measures known as the National Outcome Measures (NOMS). These measures are available upon request and are reported annually by AMH.

***Proposed key performance measures for 2011-2013***

AMH proposes to measure the percent of clients who remain crime-free during alcohol and drug treatment services. This is a critical measure of success for the treatment system since a substantial proportion of the people served in the system are referred by the criminal justice system. Successful engagement in treatment should result in an elimination of criminal activity. Data collected in 2009 will be used to establish a baseline from which targets will be set.

AMH proposes to measure the percent of clients whose income increases by the completion of alcohol and drug treatment services. One of the goals of successful treatment is employment or improvement in employment, which should result in an increase in legal income. Data collected in 2009 will be used to establish a baseline from which targets will be set.

***Other performance measures - none***

***Alcohol and drug treatment services***

Approximately 9.0 percent (or 27,592) of adolescents ages 12-17 have substance abuse issues. Among young adults ages 18-25, 21.8 percent (or 67,976) have substance abuse issues, while 8.2 percent (or 205,919) of adults 26 and older have substance abuse issues. AMH currently serves 18 percent of the adolescents and children, 18 percent of the young adults, and 21 percent of the adults in need of public alcohol and drug treatment services.

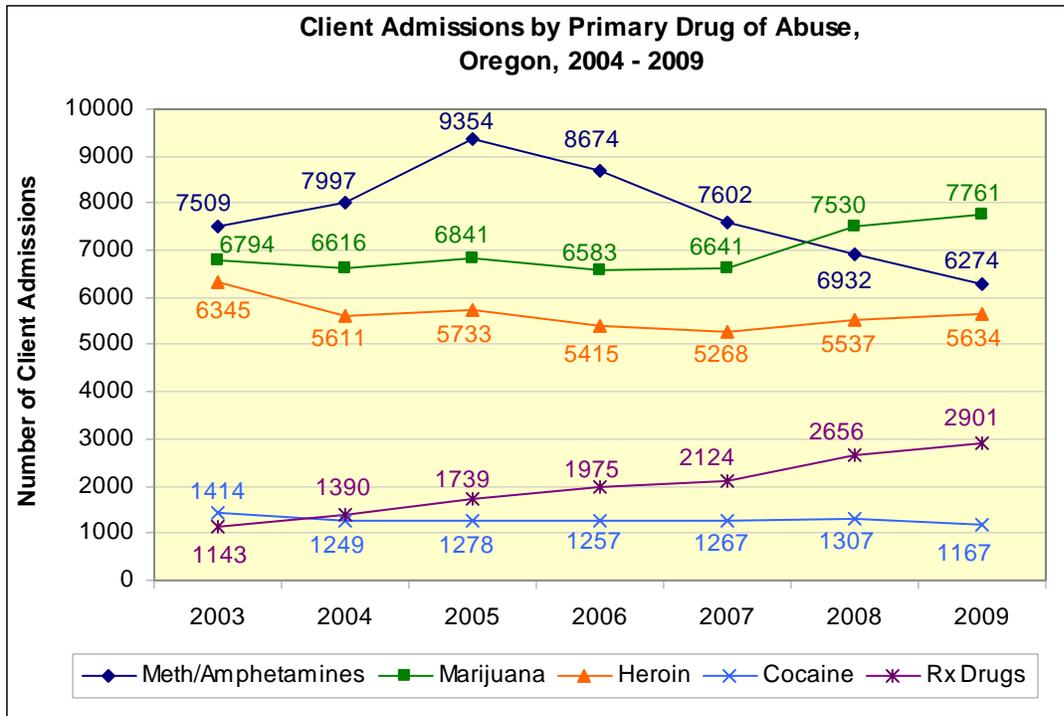
## ***Key budget drivers and issues***

### ***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).

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 (See Figure below). By contrast, since 2005 the rate of admissions with methamphetamine as a primary substance has declined by 20 percent.



### ***Complex and Multiple Challenges Among Treatment Populations***

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 have physical health concerns or complications such as Hepatitis C Virus, HIV/AIDS, pregnancy, serious dental issues, chronic pain, diabetes and other serious health-related issues. While the provider system is hopeful about federal health reform and the impact 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 to hold on to existing capacity with reduced budgets and increased fixed costs in the meantime.

In addition, according to the National Survey on Drug Use and Health (NSDUH) 20 percent of Oregonians age 18 to 25 reported experiencing serious psychological distress in the past year and more than 10 percent experiencing 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 a significant population of veterans, but since there is no military base in-state many veterans lack access to services and support. 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. Nearly 19 percent of current conflict veterans who received VA care 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 recent 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 healthcare. As such, their mental health and addiction needs go untreated, leading to higher incarceration rates, increased homelessness, family conflict, suicide, and poor health. 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 veterans with the complex needs described above.

**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 above requires alcohol and drug treatment services; in Oregon that is 205,919 people. For ages 18-25, the same research shows that 21.8 percent or 67,976 people are in need of treatment. That research also shows 8.8 percent of youth age 12-17 require treatment; in Oregon that is 27,591 youth. 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 people will have insurance and, with the approval of equal access to treatment for these disorders, more will obtain treatment paid by their insurance company. 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.

### ***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 environments with alcohol and drug abuse around them, their continued sobriety is at risk. Unfortunately, most clients of Oregon's publicly funded system live exactly in these adverse living environments. As the economy has worsened, housing insecurity has become more pronounced for people with addictions and mental health disorders. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue in treatment services, thus increasing the risk of further illness, mandated treatment and greater disability.

## ***Problem Gambling Prevention and Treatment***

---

Problem gambling prevention and treatment services prevent people from becoming addicted to gambling and assist people who are addicted in recovering from addictive and pathological gambling. People in recovery find or maintain jobs, repair family relationships and stop committing crimes. Their mental health improves, and the potential for suicide decreases.

### ***Services provided***

Problem gambling prevention and treatment services include evidence-based prevention strategies to decrease the probability that young people will begin gambling at young ages and that adults of all ages will be aware of the addictive nature of gambling, particularly on-line games and video poker. Treatment services include outpatient individual and group therapies, intensive therapies and statewide access to residential treatment for those who are at risk because of pathological gambling.

### ***Where service recipients are located***

Community mental health programs (CMHPs) for-profit and nonprofit providers deliver problem gambling prevention and treatment services in all 36 counties and in one statewide residential treatment program. Treatment to reduce the effects of problem gambling is funded through a statutory 1 percent set-aside of state Lottery revenues.

### ***Who receives services***

During 2008-2009, 2,240 people made use of the professionally staffed Problem Gambling Helpline. Problem gambling services were delivered to 2,195 people during 2008-2009.

### ***How services are delivered***

Services are delivered by CMHPs, for-profit programs, nonprofit programs and regional or statewide contractors in outpatient programs, and in one statewide residential treatment program.

### ***Why these services are significant to Oregonians***

Oregonians with problem or pathological gambling behaviors put themselves and their families at financial risk, experience family relationship disruptions, lose their jobs, are at risk of suicide and sometimes commit crimes to pay for their gambling addictions. The majority of Oregonians post-treatment reported reduction of gambling debt, reduction in suicide ideation and improvement in relationships, physical health, emotional well-being and spiritual well-being.

## **KPM 10**

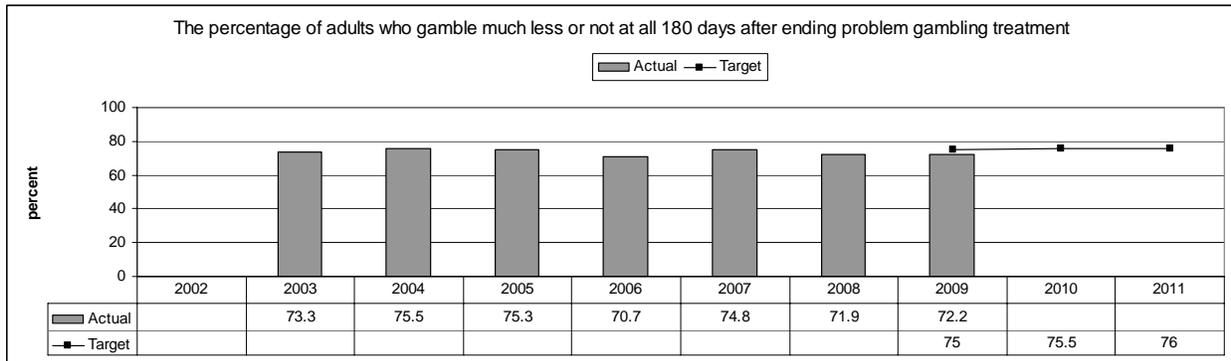
### ***Percentage of adults who gamble much less or not at all 180 days after ending problem gambling treatment***

**Purpose:** Problem gamblers and their families experience a complex array of mental health, social, financial and legal issues. The estimated social-economic cost of each pathological gambler is up to \$11,000 a year. Increasing the effectiveness of treatment contributes to the overall health of the community by eliminating these social-economic costs by aiding those treated to remain abstinent from gambling. Our partners in this effort are county and private-not-for-profit community agencies who provide treatment for problem gamblers and their families.

**Target:** AMH's target is to push overall improvement rates to 75 percent and beyond during the next few years.

**Results:** Results have shown some decline in the past two years. In 2009, AMH showed 72.2 percent of adults not gambling or gambling less 180 days after ending services. This falls short of the 75 percent goal.

**How Oregon compares to other states:** There is no national data to compare.



### ***Other Performance measures***

AMH collects additional data to measure the effectiveness of problem gambling treatment. For example:

- An estimated 50,143 adult Oregonians are problem gamblers and an additional 29,496 are pathological gamblers.
- FY 2009 data indicate 49.9 percent of problem gamblers successfully completed treatment services.
- Six months post-treatment, more than 87 percent of successful program completers reported they either no longer gambled or gambled much less than before treatment.
- For the treatment completers, 47.4 percent of those assessed at 12 months after treatment reported no gambling and another 42.9 percent reported “much less” gambling than before treatment
- Approximately two-thirds of the participants reported satisfaction with their relationships, physical health, emotional well-being and spiritual well being.
- Approximately 62.7 percent reported a return to paying bills on time.
- Importantly, at the 12-month post-treatment follow-up, people who completed service reported no significant deterioration in these indicators and, in fact, reported additional improvements in feelings of restlessness or irritability regarding not gambling.

### ***Key budget drivers and issues***

The increasing access to highly addictive gambling games online in numerous locations throughout the state create easy access for people who are interested in gambling and reinforce the behaviors that lead to addictive gambling. The increase in Internet gambling is attracting more and more young people who are showing increases in problem gambling behaviors that interfere with education and social relationships.

## ***Community Mental Health Programs (CMHPs)***

---

### ***Services provided***

Mental health services improve functioning for Oregonians with severe mental health disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for further treatment and whether other supportive services will be provided. These ongoing supports and services improve a person's ability to function in their families and communities, often reducing public safety problems and negative consequences.

Children with mental health issues are served in their local communities. Each child is screened for and served within the Integrated Service Array according to a standardized level of need determination for their mental health service needs.

Services and supports include those delivered by peers such as help establishing personal relationships, and help obtaining employment or schooling; independent living skills training such as cooking, shopping and money management; residential or adult foster care; and supervision of people who live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, doctor offices and clinics, schools, drop-in centers, and homes. The Oregon Health Plan (OHP) covers mental health services for eligible persons with conditions funded under the Health Services Commission Prioritized List for all Medicaid and SCHIP clients. The state General Fund pays for services and individuals not covered by OHP.

### ***Where service recipients are located***

Crisis services provided by qualified mental health professionals are available in all communities 24 hours a day, seven days a week. Mental health services are available in all 36 counties. These services include civil commitment procedures, acute inpatient treatment, residential treatment, adult foster care, outpatient therapy, supports needed for successful community living, medications, case

management, assistance with finding and maintaining housing and work, and social support.

### ***Who receives services***

Community mental health programs (CMHPs) provide mental health services for adults and children who have serious emotional and mental health disorders and are a danger to themselves or others, are unable to meet their needs, or are in danger of being removed from their homes due to emotional disorders. During FY 2008-2009 publicly funded programs served 73,071 adults and 34,713 children and adolescents.

### ***How services are delivered***

Mental health services for adults and children are funded in the community through:

- Financial assistance agreements with county and select tribal governments;
- Contracts with OHP mental health organizations (MHOs); and
- A limited number of direct contracts with providers of regional, statewide or specialized services.

Services are delivered in every county through the 32 CMHPs and Warm Springs Tribal Clinic. Services are provided by a combination of county employees and subcontracted private agencies.

Professionally trained staff including physicians, nurses, social workers and trained peers provide:

- Crisis evaluation, stabilization and civil commitment functions;
- Medication, counseling and other outpatient and residential treatment to help people recover from mental illness;
- Case management, housing, and supported employment and education assistance to help people continue to live successfully in community settings; and

- A range of peer-delivered services and supports.

### ***Why these services are significant to Oregonians***

As a result of publicly funded mental health services, more children remain in their homes, in school and out of trouble. Adults with major mental illnesses who receive treatment are working more and functioning better, less likely to be hospitalized, and less likely to be jailed.

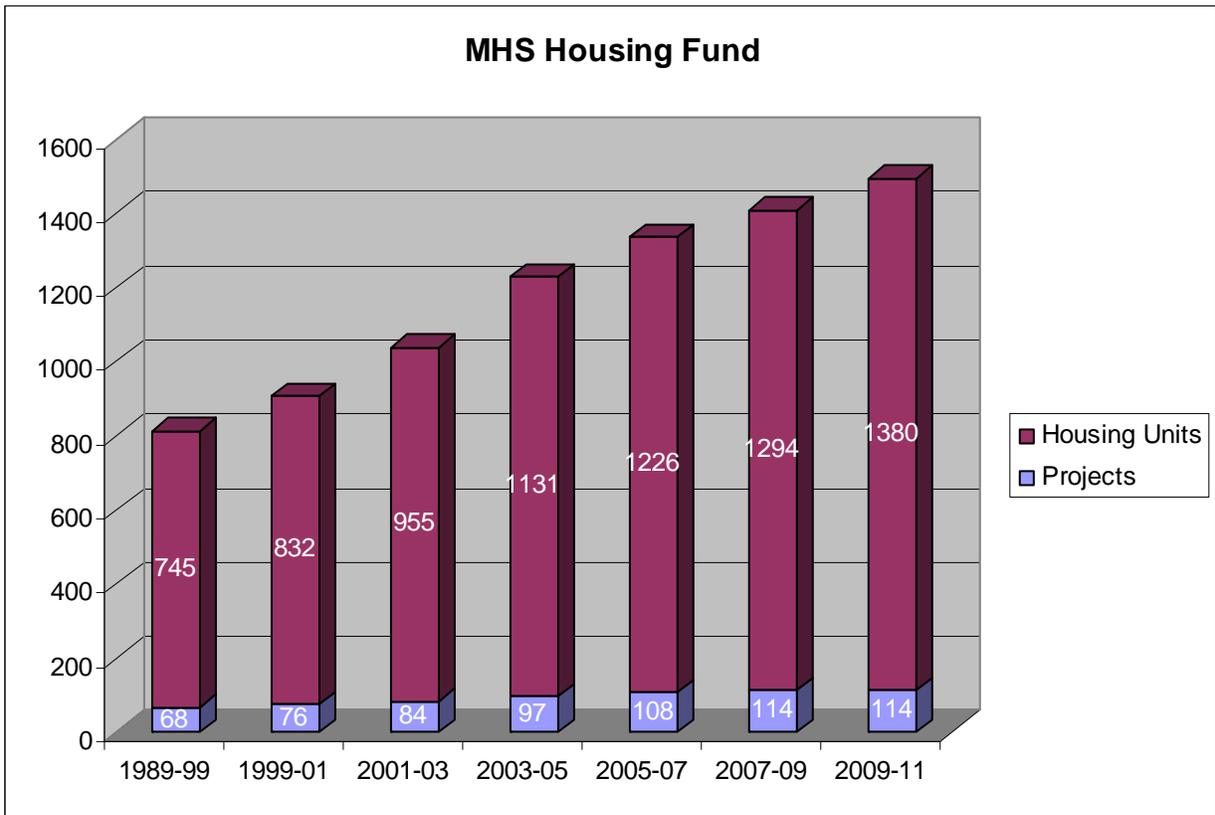
### ***Housing***

A safe and affordable place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in dangerous environments, their recovery is at risk. Homeless people with mental illness are less likely to use medications appropriately and less likely to continue treatment services, thus increasing the risk of further illness, mandated treatment and greater disability.

For mental health, AMH has two housing funds and an initiative on the former Dammasch State Hospital site in Wilsonville – the Villebois project.

***Mental Health Services (MHS) Housing Fund.*** Since 1989 AMH has provided grants to support the development of 108 housing projects in 25 counties accommodating 1,226 people with severe and persistent mental illnesses. The following chart shows the growth of projects and capacity since 1989. To date, AMH has invested \$4.4 million in the development of these projects. Each dollar invested leverages approximately \$38 from other sources.

For the 09-11 biennium, AHM set aside \$300,000 in MHS funds for Housing Renovation Grants. These grants are capped at \$4,999 per project and are available to address health and safety repairs to Adult Foster Homes, Residential Treatment Homes and Facilities within the mental health residential system of care. AMH is in the middle of the renovation application process, with 65 applications submitted, totaling more than \$265,895. The 65 facilities serve 550 residents in the residential system. AMH expects to make funding award announcements by the first week of September. The remaining MHS funds will be used during the last half of the 09-11 biennium to address special development needs for patients transitioning from Oregon State Hospital.



**Community Mental Health Housing Fund.** Established with the proceeds from the sale of the former Dammasch State Hospital property, this AMH fund has awarded an additional \$2.5 million in support of 32 projects. During 2009-011 the investment of \$600,000 made available an additional 86 units of supportive housing, leveraging \$47 for every dollar invested for total housing worth \$29 million.

The principal amount is held in the Oregon Short Term Fund (OST) with these guiding principles in priority order – preservation of principal, liquidity and yield. Additional conditions that guide the investment include the following:

- The OST fund has to maintain an average credit quality of “double-A.”
- A maximum 50 percent of the portfolio can be in corporate (non-government agency) securities.
- A maximum of 5 percent exposure can be maintained to any commercial paper or corporate note issuer.

- All investments are U.S.-dollar denominated.
- Fifty percent of the portfolio must mature within 93 days.
- No investment may be greater than three years to maturity.

**Villebois.** AMH is working with private developers to integrate community housing into the new urban village community at the former Dammasch site in Wilsonville. Originally AMH expected to develop 20 to 24 projects over a 10-year period beginning in 2005. Drastic changes in the housing market and the economy have halted most development activities at Villebois. Three multi-family projects opened in 2008 and 2009. Renaissance Court opened in June 2008 and serves 20 people with mental illness. The Charleston opened in May 2009 and has 15 of the 52 units set aside for people with mental illness. The Rain Garden opened in June 2009 and provides intensive support services to 29 people with mental illness, allowing them to live independently and have a key to their own door. There are currently no AMH projects under development, although single-family home development is starting to pick up again. AMH is working with the developers at Villebois to redefine the Master Plan approved five years ago and determine the best way to meet the housing needs of people with mental illness.

### ***Performance measures***

#### **KPM 7**

#### ***The percent of children receiving mental health service suspended or expelled from school***

***Purpose:*** The overall goal of the children's mental health system is to keep children at home, in school and out of trouble with friends. This measure demonstrates the success of keeping children in school.

***Target:*** This is a new measure and AMH wanted to establish a baseline. Based on the baseline information the target for next year will be that only 9.5 percent of the children are expelled and/or suspended.

***Results:*** Baseline information from the past four years shows that typically 13 to 10 percent of the children in mental health services are expelled and/or

suspended. This is roughly equivalent to the rate for the general school population and should be considered good.

*How Oregon compares to other states:* There are not any state-level or national data for children receiving mental health services to use for comparison.

## **KPM 8**

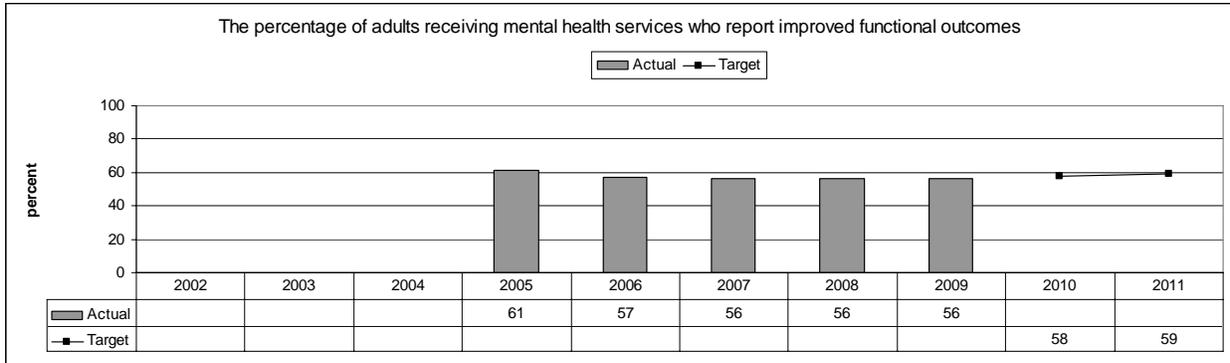
### ***The percentage of adults receiving mental health services who report improved functional outcomes as a result of those services***

***Purpose:*** Functional outcomes are really outcomes that everyone wants: good relationships with family and friends, good housing, a job, etc. This measure tracks individuals' perception of whether or not they have achieved those goals.

***Target:*** This is a new measure and AMH wanted to establish a baseline. Based on the baseline information the target for next year will be that only 58 percent of the adults experience improved outcomes.

***Results:*** Baseline information from the past five years shows that typically 60 to 56 percent of the adults experience improved outcomes during mental health services.

***How Oregon compares to other states:*** National statistics show that roughly 71 percent of adults experience improved outcomes. This indicates the Oregon has some work to do. A great deal of caution should be used in looking at comparative data from other states because of the variance in available services as well as the methodology for administering the survey.



**KPM 9**

***Mental health client level of functioning***

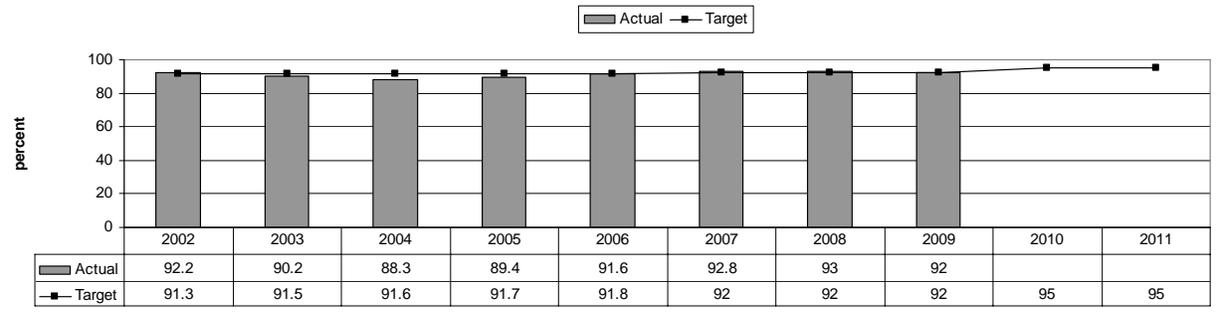
**Purpose:** Mental health clinicians use a variety of tools to track client progress during treatment. One general tool that is used by all clinicians working with adults is the Global Assessment of Functioning (GAF). Clinicians working with children use a similar tool called the Children’s Global Assessment Scale (CGAS). These tools are used to gather information during the initial assessment and throughout treatment. AMH is able to determine clients’ improvement over time by looking at changes to the GAF and CGAS scores. The goal is to demonstrate maintenance of functioning or improved functioning.

**Target:** The current target for this measure is 92 percent.

**Results:** In recent years the percentage of clients who maintain or improve functioning has steadily increased, although the most recent result for 2009 did shown a slight decline to 92 percent. This result still meets AMH’s goal. There is a concern that this tool, while in broad use, is not very sensitive to changes. AMH is exploring other ways to assess clients’ general improvement as a result of treatment.

**How Oregon compares to other states:** There are not any state-level or national data for comparison.

The percentage of mental health clients who maintain or improve level of functioning following treatment



## ***Proposed key performance measure for 2011-2013***

AMH proposes three new measures for inclusion as key performance measures (KPMs). The percentage of dollars spent on facility-based mental health services compared to community-based mental health services, the percentage of people with severe emotional disorders or severe mental illness served within the public mental health system, and the percentage of children demonstrating a decrease in the number of arrests in the 12 months following initiation of mental health services.

### ***Other performance measures***

Approximately 12 percent (106,124) of adolescents and children in Oregon are estimated to have a severe emotional disorder in any given year. Among adults, 5.4 percent (156,962) are estimated to have a severe mental illness.

AMH serves 33 percent of the children and adolescents and 47 percent of the adults with a severe emotional disorder or severe mental illness, respectively.

Involvement with criminal justice for both adults and adolescents is an important issue for AMH services to address. Caregivers of adolescents, indicated that approximately 56 percent of the children arrested in the year prior to services were not arrested in the year after services. Adults had similar success with approximately 54 percent indicating that they were not arrested in the year following services.

Housing is another important outcome. Of the adults needing improved or better housing, 54 percent of those receiving help found new housing. Homelessness is still a major issue for people receiving mental health services; encouragingly, 60 percent of children who began services homeless were not homeless by the end of services.

## *Quality and efficiency improvements*

### *Community-based services*

For the past 15 years Oregon has systematically moved from an institution-based system to a community-based system. This allows people who need publicly funded mental health services to be served in their communities. Hospitalization for acute mental illness is provided in psychiatric units of local hospitals. Increasing amounts of the long-term treatment and stabilization for adults with major mental illnesses is provided in community-based settings. This allows people the opportunity to stay connected with family, to learn the skills needed to be more independent, to be engaged in their community and, when possible, to work. Community-based services have proved to be more effective in assisting people to recover from mental illness and to live independent lives. Much of the community services created in the past 10 years have been facility-based. During the 2009-11 biennium several critical AMH Initiatives focused on creating more community based services and moving people through facility-based services to greater independence with permanent affordable housing and the supports necessary to be successful in living more independently.

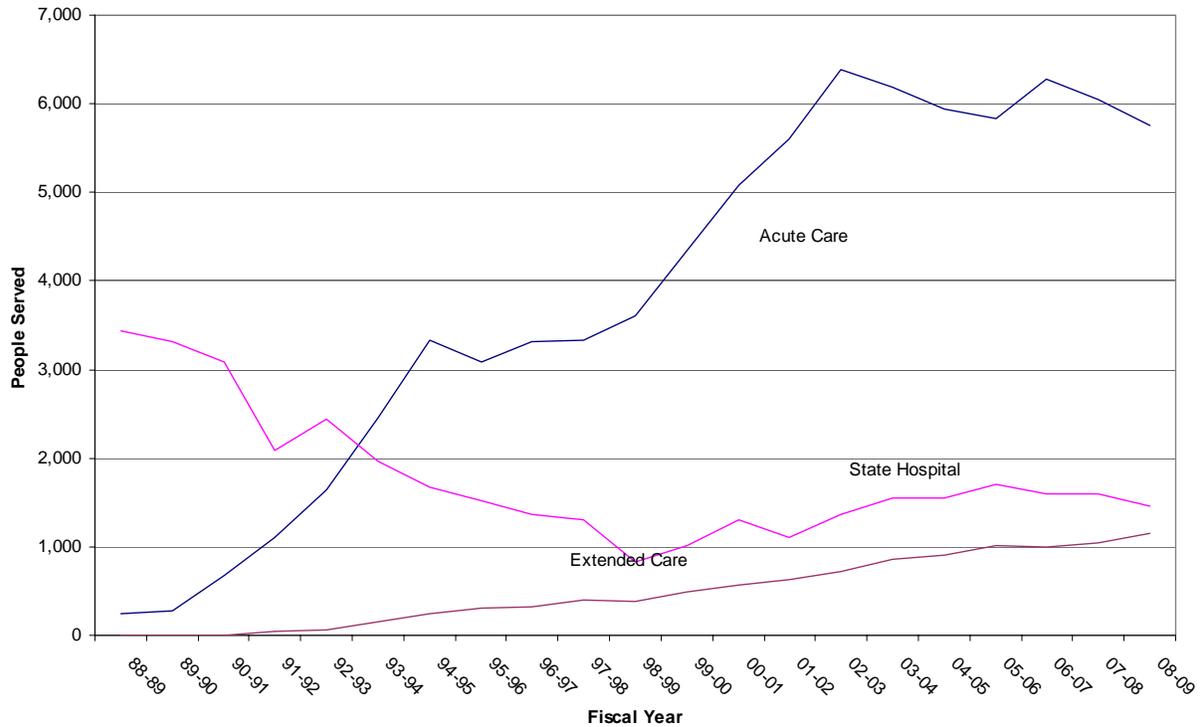
The cost to the system is less for community services than it is for institutional services. In addition, the services needed in community settings often can be supported with federal Medicaid funds not available for institutional services.

During FY 2008-2009, of the 73,071 adults receiving treatment services in the community, 1,400 people also were served in the state hospitals.

As of March 2005 Oregon no longer serves children or adolescents in a state psychiatric hospital. All Oregon youth including those who need intensive, medically directed treatment in a secure setting, are treated in community programs. The length of stay is shorter and children are more quickly returned to their home communities and receive the treatment and supports they and their families require for successful community living.

The following chart displays the admission trends in the system since 1988-1989 and shows the growth in community-based acute and extended care. The numbers reflect unduplicated individuals – an individual is counted once per year even if admitted more than one time.

**Shift from Institutions to Community-based Care**



***Key budget drivers and issues***

As Oregon’s population grows, there will be an increase in the number of people with mental health disorders. National research that looks at the need for mental health services indicates that 156,962 Oregonians (5.4 percent of the adult population) require treatment for a mental disorder. For children and adolescents, national estimates indicate that 12 percent of the population (106,124 youth) requires treatment for mental and emotional disorders. Public funds provided services for 73,071 adults (meeting 47 percent of the need) and 34,713 children and adolescents (meeting 33 percent of the need). Some of these individuals will be able to receive insurance-covered services. However, adults with major disabling mental illnesses frequently must rely on the publicly funded system.

The lack of investment in early identification and treatment for these disorders increases social costs and pushes more people into the intensive and mandated

treatment in the public system. In many cases, people with substance abuse and mental health disorders end up in the criminal justice system due to lack of treatment. They are more expensive to supervise in jail, stay longer for similar crimes and are more vulnerable to exploitation than other inmates.

## ***Housing***

A safe, affordable, alcohol- and drug-free place to live is essential to recovery from mental health disorders. When people are uncertain about where they will live or are forced to live in unpredictable and dangerous environments, their continued recovery is at risk. Unfortunately, most clients of Oregon's publicly funded system are exactly in these adverse living environments.

People with mental health disorders make up a substantial proportion of people identified as homeless in the 2010 Point in Time Count; over 3,000 people or nearly 18 percent of those identified as homeless.

## ***Mandated treatment***

There have been two groups of people in the mental health system who are mandated by the courts to receive treatment for their mental illness – those who have been civilly committed and those who are criminally committed.

Since July 1, 2007, AMH has provided on-demand treatment and support services to youth who are under the jurisdiction of the Juvenile PSRB support. These youth, who have committed crimes and have been found responsible except for serious mental condition, present substantial danger to others.

The civil commitment caseload includes people who are found through a civil court process to be dangerous to themselves or others, or to be unable to care for themselves as a result of mental illness. Through this process the individuals are mandated by court to treatment (ORS 426.070). People on this caseload are served in a variety of settings that include state hospitals and community outpatient settings.

Currently there are approximately 2,000 civilly committed people in state hospitals or other 24-hour community settings including enhanced care, adult residential and foster care. Based on the civil commitment forecast, an increase of 300 people is expected during the next biennium. Many of these people will need 24-hour community and or state hospital services.

The criminal commitment caseload is based on two separate categories of criminal commitments. The first group, known as “Aid and Assist,” includes people mandated to OSH for assessment and treatment until they are able to assist in their defense (ORS 161.370). The second group consists of people who have been found “guilty except for insanity” of a crime by a court (ORS 161.315). These individuals are placed under the jurisdiction of the PSRB. AMH is required by Oregon law to provide treatment and supervision for these individuals either in the community or in a state hospital (ORS 161.319 and ORS 161.327).

The PSRB caseload has been increasing steadily for many years, although there has been a modest slowing during the past couple years.

### ***Improving the community mental health system***

The 2007 Legislature funded improvements in community mental health that included jail diversion, acute care, crisis services, case management services, supported employment, early psychosis projects and children’s mental health. The funding was distributed to county programs through a formula that weighed both the needs of the community, as demonstrated through prevalence of severe mental illness, and the population.

Other than a \$1.0 million reduction in supported employment services, the 2009 Legislature continued funding this investment in community mental health services. The services continue to meet the increasing demand for treatment and supports in local communities.

Without continued funding at the current service levels, the following outcomes will not be replicated:

Oregon has 16 evidence-based supported employment sites across the state. From January 2008 through June 2009, 4,096 people accessed evidence-based Supported

Employment services. For the 2009-2011 biennium (07-01-09 through 03-31-10) 2,002 people accessed evidence-based Supported Employment services. The 2009 Legislature reduced \$1.0 million from these services. Without these services thousands of Oregonians will not receive the essential employment training they need that would allow them to become self-sufficient citizens. This in turn would add to the already high unemployment numbers facing Oregon.

The state has directly developed or made available 170 supportive housing beds since July 1, 2007. Oregon will develop an additional 331 supportive housing beds through the Adult Mental Health Initiative (AMHI) by June 30, 2011. Without these supportive housing beds, Oregonians in need of treatment will occupy more costly residential beds that will add a financial burden to the already strained residential system.

Jail diversion dollars have been distributed to 36 counties throughout Oregon. By county report, approximately 3,115 people have been served with these funds, including diversion activities preventing incarceration. Without these supports and interventions, thousands of Oregonians will enter the criminal justice system instead of receiving the needed mental health treatment.

The Avel Gordly Center for Healing provides between 550 and 600 units of culturally competent clinical service every three months to African and African-American individuals and their families.

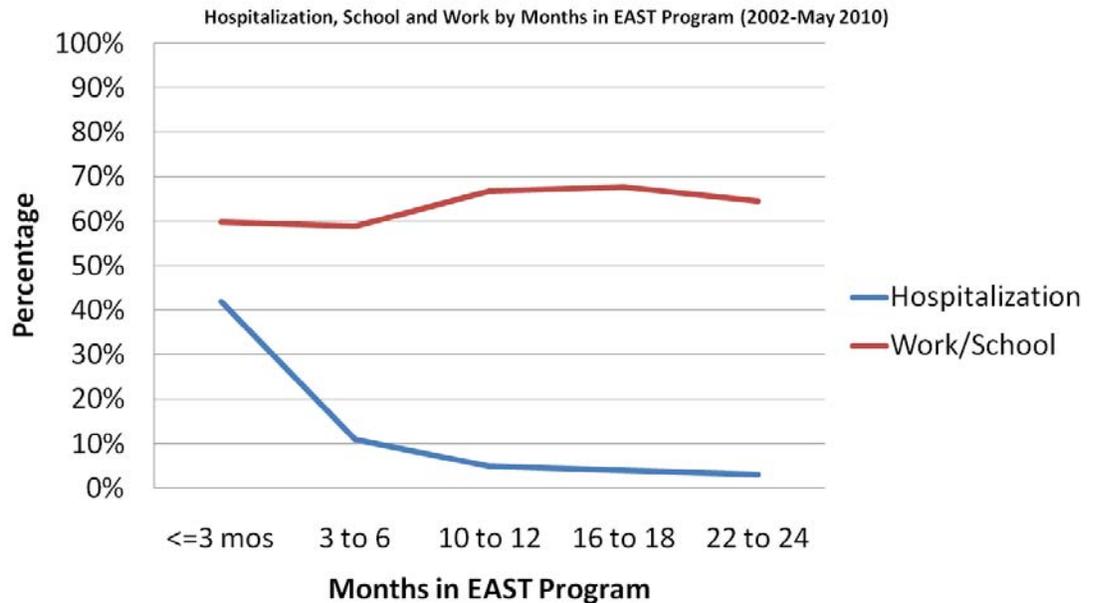
## **Early Assessment and Support Alliance (EASA)**

EASA was modeled after a successful program implemented by Mid-Valley Behavioral Health Care Network (MVBCN), which identifies individuals in the early stages of schizophrenia and other psychotic disorders and ensures they and their families have the proper resources to effectively deal with the illness. This program greatly improves communities' education about and awareness of mental illness by using it as an early warning system that helps steer people toward appropriate resources. In the long run this can have a dramatic effect on the reduced need for more institutionalized and expensive care, while promoting recovery.

EASA employees were trained by staff from MVBCN, and programs are now fully operational and achieving the same success rates as seen within the MVBCN's Early Assessment and Support Team (EAST). Approximately 584 non-Medicaid clients and their families are engaged with providers across the state. Services that will be delivered include outreach and engagement; assessment and treatment using a multi-disciplinary team consisting of a psychiatrist, social worker, occupational therapist, nurse and vocational specialist; multi-family psycho-education; cognitive behavioral therapy; vocational and educational support; prescribing medication using a low dose protocol; and support for individuals in home, community, school and work settings.

Current outcomes demonstrate that:

- Evidence-based early intervention for psychosis now exists in 16 counties (5 original EAST and 11 EASA).
- From January 2008 through June 2010, 972 referrals were made to both programs. During that same period, the EAST and EASA program served 446 individuals and their families.
- Forty percent of the participants in the EAST program were hospitalized in the three months prior to beginning service. Three months into the programs hospitalizations were reduced by 75 percent and continue to decrease over time. See graph below.



- The EASA program is demonstrating similar results and of those individuals enrolled since start up, 49 percent had hospitalization in the three prior months with more than 704 days of hospitalization. Three months into their participation, only 10 percent were hospitalized for 179 days. The average hospital day costs \$1,000; this difference in hospitalization costs alone represents a cost avoidance of \$525,000 over three months. For example, Multnomah County's EASA team has decreased young adult hospitalizations by 76 percent in its first six months of operation.
- EASA clients saw increases in both employment and education once entering into the program. Clients actively engaged in education went from 34 percent to 48 percent within the first year, while those employed went from 11 percent to 26 percent by the second year. This resulted in a total of 74 percent of EASA clients being actively engaged in either a school or work setting after at least one year of service provision.
- Arrest rates decreased from 20 percent in the three months prior to starting in the program to 2 percent for the entire period since enrollment.
- Overall, the EAST and EASA programs retain 95 percent of the people who begin services. Most of these families choose not to apply for public assistance except for those who lack health insurance.

## *State Delivered Secure Residential Treatment*

---

### *Facility Program*

The State-Delivered Secure Residential Treatment Facility Program was enacted through HB 5031, the DHS Operating Budget. In passing HB 5031, the Legislature approved the program authorizing AMH to operate secure residential treatment facilities.

### *Services provided*

State-delivered secure residential treatment services provide long-term treatment for individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB) who have been deemed ready for conditional release. These individuals actively participate in an array of treatment options while under the jurisdiction of the PSRB. The PSRB closely monitors the progress these individuals make in their treatment and play a role in the evaluation process to determine when residents are ready to transition to a lower level of care.

### *Where service recipients are located*

The first program opened in Pendleton in early January 2009. Slots have not been located at this time due to the economic situation and the vacancies in other facilities serving the same population.

### *Who receives services*

Services are provided to people under the jurisdiction of the PSRB who no longer need hospital-level care. Providing services to those under the PSRB jurisdiction in the community lowers the census at the Oregon State Hospital. There are 16 people in the first program.

## *State Hospital Services*

---

Mental health services for adults who need long-term psychiatric hospitalization are provided in both extended community care services and state hospitals with campuses in Salem, Portland and Pendleton. These services are essential to restoring patients to a level of functioning that allows successful community living. These services in a secure setting promote public safety by treating people who are dangerous to themselves or others, and who have committed crimes and are adjudicated guilty and insane. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of non-profit and for-profit providers.

### *Oregon State Hospital (OSH)*

#### *Services provided*

With campuses in Salem and Portland, the Oregon State Hospital (OSH) provides in-patient and residential services with a budgeted capacity of 641 beds and a licensed capacity of 732 beds. OSH is accredited by the Joint Commission. Patient ward 34C in Geropsychiatric Treatment Services is certified to receive Medicaid Title XIX funding by the Centers for Medicare and Medicaid Services (CMS). OSH is part of the Oregon State Hospital System and is operated by the Oregon Health Authority (OHA) Addictions and Mental Health Division. Services include:

- ***Adult treatment services:*** These services are provided in a 92-bed leased facility in Portland. This program provides hospital-level psychiatric services for 92 adult patients with major psychiatric illnesses who are 18-65 years of age. Patients treated in this program are unable to be treated in a less structured environment; they are civilly committed and assigned to hospital-level care. This program provides intermediate and long-term state hospital treatment for patients transferred from community acute care hospitals.
- ***Neuro/medical services:*** These services are provided in 114 beds in four units of specialized active in-patient treatment for elderly persons with mental illness and a specialty unit for neurologically impaired patients of all ages. Five beds

providing acute nursing care for patients suffering from medical conditions are included on one of the geropsychiatric wards. In-patient services are available to older adults who have major psychiatric disorders and adults over 18 who have brain injuries. These adults require nursing care and have behaviors that cannot be managed in a less restrictive nursing home environment. The in-patient medical services are available to any OSH patient who develops an acute medical disorder not requiring hospitalization at an acute care medical/surgical hospital.

- ***Forensic psychiatric services:*** This program provides hospital treatment services to patients committed by the courts for evaluation or treatment to be able to aid and assist in their own trials or to the jurisdiction of the PRSB under the “guilty except for insanity” adjudications. These services consist of 399 hospital-level beds on 11 treatment units. A full array of treatment services is offered in maximum and medium security levels. This in-patient care is available to patients who are adjudicated guilty except for insanity and who are committed to the jurisdiction of the PSRB and placed in the custody of OSH. In addition, this program provides services for some civilly committed patients who are either too dangerous or too difficult to manage in the less restrictive and secure environment of a general adult hospital program. This program also provides evaluation of a general adult hospital program. This program also provides evaluation and treatment services for patients determined by the courts to be unable to assist in their own defense (ORS 161.365 and 161.370). Specialty services are provided to patients adjudicated for sex offenses or those with histories of sexually inappropriate behaviors.
- ***Forensic residential transitional services:*** These services provide treatment for 36 patients in six cottages. These are transitional units providing treatment to PSRB patients who have shown substantial improvement in their conditions and who require a less restrictive environment in preparation for placement in a community setting.

### ***Where service recipients are located***

Clients residing at OSH are admitted from all areas of the state.

## **KPM 11**

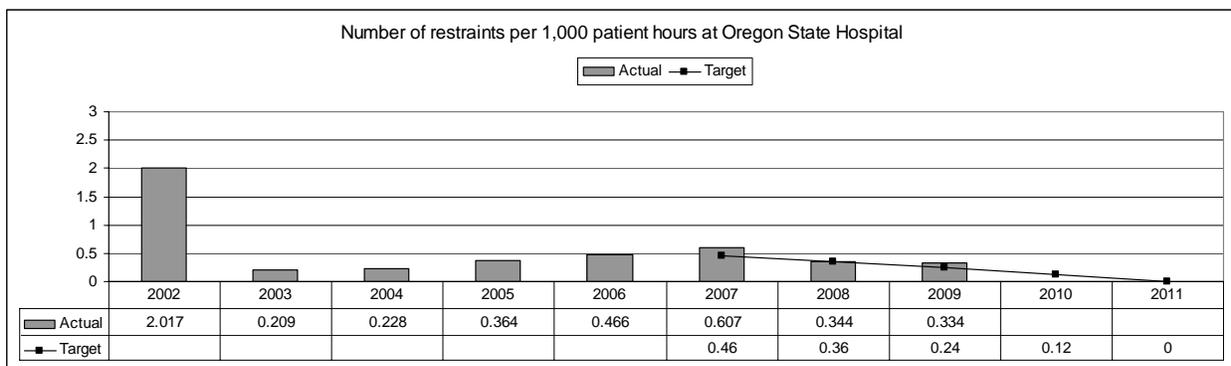
### ***Number of restraints per 1,000 patient hours at Oregon State Hospital***

**Purpose:** The goal is to reduce and eventually eliminate the use of emergency restraint. All employees are trained in a procedure known as ProACT to help implement this goal. ProACT teaches staff to use the least restrictive approaches to controlling aggression, including early intervention to prevent the escalation of aggressive behavior

**Target:** The current target for this measure is .24 restraints per 1,000 patient hours.

**Results:** OSH has not achieved the target for 2009 but showed a slight reduction over the previous year. A very small number of patients account for more than half of the use of restraint at OSH. One patient in particular is considered an outlier, due to her frequent assaults on staff members and subsequent restraints.

**How Oregon compares to other states:** Based on monthly data collected through the National Research Institute of the National Association of state Mental Health Program Directors, OSH's restraint rate has been below the national mean seven of the past 12 months. National comparisons are difficult because of the variability (size and function) in hospitals across the states.



**KPM 12**

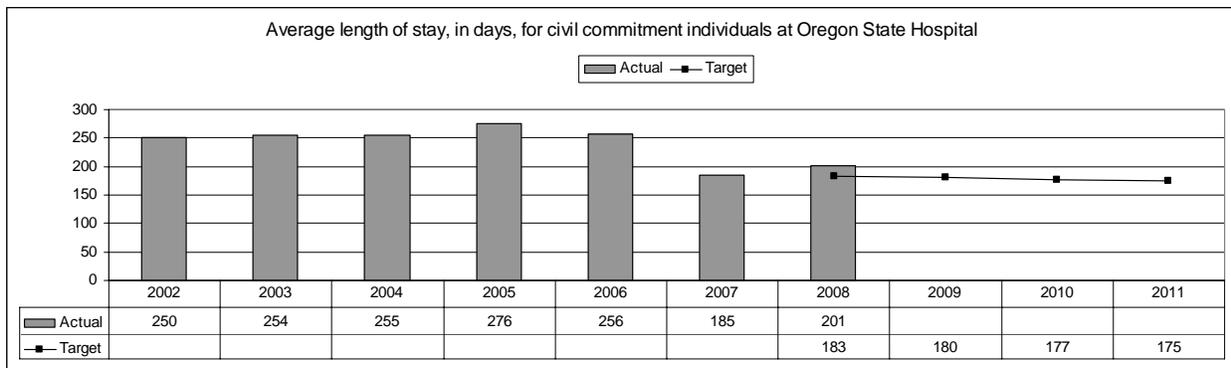
***Average length of stay, in days, for civil commitments at Oregon State Hospital***

**Purpose:** The goal is to reduce the projected length of stay of individuals at OSH and ensure they are at the most appropriate level of care.

**Target:** The current target for this measure is 183 days.

**Results:** OSH did not achieve the target for 2008 and there is not yet enough time to assess the projected length of stay for individuals who entered the hospital in 2009.

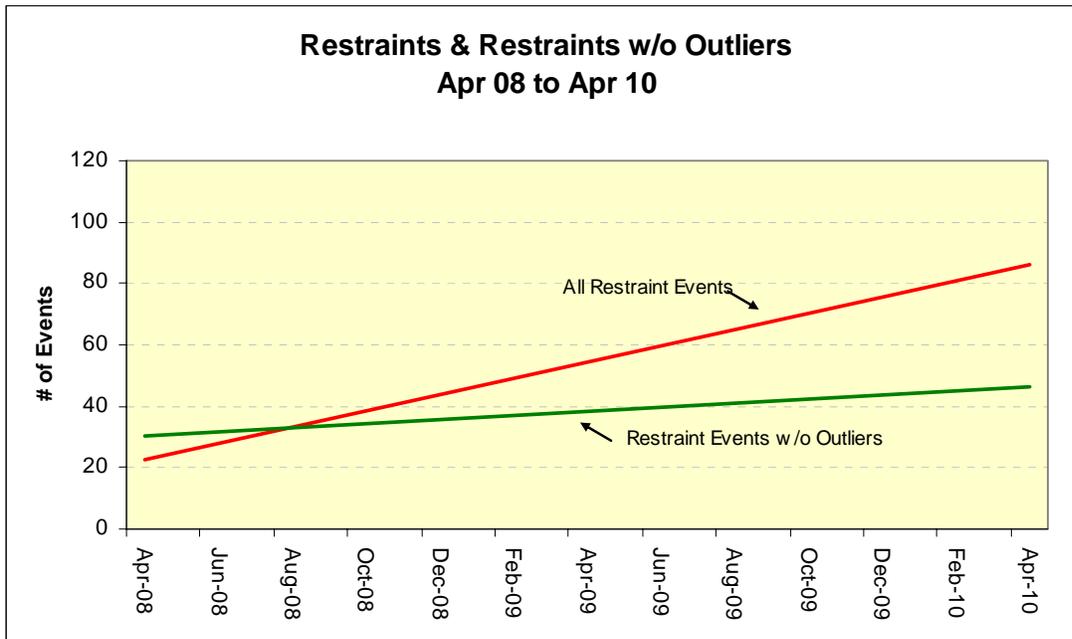
**How Oregon compares to other states:** While there is national data for lengths of stay, it would not be good to compare because of the varying nature and population at other state hospitals.

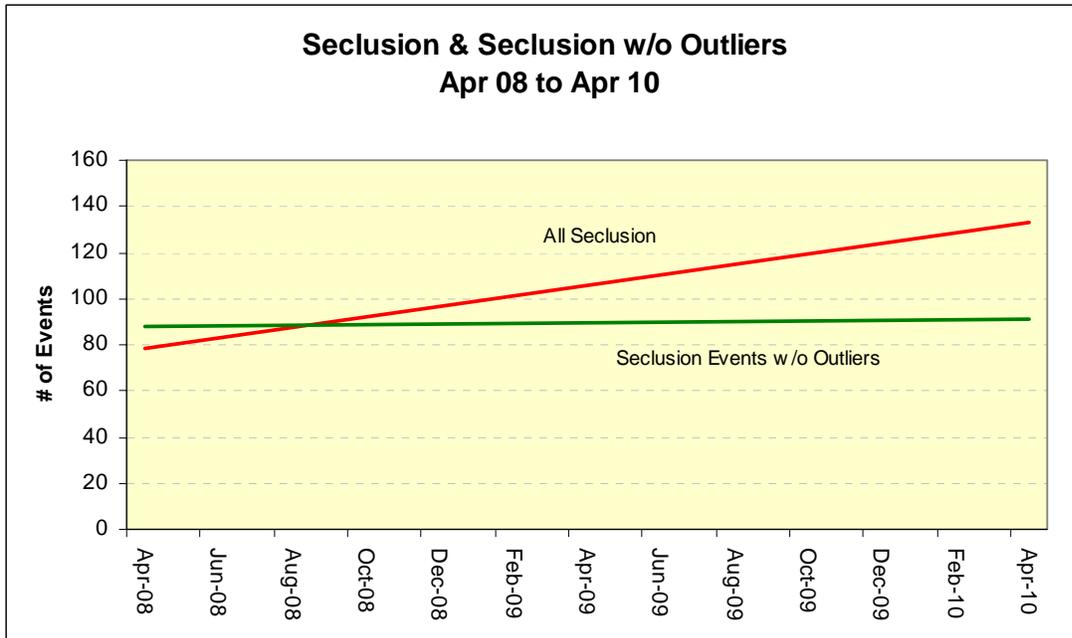


***Additional information regarding restraint use and seclusions***

As required by the Joint Commission, OSH submits data on restraints and seclusion to the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. OSH data, along with data from hospitals around the country, are analyzed and reported back to OSH, resulting in a delay in the publishing of recent OSH results.

Hours of restraint and seclusion remain at or below the national average for hospitals reporting to NASMHPD. As reflected in the following two charts, restraint and seclusion use has risen during the past two years. However, the increase is due to five patients with difficult-to-manage behaviors.





## *Quality and efficiency improvements*

### *OSH compliance with oversight agencies*

OSH completed a Continuous Improvement Plan (CIP) in January 2008 that had been drafted in late 2006 and revised following the November 2006 review by the U.S. Department of Justice (USDOJ). The hospital’s CIP, a multi-year effort, is guiding improvements in the following areas:

- Adequately protecting patients from harm,
- Providing appropriate psychological care and treatment,
- Use of seclusion and restraints in a manner consistent with generally accepted professional standards,
- Providing adequate nursing care, and
- Providing discharge planning to ensure placement in the most integrated settings.

A team of two CMS surveyors made an unannounced visit to OSH June 16-18, 2008, to follow up on CMS surveys conducted in February and April 2008. The survey team found that patient ward 34C was acceptable for certification.

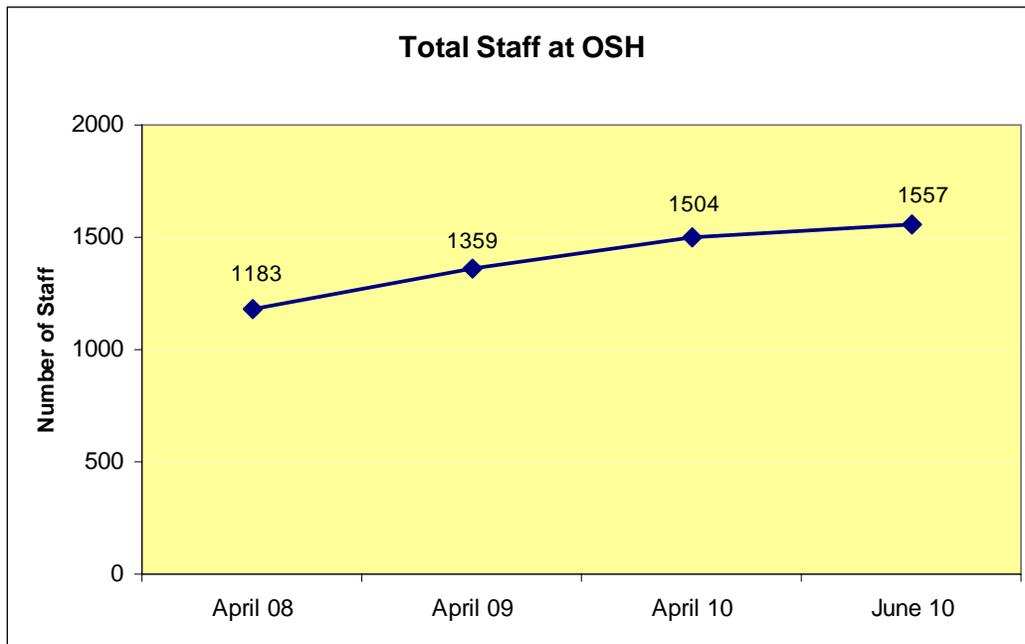
The Joint Commission conducted its full and unannounced survey in February 2009. The survey team requested Requirements for Improvement that were all subsequently met and full accreditation was granted retroactive to February 2009. The hospital's clinical laboratory was also surveyed and granted full accreditation.

***Improved incident reporting system***

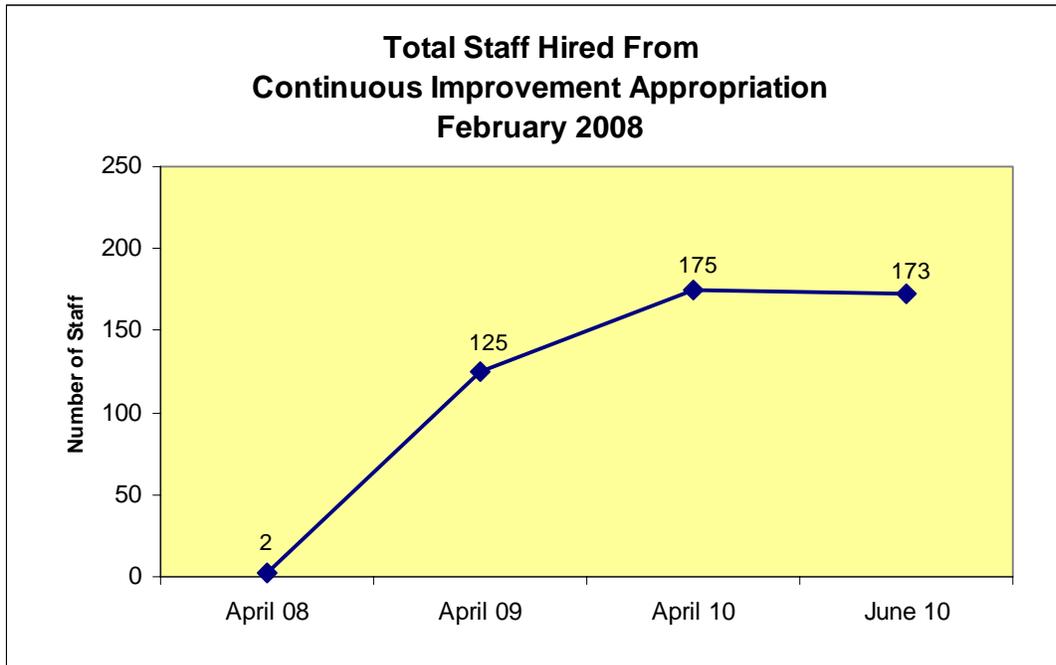
OSH has improved procedures for completing and submitting incident reports. Incidents are reported daily and follow-up, when necessary, can happen immediately. The Critical Incident Review Panel meets regularly and in a timely manner to ensure incident reports and corrective actions are comprehensive and appropriate. Corrective actions have included modification in patient behavioral plans, medication regimens and supervision, as well as enhancements to physical characteristics of select areas of the hospital. The Critical Incident Review Panel is educating staff about incident trends as well as evaluating whether reviewed corrective actions have been effective in reducing the number of hospital incidents, both on an individual patient and system-wide basis.

***Staff additions at OSH***

OSH continues to advertise, recruit and qualify candidates for certain key positions such as registered nurses, physicians and pharmacists, as well as other existing vacancies at the hospital.



In February 2008, OSH received an appropriation of 211 staff. The following chart shows the hospital's progress in filling those positions.



In 2009, the hospital's policy option package was funded with 527 new positions. Since OSH received the appropriation, 209 positions have been filled.

In order to enhance recruitment efforts, OSH continues to train certified nursing assistants (CNAs) due to a significant shortage in the marketplace. Currently 16 students are waiting to take their CNA exam. Once certified, they will begin to work as CNAs at OSH.

### **Response to Office of Investigations and Training (OIT) Report**

In response to a report issued by the Office of Investigations and Training that investigated an October 2009 patient death, OSH created a comprehensive follow-up action plan. A number of improvements were made including: the revising of the Continuous Rounds Policy to monitor patients, establishment of morning report for all patient units to improve communications among staff, hiring of 14 Treatment Care Plan Specialists (TCPS), with plans to hire an additional nine more, to facilitate Interdisciplinary Treatment Teams (IDTs), auditing of all patient records to determine if patient's medical care issues are being actively addressed (initial audit showed 91 percent compliance), revision of frequency of documentation standards and establishment of required elements of documentation,

revision of two policies, the Communication with Patient's Family, and the Interpreter Services policy.

### ***Improved patient assessment compliance***

Patient assessments are a critical element to effective mental health treatment. At the time of admission, clinical disciplines conduct assessments of all patients. Within the first 10 days of admission, the following assessments are completed – a psychiatric admission note and history (psychiatric), a medical history and physical exam (nurse practitioner), a comprehensive nursing assessment (registered nurse), a psychosocial history (social worker), a rehabilitation services assessment (rehabilitation therapist), a patient education assessment (assigned staff), and any psychological testing ordered by the physician (psychologist).

Completion rates for all assessments are tracked by the Quality Improvement Department. The completion rate for 2009 was 93.3 percent. The 2009 rate is an improvement when compared to a 91.2 percent completion rate in 2008.

### ***Increased use of behavioral support plans***

The OSH Continuous Improvement Plan included, as a high priority, the development of behavioral support plans for identified patients. Behavioral support plans (BSPs) provide specific treatment strategies for patients whose behavior is difficult to manage. Use of BSPs is expected to contribute to a decrease in aggressive acts by patients and the use of restraints and seclusion. The initial focus was on patients within the Geropsychiatric Treatment Services Program on the Salem campus, and the four units on the Portland campus. The focus was expanded to include patients in the Forensic Psychiatric Services Program. There currently are 64 patients with behavioral support plans, and eight new BSPs are in process. BSP has assisted 12 patients to be discharged from OSH.

### ***Improved Master Treatment Care Plans***

OSH provides recovery and rehabilitation to the patients it serves through active treatment. Central to effective treatment is patient care planning. With input from two nationally recognized consultants, changes have been made to the functioning of treatment teams, and to the form and content of treatment care plans.

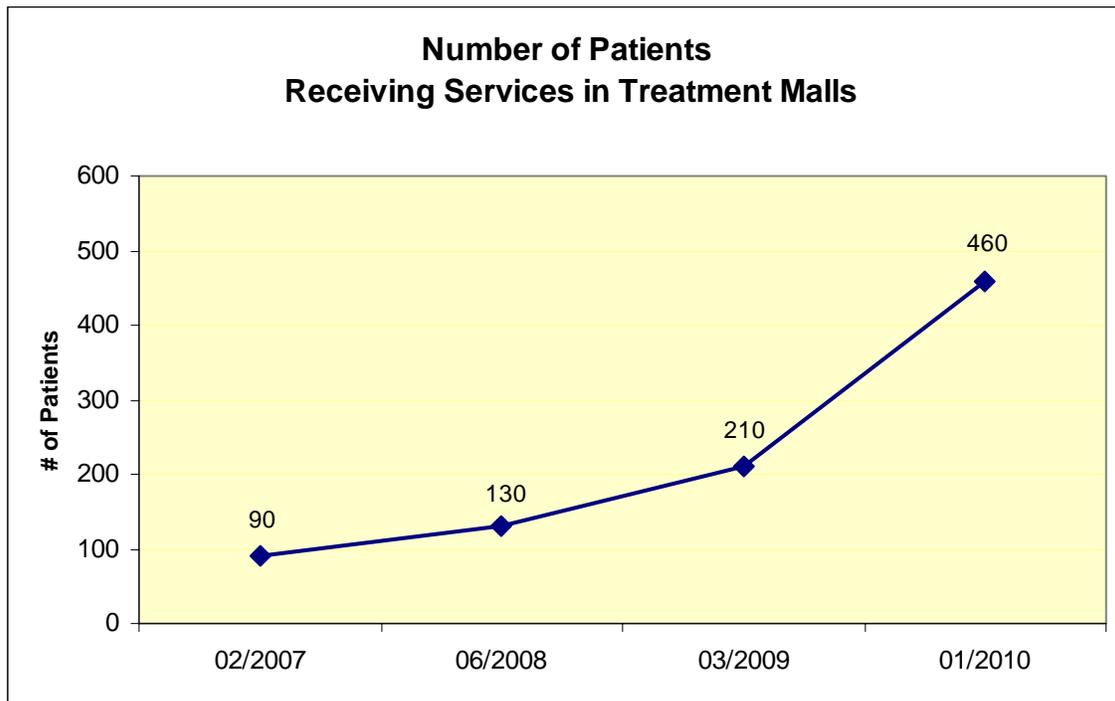
A new electronic Master Treatment Care Plan format was piloted in Geropsychiatric Treatment Services in November 2009. The revised format was found to ensure that care was patient-centered, individualized and responsive to patient needs. As a result of these positive outcomes, it was decided to implement

the new format hospital-wide. Implementation dates occur as wards are assigned employees in their newly created Treatment Care Plan Specialist (TCPS) positions. The TCPS coordinates the functioning of the Interdisciplinary Treatment Team, ensures the team meets regularly, has pertinent patient information, and communicates with Treatment Mall staff to ensure continuity of care.

The new Treatment Care Plan has been fully implemented on all four wards of the Portland Campus of OSH. In Salem, 53 percent of the units are using the new format. As more Treatment Care Plan specialists are hired the new format will be implemented in the remaining units.

### ***Centralized Treatment Malls***

A fundamental element of the hospital's Continuous Improvement Plan is delivering centralized services at treatment malls. Four treatment malls now provide active treatment to a majority of OSH patients. The chart below shows the steady increase in the number of patients served.

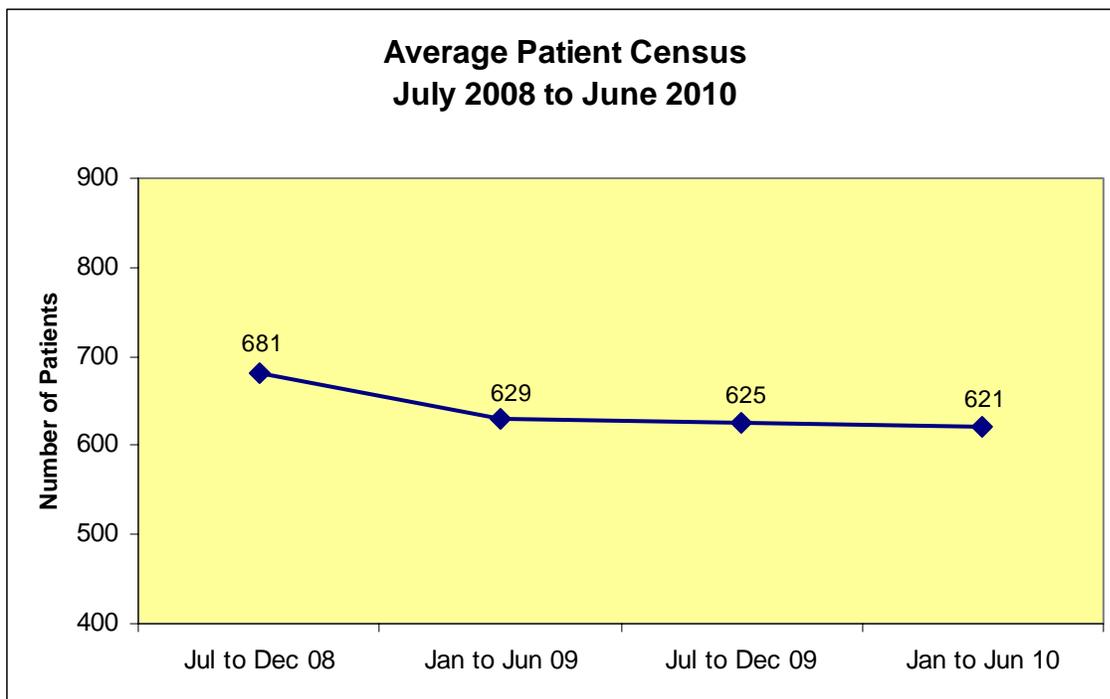


- Portland Mall opened February 2007
- Geriatric Mall opened June 2008

- Transition Mall opened March 2009
- Forensic Mall opened January 2010

***Patient Census***

During the past 24 months, OSH has experienced a 9 percent decrease in patient census. The decrease has been due to multiple factors. Improved discharge planning at OSH, the implementation of a Peer Bridger Program, participation in a Transformation Initiative 01 to Transition Patients, and increased cooperation with the Blue Mountain Recovery Center, the Psychiatric Security Review Board and community partners have all contributed to reduced patient census. There remains a group of patients whose histories and complex needs are a challenge for timely discharge. During this period of decreased census, the number of patients waiting for admission has remained low.



***Transformation Initiative***

In collaboration with the DHS Transformation Initiative, hospital staff have undertaken five Rapid Process Improvements (RPIs). An RPI is a three-day focused effort that brings together multiple disciplines and stakeholders to map out a current work process, eliminate waste and build a new streamlined process. Four

of the RPIs have focused on Process Improvements and one on Quality Improvements.

### ***Process Improvements***

OSH is using rapid process improvement events and Lean principles to improve existing processes and streamline processes as part of the planning to move into the new facility. The work design has resulted in dramatic improvements in the process for hiring RNs, physician billing for Medicare covered services, the documentation of group treatment in the treatment malls, and most recently the hiring of direct care Certified Nursing Assistants.

The RN Hiring and the Certified Nursing Assistant Hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates by improving the hiring processes. Since the RN Hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA Hiring rapid process improvement event was launched in May 2010 with the goal of eliminating 85 CNA vacancies by December 2010. The streamlined hiring process has resulted in 59 hires. The date by which the goal will be achieved has been revised to September 2010.

The Group Documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation processes into one streamlined process and format that is now used across clinical disciplines.

The MD Billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

### ***Quality Improvements***

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients, made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their Dietary Consultation process improvement efforts in 2008; dietitians are completing twice as many consultations every month and people receive their dietary consultations 85 percent more quickly than before the process improvement efforts.

### ***Key budget drivers and issues***

The key driver for the OSH budget is the requirement to hire sufficient staff to open the new facility in 2011. The new facility includes four smaller programs inside the 620-bed facility. Within each program there are small residential units for 20 to 25 people in either single or double rooms. The patients will leave the residential units each day to participate in treatment in program-specific central treatment malls within the hospital. The facility will be staffed adequately to ensure the provision of at least 20 hours of active psychiatric treatment per week.

## ***Blue Mountain Recovery Center (BMRC)***

### ***Services provided***

Blue Mountain Recovery Center (BMRC) in Pendleton, formerly known as the Eastern Oregon Psychiatric Center (EOPC), is an in-patient adult psychiatric hospital built in 1948. Clients reside on two 30-bed units and attend groups and activities throughout the facility. BMRC is part of the Oregon State Hospital System and is operated by the OHA Addictions and Mental Health Division.

Specific services provided by BMRC include: medication management; evidence-based educational classes; life skills training; vocational services; physical and recreational activities; alcohol and drug counseling; individual cognitive-behavioral therapy; and spiritual counseling. Transition services are provided to prepare clients for successful discharge into community-based services. Medical services are provided by contract physicians and local community hospitals.

### ***Where service recipients are located***

Clients residing at BMRC are admitted from all areas of the state.

### ***Who receives services***

BMRC provides long-term treatment for civilly committed clients who, due to a mental disorder, are deemed dangerous to themselves or others, or are unable to care for themselves. These individuals actively participate in an array of treatment options at BMRC until they are able to manage their psychiatric symptoms and maintain their mental health in community settings. In addition, BMRC provides care and treatment for a small number of forensic clients who have close family ties in eastern Oregon.

### ***How services are delivered***

BMRC embraces the Recovery Model, which supports clients learning to live well with the least amount of professional intervention. Dedicated physicians, nurses, therapists and other staff members at BMRC help clients start their road to recovery from acute exacerbations of psychiatric illness. The goal is to return clients to the fullest possible participation in their families, jobs and community as

quickly as possible. Clients learn how to take charge of their lives by managing emotions across settings, staying out of conflicts, using medications wisely, and avoiding drugs and alcohol. This delivery system is in direct alignment with all of the OHA goals for Oregonians, of which BMRC clients are a distinct subset.

### ***Why these services are significant to Oregonians***

One of the primary functions of BMRC is to ensure that individuals with psychiatric disabilities are kept safe until they are able to manage their symptoms and behaviors in a community setting. Another primary function is to ensure public safety through secure, intensive treatment of clients while they regain psychiatric stability.

Since the beginning of 2008, BMRC has averaged 145 admissions and discharges per year. This represents more than 18,000 in-patient days per year, a figure that cannot easily be absorbed by existing facilities in the community, or by the other two state hospital campuses.

Furthermore, BMRC is the primary state hospital resource for central and eastern Oregon. Clients from St. Charles Bend are given preferential admission in order to maintain open acute psychiatric beds in the region.

One of the desired outcomes of the use of evidence-based practices is that funded programs “improve the mental health of a person with the result of reducing the likelihood that the person will commit a crime or need emergency mental health services.” BMRC provides vital psychiatric services that achieve that very outcome. The BMRC current treatment model has resulted in fewer 30-day readmission rates, longer stays in the community between hospital readmissions, shorter stays in the hospital and, overall, a better quality of life for one of Oregon’s most vulnerable populations, persons with psychiatric disabilities.

# *Capital Construction*

---

## *Oregon State Hospital Replacement Project*

### *History*

Oregon is in critical need of a new hospital for its citizens with mental illness. The Oregon State Hospital (OSH) is one of the oldest continuously used mental health hospitals on the West Coast. It also has the distinction of being one of most decrepit mental health facilities in the nation. More than 40 percent of the building space is unusable, with water leaks from roofs, crumbling walls, and the toxic hazards posed by the presence of asbestos and lead.

For at least 20 years, state lawmakers have heard from patients, advocates, citizens and staff about the inadequacy of the state hospital. In addition, the state has faced several challenges including legal suits over a variety of hospital deficiencies. The Governor, Oregon Legislature and DHS/OHA have collectively acknowledged the critical need for new mental health facilities.

During 2003 the Governor established, by Executive Order, a 21-member Mental Health Task Force to identify key problems in the state's mental health system and recommend improvements. The task force report released in 2004 its recommended changes to OSH.

Ongoing concern about the hospital prompted the November 2004 Legislative Emergency Board to allocate funds to DHS for an independent examination of the mental health system with a specific focus on OSH.

With those funds, the Governor and Legislature commissioned KMD Architects, a firm with more than 40 years' experience in 15 states, to begin preparing a master plan for replacing OSH.

The May 2005 OSH Framework Master Plan Phase I Report identified significant structural issues, including a potential that the "J" Building complex on the Salem campus would collapse in an earthquake. In addition, the Phase I Master Plan notes

that the existing facilities on this campus have physical limitations that cannot be remediated to provide safe and secure treatment environments. Along with these issues, the 92-bed Portland campus lease ends in February 2015, requiring the relocation of the 92 patients housed there. The Phase II Report on the Framework Master Plan was released on March 1, 2006. That report provided the Governor and legislative leadership with three options to consider for replacing OSH. The leadership has provided direction to DHS to proceed using the configuration listed in the document as “Option 2”: one 620-bed facility located in the North Willamette Valley, one 360-bed facility located south of Linn County on the west side of the Cascades, plus two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

As the project moves forward, the replacement team continues to look for opportunities to improve patient care and reduce state costs. At this time the team members are evaluating the appropriate size and patient service configuration of the proposed 360-bed facility. For example, working with AMH and SPD they are researching the opportunities to place some of the geriatric patients now being served at OSH and projected in the population growth number in a smaller community setting. It is anticipated the recommendations from this research will result in a reduced bed need at Junction City, the location of the 360 facility, and an improved service delivery model, possibly eligible for federal match.

Based on recommendations from a Joint Legislative and Executive Branch Task Force, the 2007 Oregon Legislature authorized Certificate of Participation (COP) financing estimated at \$458.1 million to build two new state-operated psychiatric facilities. The Salem facility is scheduled to open in 2011 and the Junction City facility in 2013. Both sites will be modern psychiatric treatment and recovery facilities designed for up-to-date psychiatric practices. They will be structured, along with a strengthened community mental health system, to support healing, recovery and a return to successful community living.

Although the current state hospital is inadequate for long-term continued use for the care and treatment of those with mental illness, the OSH Salem campus has been selected as the best site for construction of the new 620-bed facility. Using legislatively mandated selection criteria developed with public input, this site scored highest among those considered. The Salem site maximizes opportunities to attract and retain quality professional staff and places 55 percent of patients reasonably close to their home communities. In addition, the larger Salem

community is accustomed to having a large psychiatric hospital on this site and is generally supportive of the hospital being there.

### **Historic preservation**

DHS/OHA is committed to protecting and preserving valued historic and cultural resources while investing and growing a mental health system of care to serve Oregonians now and in the future. Using the current OSH site provides an optimal opportunity to include historic buildings and structures in the design of the new facility and an optimal opportunity to include an above-ground memorial for cremains and a museum for the history of the West Coast's oldest continually operating psychiatric hospital.

### ***Status***

To date, the hospital replacement team has enlisted expertise from renowned architectural, construction and engineering firms, including numerous subcontractors, who are working together to find ways to keep the project on time, address budget issues and deliver the best mental health facility for Oregonians. During 2007 project team members and their consultants began working in earnest with OSH administrators, staff, patients, health care providers, a 40-member stakeholders group (representing current and former OSH patients, mental health advocates, city government, county government, state policymakers, legal representatives, union members, neighborhood associations, other state agencies, the Governor's Office, and DHS and OSH leadership), and numerous other interested parties to guide the development of the new facility. The team worked diligently to analyze the site's existing buildings, topography, environmental qualities, archaeological importance, and parking and traffic conditions.

The building of replacement hospital facilities in Salem and Junction City, repurposing of facilities on the present OSH campus, and planning for the transition to the new facilities is in process and on-target to be completed at the end of 2013.

### ***Centralized treatment model***

DHS/OHA has adopted a centralized services model with "neighborhood" and "downtown" treatment concepts, within a secure perimeter, for the new facility. This model supports providing comprehensive and consistent therapeutic

opportunities to all patients. In keeping with the Recovery Model for mental health, the design for the new facility and its campus was driven by programming needs to ensure a patient-first, patient-driven and patient-focused mental health system. With this model, patients live on a unit but receive their treatment and meals and attend activities or classes elsewhere in the facility, away from the unit.

The new design requires patients to participate in their treatment and function during the day in a manner similar to that of daily life outside the hospital. The “downtown” includes large and small group activity rooms, a gymnasium, fitness center, library with required legal materials, nutrition center, classrooms, music and art therapy rooms.

Because patients do not have access to bedrooms, TV rooms and other non-treatment rooms and activities during treatment hours, patients are motivated to engage in treatment. The idea is to provide a place adjacent to the residential areas where a larger number of patients can go each day to participate in treatment programs. The new facilities will be designed with smaller areas for treatment so clinicians will have a manageable number of patients at any one time. The new hospital design also includes better security, more secure open space, one- and two-patient rooms, more quiet space, more light in patient rooms, and modern heating and air conditioning.

### ***Behavioral Health Integration Project***

In addition to the facilities replacement needs, the current OSH has antiquated technology for collecting information, referred to as the Oregon Patient/Resident Care System (OP/RCS), as well as a reliance on paper charts that no longer meet the business needs of the hospital. Dependence on these obsolete systems presents considerable risks in relation to licensing and patient care. The Joint Commission (TJC) has cited the information system as a major deficit jeopardizing future accreditations, which are a severe financial risk to DHS/OHA and a health risk to the State’s mental health service recipients. The U.S. Department of Justice (USDOJ) Civil Rights Division submitted a report in January 2008 for an investigation conducted in 2006 under the Civil Rights of Institutionalized Persons Act (CRIPA). This report stated that OSH’s ability to address patient safety is hampered by inadequate incident management and quality assurance systems. In order to support integrated treatment for clients, there is a need for a data system that can share client information throughout the system of care.

The Behavioral Health Integration Project (BHIP) is a subset of the overall OSH Replacement Project with a business goal of improving the ability to document services provided to individuals in the Oregon State Hospital, increase time spent by hospital personnel in treatment activities, and improve the ability of the state to report accurate and timely information to a variety of funding sources. BHIP has identified a vendor for a commercial-off-the-shelf (COTS) product and is currently working to implement the new system, ensuring that it meets the needs of the Oregon State Hospital System and the individuals served.

## ***Challenges***

There are a number of cost drivers that may affect the financial bottom line of this project. Examples of these are found in the USDOJ report in January 2008, which identified the need for improvements in the facilities, treatment plan and record keeping. As reported previously to the Joint Ways and Means Committee, an important aspect of the new hospital facilities is the additional 200,000 square feet of treatment spaces on the Salem campus and 100,000 square feet at the Junction City campus that will be needed to provide the minimum of 20 hours per week of patient treatment activities, as well as accommodate the additional staffing needs. The minimum standard of 20 hours of active patient treatment has become the accepted measure for modern psychiatric facilities, and is set forth in the hospital's Continuous Improvement Plan. This will be a critical part of the improved care for patients and will create a climate of recovery and provide patients the needed skills to make successful transitions back to their own communities. Various experts agreed that the only way to ensure the number of treatment hours expected in industry standards was by using a centralized treatment model.

In addition to the increased space, the project has further requirements such as: Center to State Street connector road, historic district requirements, significant site improvements, and energy costs. The Junction City site must meet the requirement of ORS 279C.527 to 279C.528 for the solar energy bill, which adds costs not included in the original budget approved by the Legislature.

A final cost driver comes as a direction from the Legislature to absorb the cost of furniture, fixtures and equipment (FF&E) into the budget. The rough estimate in 2007 for FF&E was \$10.5 million – \$7.5 for Salem and \$3 million for Junction City.

The USDOJ report also identified the need for adequate tracking of patient treatment plans, medication management and connection of various data collection methods throughout the hospital. The project includes the design of a new OSH computer system, which will address data management, risk management, training, quality management, and maintenance and support issues, as well as treatment plans and medication management.

In addition to challenges presented by these and other cost drivers, the success of the replacement treatment facilities is dependent on significant investments in the entire mental health service continuum. These investments must continue to build the community system that prevents individuals from needing hospital-level services. It also must build capacity to help patients transition successfully back to the community. To support the functions of the state hospitals, Oregon has developed more than 1,698 extended care placements provided by counties and a variety of non-profit and for-profit providers.

### ***Funding***

The 2007 Legislature passed SB 5504 and HB 5006, which provided the budgetary authority of \$458.1 million for DHS to proceed with construction of two facilities in Salem and Junction City to replace the existing OSH.

Construction of the two new facilities will continue to be financed with certificates of participation (COP) requiring accurate and specific recording and accountability for expenditures of COP proceeds. COPs are a principal means of financing government projects and are used for many state facilities that are expected to have 40 to 60 years of useful service.

The Project has been working diligently to mitigate the various programming and site impacts listed above. From the first evaluation it was clear that these additional needs had the potential to add over \$150 million in additional project costs to Salem alone. Through aggressive management of all areas from design to individual sub-contractor selection we have been able to reduce this to a request for an increase of \$66 million in COP sales for the project as a whole.

Actual operating costs will depend on many factors including legislative decisions about staffing, salaries, wages and community supports that relieve pressure on the facilities. Additional pressures on operating costs could come in the form of rising

fuel and utility costs and a possible increase in the number of forensic commitments.

## ***Opportunities***

### ***Junction City***

Both DOC and DHS/OHA are on time and proceeding with the legislatively approved projects related to the Junction City site, where corrections facilities and the psychiatric hospital will be co-located. One of the directions DOC and DHS/OHA received from the Legislature was to maximize the benefits of a collaborative partnership in developing this site. By building the OSH 360-bed project and the DOC minimum and medium security facilities on the same site, there are potential efficiencies and savings associated with the infrastructure. There also is the ability for DOC to provide laundry services for both their facilities and OSH. In addition, it is possible for both facilities to share one warehouse rather than building redundant facilities. DOC and DHS/OHA estimate the joint savings of a single site development at approximately \$20-\$25 million.

### ***Reusable materials***

In recent months OSH staff have found many reusable materials from previous construction and maintenance projects that are being transferred to the general contractor for use on the replacement project. This has resulted in a cost reduction for the project of more than \$100,000. Examples of such items include fencing materials, electrical wire, drainpipe and electric gates.

### ***BHIP***

BHIP is approved as part of the COP funding at \$27.9 million. However, the project is looking for ways to implement BHIP for \$25.9 million at the direction of the Legislature. Unless needed by BHIP, the \$2 million savings will be used to help address the budget challenges facing the construction budget.

### ***Value engineering study***

A draft value engineering study was conducted in August 2008 for Salem and July 2010 for Junction City in which the project team, with assistance from the consultants, analyzed all aspects of the design of the facilities to ensure that no critical features were missed and to identify opportunities to reduce construction costs and improve operational efficiencies. Opportunities identified from the Salem value engineering have been incorporated where feasible. The results of the

Junction City value engineering study are being analyzed, and opportunities for reductions and improvements will be incorporated into the project.

### *Summary*

Replacing the Oregon State Hospital is critical to growing a mental health system of care, which has been a priority of the Governor since taking office eight years ago. By integrating the new facility in Salem with most of the historic buildings within the district, using many of the new buildings for the new hospital, and restoring and putting the Kirkbride U into full use again, DHS/OHA creates a project that will meet its state mandate to build a hospital on the existing OSH Salem site while creating a project that protects the historic significance of the site. The agency will also continue to develop the Junction City campus as mandated, working with DOC to maximize all co-location efficiencies. At the same time, information technology is critical to the operation of a modern, accredited and certified state hospital. The Behavioral Health Integration Project will further ensure patient safety and quality of care by bringing a modern information system to both the hospital and, in the future, to the community mental health and addictions system.

## *Program Administration and Support*

---

AMH, in collaboration with external partners and stakeholders, creates the vision for mental health and substance abuse and problem gambling prevention and treatment systems of care, and sets policy to bring the vision into practice. The OHA Assistant Director for AMH supervises the state hospitals and works with the leadership of the state hospitals to integrate their services into the statewide system of care for people with mental illness.

AMH Program Administration and Support (PAS) is responsible for:

- Developing state plans for substance abuse prevention and treatment services and mental health services;
- Implementing state addictions, gambling and mental health programs and laws;
- Directing services for persons with substance use disorders and with problem and pathological gambling;
- Directing services for persons with mental health disorders;
- Directing services for persons with co-occurring mental health and substance use disorders; and
- Maintaining custody of persons committed by courts to the state for care and treatment of mental illness.

PAS staff share responsibility with the counties for developing and managing community programs as part of the overall state mental health and addictions system. If a county is unable to operate a program area, AMH is responsible for contracting for services directly with providers. PAS is responsible for protecting the safety of clients and ensuring quality of care.

PAS ensures the efficient and effective functioning of the program office and the necessary supports to the program and policy staff. AMH central administration staff work closely with the department budget staff and contract administration staff to ensure sound financial management of the addictions and mental health services community and state hospital program budgets, and the appropriate

implementation of community treatment programs through contractual relationships.

PAS is composed of four sections – Alcohol and Drug Prevention, Alcohol and Drug Treatment, Problem Gambling Prevention and Treatment, and Community Mental Health. These sections set policy for the alcohol and drug abuse prevention and treatment system, the mental health treatment system, and the problem gambling prevention and treatment system.

This is accomplished through:

- Program development;
- Administrative rules development;
- Planning and policy development;
- Coordinating policy and contracts for all Medicaid-covered services including the Oregon Health Plan for mental health and addictions services;
- Strengthening coordination between the state hospitals and the community mental health programs to ensure appropriate admission to and timely discharge from the hospitals;
- Conducting site reviews;
- Conducting licensing and certification inspections;
- Providing training and technical assistance;
- Providing administrative oversight;
- Overseeing quality improvement;
- Developing program management data;
- Conducting research on effective programs and measuring outcomes;
- Providing technical assistance to community programs;
- Implementing evidence-based practices as required by ORS 182.525;
- Managing development of alcohol and drug free community housing for individuals with addiction disorders and those with mental illness; and
- Collaborating with state and local partners to reduce and end homelessness.

## ***Alcohol and Drug Prevention***

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based and statewide alcohol and drug prevention programs. These programs work closely with local partners including the state and local Commissions on Children and Families, and the tribes.

## ***Alcohol and Drug Treatment***

This section of PAS is responsible for policy direction, program development, technical assistance and oversight of the community-based alcohol and drug treatment system providing services in all Oregon counties and to the tribes.

## ***Problem Gambling Prevention and Treatment***

This unit within the Alcohol and Drug Treatment section is responsible for setting policy and developing programs that prevent problem gambling in Oregon and overseeing the service delivery system for the treatment of problem gambling.

## ***Community Mental Health***

This section of PAS provides oversight, policy direction, program development and technical assistance to the community mental health system for both adults and children. Specific units within this section include:

- The Extended Care Unit ensures linkages between the state hospitals and communities.
- The Community and Housing Supports Unit is responsible for the development of new community-based resources to treat adults who are ready to be discharged into the community.
- The Children's Treatment System provides oversight, development, training and technical assistance to the community-based system to maximize the effective treatment of children in their home communities.

- The Mental Health and Substance Abuse Medicaid Policy staff members ensure appropriate policy considerations in rate setting for managed care, contract for managed mental health services, and monitor federal Medicaid and Medicare policy affecting services to people with mental health and substance abuse problems.

## ***Transformation Initiative***

AMH has integrated the tools, skills learned and resources available as a result of the Transformation Initiative to manage nine active transformation initiatives and one cross-divisional initiative. These tools are also used to manage 12 key strategic initiatives that will drive system improvement and are in response to legislative direction. The implementation of the Lean Daily Management System throughout the office has empowered staff to resolve process problems, streamline and improve the quality of work. Staff are building new skills and finding more efficient and effective ways to do critical work in times of scarce resources that require holding positions vacant and reprioritizing and shifting critical work functions to remaining staff.

## ***Transformation Initiatives***

### ***01 – Transitioning People***

Staff members in the AMH central office and at OSH worked with key community stakeholders to develop and implement improved methods for timely transition of people from the state hospital into community-based treatment. The goal is to provide access to the right type of services in the most appropriate environment, for the right amount of time. The work has resulted in the use of standardized tools for decision making, agreed-upon criteria for when an individual is ready for discharge from the state hospital, and full implementation of a Co-Management Plan that holds counties accountable for timely discharge of their members from the hospital. The initiative has resulted in more timely communication regarding available community resources. The work started in late 2009 and continued through out the winter and spring of 2010 with full implementation by July 2010.

### ***03 – OSH Process Improvement***

OSH is using rapid process improvement events and Lean principles to improve existing processes and streamline process as part of the planning to move into the new facility. The work has resulted in dramatic improvements in the process for

hiring RNs, physician billing for Medicare covered services, the documentation of group treatment in the treatment malls, and most recently the hiring of direct care Certified Nursing Assistants.

The RN Hiring and the Certified Nursing Assistant Hiring rapid process improvement events focused on reducing the overall RN and CNA vacancy rates by improving the hiring processes. Since the RN Hiring event in 2008, OSH has maintained a 0 percent vacancy rate for RNs. The CNA Hiring rapid process improvement event was launched in May 2010 with the goal of eliminating 85 CNA vacancies by December 2010. The streamlined hiring process has already resulted in 59 hires by the end of July 2010. The date by which the goal will be achieved has been revised to September 2010.

The Group Documentation rapid process improvement event focused on developing and implementing a standard process to record clinical progress for patients participating in treatment mall groups. This event merged over 22 documentation processes into one streamlined process and format that is now used across clinical disciplines.

The MD Billing rapid process improvement event focused on increasing revenue by streamlining the MD billing process for Medicare covered services at the Oregon State Hospital. This team worked with the medical doctors who document billable Medicare services and the billing office staff who process the Medicare claims.

#### ***04 – OSH Quality Improvements***

The purpose of this initiative is to improve the quality of services delivered at OSH. The major work thus far has been to streamline and improve the timeliness of obtaining dietary consultations for patients. This is important given the prevalence of obesity and metabolic syndrome problems among the patients made worse by poor diets.

Oregon State Hospital dietary staff members have maintained the gains they made with their Dietary Consultation process improvement efforts in 2008; dietitians are completing twice as many consultations every month and people receive their dietary consultations 85 percent more quickly than before the process improvement efforts.

### ***08 – AMH Central Office Process Improvements***

This initiative provides the structure for rapid process improvements to streamline administrative work, reduce errors and time needed. This initiative resulted in major reductions in paper files with the move to a fully electronic filing system for all office correspondence. This will be the home for other cross unit improvements that are recognized during team daily huddles.

### ***09 – Lean Daily Management System Roll Out***

AMH joined the other Divisions in both the Oregon Health Authority and Department of Human Services in adopting a Lean Daily Management System (LDMS). All components of the office have implemented huddles, visual display boards, continuous improvement sheets, skill assessment and the development of unit “business goals” with the assistance of trained Lean Practitioners. This model allows more staff to be trained and take leadership roles in Transformation activities. The next phase will be to complete the training for managers to lead in a new environment with empowered staff and to develop 20 Keys for the units. This will be supported by training and coaching from highly trained staff. This work will be more critical as we look forward to additional years of scarce resources and increased demands for services.

### ***010 – Vacancy Exceptions***

As a result of this initiative, a new administrative rule governing the occupancy payments for residential treatment has been adopted and is being implemented with new policies and procedures which will minimize the payment for vacant beds in community-based residential treatment programs and maximize the use of these valuable resources.

### ***011 – NIATx Expansion***

This initiative will build on a pilot program that successfully improved the quality of services, the efficient use of capacity and improved access to and retention in treatment for people with addiction disorders. The Network for the Improvement of Addiction Treatment (NIATx) is a nationally known effective model for improving services and assisting states and programs in improving the tracking and communication of improvements.

### ***012 – Adult Mental Health Initiative***

This initiative will promote the more effective utilization of current capacity in facility-based treatment settings, increase care coordination and increase

accountability at the local and state level. This initiative is scheduled to be implemented September 2010 and will result in more people living in more independent housing with the supports needed for success and in the optimal use of the expensive facility-based treatment. It supports achieving the goal of treating the right people, at the right intensity, for the right amount of time with the end goal of maximum independence and a key to their own door. This initiative has taken in the supportive housing initiative as that will be the key strategy to successful management of intensive services for people with major mental illness.

#### ***014 – OSH Diversion - Newpath***

This initiative is being done between AMH, the Oregon State Hospital Replacement Project (OSHRP), OSH and Seniors and People with Disabilities (SPD). The purpose is to develop a new model of serving people in the community who are not best served in the Oregon State Hospital. These are patients who have either maximally benefited from active psychiatric treatment at the hospital or who are admitted to the hospital because the existing community treatment programs are unable to manage aggressive and/or sexual acting-out behaviors. A new model of service delivery should be developed and ready to be tested late in the 2009-11 biennium.

#### ***Cross-Organization Initiative – Children’s Wraparound***

This initiative is the first phase of implementing the requirements of HB 2144 passed by the 2009 Legislature which established the Children’s Wraparound Initiative in state law. It is collaboration between AMH, Division of Medical Assistance Programs and Children Adults and Family, child welfare. The purpose is to increase system efficiency and outcomes for children and their families. This is being accomplished through a child and family team-driven planning process based on the national evidence-based practice known as Wraparound, care coordination across local child serving agencies, and flexible community services and supports. This effort begins with children in the custody of DHS for more than one year and who have had at least four placements or who have come into custody and immediately need specialized behavioral health services and supports. The three first areas of the state started July 2010 and will serve 385 children on a daily basis in eight counties by July 1, 2011.

#### ***Strategic Planning 2009-2011 Initiatives***

AMH used the skills and tools of transformation to assure the successful conclusion or progress of twelve key system change initiatives. The

implementation of the Alcohol and Drug Policy Commission resulted in the hiring of the executive director and turning over the ongoing work of the Commission. The work needed for the successful July 1, 2010, implementation of the Impaired Health Professionals program as required by HB 2345-B was completed on time. The program established contracts for independent monitoring of the substance use disorder and mental health treatment of impaired health professionals who are either self referred or diverted by their licensing boards in lieu of disciplinary action. This work was done in complete collaboration with the health licensing boards to allow the successful transition of participants in the board programs to the new independent program on July 1, 2010.

The adoption of the Integrated Services and Supports Rule in March, 2010 ended a two-year stakeholder-driven process to create a single set of administrative rules across all addiction and mental health program areas that were coordinated with the Medicaid payment requirements and allowed the abolishment of 10 conflicting rules.

***The remaining initiatives include:***

***1915(i) Medicaid Home and Community Based State Plan Amendment***

This initiative will create a new approach to community-based treatment for people with serious mental illness, a history of hospitalization and a need for daily service contact through the submission of a Medicaid State Plan Amendment to the federal Centers for Medicare and Medicaid Services. When approved, the amendment will make an expanded array of services available in community-based settings to better meet the needs of consumers and to simplify the billing and documentation requirements for providers. The amendment will be submitted in July 2010. The results of this initiative will support Oregon's efforts to serve people in the most independent setting and will support the work of the initiative to redesign the adult mental health system.

***Blue Mountain Recovery Center: The Future***

This initiative created a collaborative process with local and regional stakeholders to consider alternative use of the facility and program and to determine the use that would best meet the needs of the state, patients, staff and local community and region. It will result in a plan for the future of the hospital. The initial plan should be drafted not later than September 2010. The final phase of the work will be to engage state and legislative leadership in adopting a plan for the future of BMRC.

### ***Integrated Services & Management Demonstration***

AMH worked with legislative leadership in the 2009 Session to recommend a system change effort focused on integrating the management and service model including health, mental health and addiction services. The Legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in improved access, improved quality, improved outcomes and the containment of costs.

### ***Peer Delivered Services***

Peer delivered services are a key component of a successful service delivery system and an important addition to the health care workforce. AMH is working with service population stakeholder groups to develop strategies to increase the use and availability of peer delivered services. This work is in the initial stages and is building on existing peer delivered services in the state and is looking at a variety of funding strategies and options.

### ***Strategic Prevention Framework***

Oregon was awarded a federal State Prevention Framework Grant on July 1, 2009, for five years. This work will engage 10 counties, communities and tribes. The result will be a common framework for assessing state and local needs and priorities, making data-driven decisions about the right evidence-based prevention programs delivered to the right audiences and mobilizing communities and tribes to implement these programs to improve the outcomes in their communities. During the implementation of the grant the state's understanding about the most effective prevention strategies will be improved. This allows a focused approach to preventing and reducing the disabling effects of substance use and abuse.

### ***MH Adults Residential Utilization Analysis***

This initiative implemented an independent, comprehensive review of adult mental health residential services to understand the current use of the services and the readiness of people to transition to a more independent level of care. As a result of the analysis, AMH will have an improved understanding of rate of admission to and discharge from programs, movement between the levels of care, length of stay and will be able to do financial modeling. The results of this study will inform future planning and decision making relative to the most effective and efficient use of the most intensive community-based treatments.

### ***Wellness***

This initiative builds on the integration efforts between physical and behavioral health. The work is being carried out by a broad group of stakeholders and is driven by consumers of mental health and addiction services. The work is critical to improve the health disparities among people who are served in the publicly funded behavioral health system. This work will improve access to appropriate care, improve the quality of care that people receive and will contribute to the health and well being of the public clients.

### ***Young Adults in Transition***

Youth who are between the ages of 14 and 25 are not well served by the current delivery system. They are frequently thrust into a poorly prepared adult system on their 18<sup>th</sup> birthday. This does not provide appropriate care or good outcomes for these youth. This initiative is looking at structural, administrative, financial and clinical barriers to developmentally appropriate services that are effective in supporting youth in gaining the skills to manage their illness, complete education, gain employment, and form healthy, appropriate social relationships. This work is necessary and is ongoing.

### ***The Criminal Justice Door to the Mental Health System***

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to aid and assist in their defense at trial or who have been found Guilty Except for Insanity. These two entry points do not necessarily result in the most appropriate treatment or location for the individual entering the system through these court processes. The work under this initiative will engage all parties, including consumers, the court system, community mental health programs and law enforcement, to explore alternative processes that may result in more effective and appropriate placement and services for people with mental illness who come in contact with the criminal justice system as a result of their mental illness.