Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

Diane Linn, Chair
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-3308 FAX (503) 988-3093
Email: mult.chair@co.multnomah.or.us

Maria Rojo de Steffey, Commission Dist. 1
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5220 FAX (503) 988-5440
Email: district1@co.multnomah.or.us

Serena Cruz Walsh, Commission Dist. 2
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5219 FAX (503) 988-5440
Email: serena@co.multnomah.or.us

Lisa Naito, Commission Dist. 3
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5217 FAX (503) 988-5262
Email: district3@co.multnomah.or.us

Lonnie Roberts, Commission Dist. 4
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5213 FAX (503) 988-5262
Email: lonnie.j.roberts@co.multnomah.or.us

On-line Streaming Media, View Board Meetings
www.co.multnomah.or.us/cc/live_broadcast.shtml

On-line Agendas & Agenda Packet Material
www.co.multnomah.or.us/cc/agenda.shtml

Americans with Disabilities Act Notice: If you need this agenda in an alternate format, or wish to participate in a Board Meeting, please call the Board Clerk (503) 988-3277, or the City/County Information Center TDD number (503) 823-6868, for information on available services and accessibility.

REVISED

APRIL 18 & 20, 2006 BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

Pg 2	9:30 a.m. Tuesday Mental Health Risk Analysis Briefing
Pg 2	9:50 a.m. Tuesday Mental Health and Addictions Services Safety Net Briefing
Pg 2	10:00 a.m. Tuesday Mental Health and Addiction Services Biennial Implementation Plan
Pg 3	9:30 a.m. Thursday Opportunity for Public Comment on Non-Agenda Matters
Pg 4	9:50 a.m. Thursday Resolution Endorsing the Central Eastside Stakeholders Committee Recommendation
Pg 4	10:30 a.m. Thursday Public Hearing to Consider and Possibly Act Upon a Measure 37 Claim Filed by Albert and Deane Dilnik

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30
Friday, 11:00 PM, Channel 30
Saturday, 10:00 AM, Channel 30
Sunday, 11:00 AM, Channel 30

Produced through MetroEast Community Media
(503) 667-8848, ext. 332 for further info
or: http://www.mctv.org

Tuesday, April 18, 2006 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

B-1 Mental Health Risk Analysis Briefing. Presented by Dave Boyer, Wendy Lear, Mindy Harris, Rex Surface and Iris Bell. 20 MINUTES REQUESTED.

B-2 Mental Health and Addictions Services Safety Net Briefing. Presented by Rex Surface, Sandy Haffey and David Hidalgo. 10 MINUTES REQUESTED.

B-3 Fiscal Year 2007-2009 Mental Health and Addiction Services Division Biennial Implementation Plan. Presented by Nancy Winters, Ray Hudson, Sandy Haffey and Godwin Nwerem. 10 MINUTES REQUESTED.

Tuesday, April 18, 2006 - 10:10 AM
(OR IMMEDIATELY FOLLOWING BOARD BRIEFINGS)
Multnomah Building, First Floor Commissioners Conference Room 112
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners will meet in Executive Session Pursuant to ORS 192.660(2)(h). Only Representatives of the News Media and Designated Staff are allowed to attend. News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Session. No Final Decision will be made in the Session. Presented by Agnes Sowle. 15-30 MINUTES REQUESTED.

Thursday, April 20, 2006 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
DEPARTMENT OF COMMUNITY SERVICES

C-1 Amendment 1 to Expenditure Agreement 4600003756 with the State of Oregon Department of Transportation Regarding the Corbett Hill Road Viaduct Replacement Project

C-2 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to HMH PROPERTIES LLC [Tax Account Number R232067]

C-3 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to HMH PROPERTIES LLC [Tax Account Number R232069]

C-4 RESOLUTION Authorizing Execution of a Contract between Multnomah County, Seller, and CARL & STEPHANIE E. SMITH, Purchasers, for Tax-Foreclosed Property Sold at Public Sale and Deed to Purchasers at Contract Completion

REGULAR AGENDA - 9:30 AM
PUBLIC COMMENT - 9:30 AM

Opportunity for Public Comment on non-agenda matters. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

DISTRICT ATTORNEY'S OFFICE - 9:30 AM

R-1 PROCLAMATION Proclaiming the Week of April 23, through April 29, 2006 as NATIONAL CRIME VICTIMS' RIGHTS WEEK in Multnomah County, Oregon

DEPARTMENT OF COUNTY MANAGEMENT - 9:35 AM

R-2 RESOLUTION Certifying an Estimate of Expenditures for Fiscal Year 2006-2007 for Assessment and Taxation in Accordance with ORS 294.175

NON-DEPARTMENTAL - 9:40 AM

R-3 PROCLAMATION Proclaiming April 23rd through April 29, 2006 as Multnomah County Volunteer Week and April 25th as a Special Day of Recognition for Multnomah County Volunteers

R-4 PROCLAMATION Proclaiming the Accomplishments of the Multnomah Education Service District's 2006 Academic All-Stars

R-5 RESOLUTION Endorsing the Central Eastside Stakeholders Committee Recommendation and Requesting that the Portland Development Commission Concentrate Urban Renewal Funding on Projects that Provide Economic Development, Job Growth, Job Retention, and Special Needs Housing

R-6 Report on Outcomes, Court Appearance Notification System. Presented by Matt Nice and Judy Shiprack. 30 MINUTES REQUESTED.

HOSPITAL FACILITIES AUTHORITY - 10:20 AM

(Recess as the Multnomah County Board of Commissioners and convene as the Hospital Facilities Authority of Multnomah County, Oregon)

R-7 RESOLUTION Adopting Amended Rules and Bylaws of The Hospital Facilities Authority of Multnomah County

(Adjourn as the Hospital Facilities Authority of Multnomah County, Oregon and reconvene as Multnomah County Board of Commissioners)

DEPARTMENT OF COMMUNITY SERVICES - 10:25 AM

R-8 First Reading and Possible Adoption of an ORDINANCE Amending County Land Use Code, Plans and Maps to Adopt Portland's Recent Land Use Code, Plan and Map Revisions Related to the Adoption and Implementation of the Regulatory Improvement Package 1 and Living Smart Code Amendments in Compliance with Metro's Functional Plan and Declaring an Emergency

R-9 PUBLIC HEARING to Consider and Possibly Act Upon a Measure 37 Claim Filed by Albert and Deane Dilnik Seeking a Waiver of Land Use Rules that Allow them to Transfer to a Third Party the Right to Construct Homes on Three Existing Lots that they Own. Presented by Adam Barber and Sandra Duffy. 30 MINUTES REQUESTED.

DEPARTMENT OF COMMUNITY JUSTICE - 11:00 AM

R-10 Budget Modification DCJ-29 Appropriating $21,690 in State of Oregon Funds from Oregon Youth Authority to Provide Residential Sex Offender Treatment to a 17 Year Old Male Youth from Polk County **[Continued from April 13, 2006]**

R-11 Intergovernmental Expenditure Agreement 0506100 with the Oregon Youth Authority, Providing Residential Sex Offender Treatment to a 17 Year Old Male Youth from Polk County **[Continued from April 13, 2006]**

Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

Diane Linn, Chair
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-3308 FAX (503) 988-3093
Email: mult.chair@co.multnomah.or.us

Maria Rojo de Steffey, Commission Dist. 1
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5220 FAX (503) 988-5440
Email: district1@co.multnomah.or.us

Serena Cruz Walsh, Commission Dist. 2
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5219 FAX (503) 988-5440
Email: serena@co.multnomah.or.us

Lisa Naito, Commission Dist. 3
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5217 FAX (503) 988-5262
Email: district3@co.multnomah.or.us

Lonnie Roberts, Commission Dist. 4
501 SE Hawthorne Boulevard, Suite 600
Portland, Or 97214
Phone: (503) 988-5213 FAX (503) 988-5262
Email: lonnie.j.roberts@co.multnomah.or.us

On-line Streaming Media, View Board Meetings
www.co.multnomah.or.us/cc/live_broadcast.shtml

On-line Agendas & Agenda Packet Material
www.co.multnomah.or.us/cc/agenda.shtml

Americans with Disabilities Act Notice: If you need this agenda in an alternate format, or wish to participate in a Board Meeting, please call the Board Clerk (503) 988-3277, or the City/County Information Center TDD number (503) 823-6868, for information on available services and accessibility.

APRIL 18 & 20, 2006 BOARD MEETINGS
FASTLOOK AGENDA ITEMS OF INTEREST

Pg 2	9:30 a.m. Tuesday Mental Health Risk Analysis Briefing
Pg 2	9:50 a.m. Tuesday Mental Health and Addictions Services Safety Net Briefing
Pg 2	10:00 a.m. Tuesday Mental Health and Addiction Services Biennial Implementation Plan
Pg 3	9:30 a.m. Thursday Opportunity for Public Comment on Non-Agenda Matters
Pg 4	9:50 a.m. Thursday Resolution Endorsing the Central Eastside Stakeholders Committee Recommendation
Pg 4	10:30 a.m. Thursday Public Hearing to Consider and Possibly Act Upon a Measure 37 Claim Filed by Albert and Deane Dilnik

Thursday meetings of the Multnomah County Board of Commissioners are cable-cast live and taped and may be seen by Cable subscribers in Multnomah County at the following times:

Thursday, 9:30 AM, (LIVE) Channel 30
Friday, 11:00 PM, Channel 30
Saturday, 10:00 AM, Channel 30
Sunday, 11:00 AM, Channel 30

Produced through MetroEast Community Media
(503) 667-8848, ext. 332 for further info
or: http://www.mctv.org

Tuesday, April 18, 2006 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

B-1 Mental Health Risk Analysis Briefing. Presented by Dave Boyer, Wendy Lear, Mindy Harris, Rex Surface and Iris Bell. 20 MINUTES REQUESTED.

B-2 Mental Health and Addictions Services Safety Net Briefing. Presented by Rex Surface, Sandy Haffey and David Hidalgo. 10 MINUTES REQUESTED.

B-3 Fiscal Year 2007-2009 Mental Health and Addiction Services Division Biennial Implementation Plan. Presented by Nancy Winters, Ray Hudson, Sandy Haffey and Godwin Nwerem. 10 MINUTES REQUESTED.

Tuesday, April 18, 2006 - 10:10 AM
(OR IMMEDIATELY FOLLOWING BOARD BRIEFINGS)
Multnomah Building, First Floor Commissioners Conference Room 112
501 SE Hawthorne Boulevard, Portland

IF NEEDED EXECUTIVE SESSION

E-1 The Multnomah County Board of Commissioners will meet in Executive Session Pursuant to ORS 192.660(2)(h). Only Representatives of the News Media and Designated Staff are allowed to attend. News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Session. No Final Decision will be made in the Session. Presented by Agnes Sowle. 15-30 MINUTES REQUESTED.

Thursday, April 20, 2006 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
DEPARTMENT OF COMMUNITY SERVICES

C-1 Amendment 1 to Expenditure Agreement 4600003756 with the State of Oregon Department of Transportation Regarding the Corbett Hill Road Viaduct Replacement Project

C-2 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to HMH PROPERTIES LLC [Tax Account Number R232067]

C-3 RESOLUTION Authorizing the Private Sale of a Tax Foreclosed Property to HMH PROPERTIES LLC [Tax Account Number R232069]

C-4 RESOLUTION Authorizing Execution of a Contract between Multnomah County, Seller, and CARL & STEPHANIE E. SMITH, Purchasers, for Tax-Foreclosed Property Sold at Public Sale and Deed to Purchasers at Contract Completion

REGULAR AGENDA - 9:30 AM
PUBLIC COMMENT - 9:30 AM

Opportunity for Public Comment on non-agenda matters. Testimony is limited to three minutes per person. Fill out a speaker form available in the Boardroom and turn it into the Board Clerk.

DISTRICT ATTORNEY'S OFFICE - 9:30 AM

R-1 PROCLAMATION Proclaiming the Week of April 23, through April 29, 2006 as NATIONAL CRIME VICTIMS' RIGHTS WEEK in Multnomah County, Oregon

DEPARTMENT OF COUNTY MANAGEMENT - 9:35 AM

R-2 RESOLUTION Certifying an Estimate of Expenditures for Fiscal Year 2006-2007 for Assessment and Taxation in Accordance with ORS 294.175

NON-DEPARTMENTAL - 9:40 AM

R-3 PROCLAMATION Proclaiming April 23rd through April 29, 2006 as Multnomah County Volunteer Week and April 25th as a Special Day of Recognition for Multnomah County Volunteers

R-4 PROCLAMATION Proclaiming the Accomplishments of the Multnomah Education Service District's 2006 Academic All-Stars

R-5 RESOLUTION Endorsing the Central Eastside Stakeholders Committee Recommendation and Requesting that the Portland Development Commission Concentrate Urban Renewal Funding on Projects that Provide Economic Development, Job Growth, Job Retention, and Special Needs Housing

R-6 Report on Outcomes, Court Appearance Notification System. Presented by Matt Nice and Judy Shiprack. 30 MINUTES REQUESTED.

HOSPITAL FACILITIES AUTHORITY - 10:20 AM

(Recess as the Multnomah County Board of Commissioners and convene as the Hospital Facilities Authority of Multnomah County, Oregon)

R-7 RESOLUTION Adopting Amended Rules and Bylaws of The Hospital Facilities Authority of Multnomah County

(Adjourn as the Hospital Facilities Authority of Multnomah County, Oregon and reconvene as Multnomah County Board of Commissioners)

DEPARTMENT OF COMMUNITY SERVICES - 10:25 AM

R-8 First Reading and Possible Adoption of an ORDINANCE Amending County Land Use Code, Plans and Maps to Adopt Portland's Recent Land Use Code, Plan and Map Revisions Related to the Adoption and Implementation of the Regulatory Improvement Package 1 and Living Smart Code Amendments in Compliance with Metro's Functional Plan and Declaring an Emergency

R-9 PUBLIC HEARING to Consider and Possibly Act Upon a Measure 37 Claim Filed by Albert and Deane Dilnik Seeking a Waiver of Land Use Rules that Allow them to Transfer to a Third Party the Right to Construct Homes on Three Existing Lots that they Own. Presented by Adam Barber and Sandra Duffy. 30 MINUTES REQUESTED.

Commissioner Serena Cruz Walsh, District 2

MULTNOMAH COUNTY OREGON
501 SE Hawthorne, Suite 600
Portland, Oregon 97214
(503) 988-5219 phone
(503) 988-5440 fax
www.co.multnomah.or.us/cc/ds2/
Serena@co.multnomah.or.us

MEMORANDUM

TO: Chair Diane Linn
Commissioner Maria Rojo de Steffey
Commissioner Lisa Naito
Commissioner Lonnie Roberts
Clerk of the Board Deb Bogstad

FROM: Tara Bowen-Biggs
Staff to Commissioner Serena Cruz Walsh

DATE: April 13, 2006

RE: April 18, 2006 Board Briefings and Executive Session

Commissioner Cruz Walsh will not attend the April 18, 2006 Board Briefings and Executive Session. She will be out of town.

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

Board Clerk Use Only	
Meeting Date:	04/18/06
Agenda Item #:	B-1
Est. Start Time:	9:30 AM
Date Submitted:	03/24/06

BUDGET MODIFICATION: -

Agenda Title: **Briefing on Mental Health Risk Analysis**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Date Requested:	April 18, 2006	**Time Requested:**	20 minutes
Department:	**Department of County Management**	**Division:**	Directors Office
Contact(s):	Dave Boyer		
Phone:	503-988-3903 **Ext.** 83110	**I/O Address:**	503/5
Presenter(s):	Dave Boyer, Wendy Lear, Mindy Harris, Rex Surface and Iris Bell		

General Information

1. **What action are you requesting from the Board?**

   Present Mental Health Risk Analysis

2. **Please provide sufficient background information for the Board and the public to understand this issue.**

   At a Board briefing by County Human Services on November 8, 2005 the County CFO was asked to assess the risks associated with the financial changes and the risk and benefits of proposed business model changes in Mental Health, specifically the risk of Verity going to a fee-for-service payment model.

3. **Explain the fiscal impact (current year and ongoing).**

   A fee for service payment method is the most effective way to maximize the documentation of service delivery and it provides a financial incentive to provide billable treatment services. The downside is all of the financial risk resides with Verity's ability to design, implement and monitor a system within the resources available.

   Verity has contracted with outside consultants to revise the clinic system and create a financial plan.

That original plan was prepared in 2005 and has since been revised and updated. The plan for the adult system deviates in total cost by about $5.3 million. We were unable to obtain a comparison for the Children's plan, but an initial review had a variation of about $2 million between the first draft plan, prepared a year ago, and the proposed plan.

4. **Explain any legal and/or policy issues involved.**

   None

5. **Explain any citizen and/or other government participation that has or will take place.**

   None

Required Signatures

Department/ Agency Director: David G Boyer **Date:** 03/20/06

Budget Analyst: _____ **Date:** _____

Department HR: _____ **Date:** _____

Countywide HR: _____ **Date:** _____

Department of County Management
MULTNOMAH COUNTY OREGON

TO: Board of County Commissioners

FROM: Dave Boyer, Chief Financial Officer
Mindy Harris and Wendy Lear, Co-Chair's Mental Health Financial Review Team

DATE: April 7, 2006

SUBJECT: Mental Health Financial Risk Analysis

Mental Health Financial Risk Analysis

The Mental Health and Addiction Services Division (MHASD) in County Human Services is facing a number of financial uncertainties including a major downturn in Medicaid funding for Managed Mental Health care.

At a Board briefing by County Human Services on November 8, 2005 the County CFO was asked to assess the risks associated with the financial changes and the risk and benefits of proposed business model changes in Mental Health, specifically the risk of Verity going to a fee-for-service payment model. After multiple meetings with the Department of County Human Services, the County CFO chartered a cross-Department finance team on December 19, 2005 to assess the financial risks facing mental health. The review is now complete and the following is our report back to the Board of County Commissioners

Executive Summary of Financial Risk Issues

Area	Exceed Budget/ Worse Case
MHO Verity Adult Outpatient (Program Offers 25062 and 25106	$5.3 million
MHO Verity Children's Outpatient (Program Offers 25068, 25071 and 25077)	Uncertain
LMHA Emergency Holds (Program Offer 25075)	$500,000 to $1 million
LMHA Loss of ITAX support to Crisis System and Call Center (Program Offers 25056 and 25055)	$3.8 million

The financial review is organized by the three major lines of business for MHASD:

- The Mental Health Organization (MHO) insurance plan Verity
- The Local Mental Health Authority (LMHA) community safety net responsible for monitoring and enforcement
- Direct Service & Treatment where the County is a provider of mental healthcare.

MHO (VERITY)

Background

✓ Medicaid insurance coverage for Oregon Health plan enrolled members in Multnomah County (children and adults.)

✓ Verity is "at-risk" for providing all the care needed by the Oregon Health plan members assigned to them, regardless of changes in the funding.

✓ The Verity revenue dropped by approximately 12 percent effective January 1, 2006, with no corresponding reduction in the number, type or medical need of the enrollees.

The estimated Verity budget for FY07 is $34.9 million, down from $35.6 million estimated for FY06. The Verity business plan allocates the revenue into the service buckets below. The distribution amongst the services is essentially the same for FY06 and FY07. The distribution amongst the services is essentially the same for FY06 and FY07 with the exception of 'System of Care Services'. (This funding category sustained an increase of dedicated funds from the State that did not appear in the FY06 budget. These funds will not necessarily mitigate the 12 percent revenue losses addressed above.)

Verity MHO Contract FY06:	**$35.6 million**	
Verity MHO Contract FY07:	**$34.9 million**	
Service	Adults	Children
Inpatient	$3.6 million	$0.7 million
System of Care Services (i.e. respite, day treatment, residential)	$0.6 million	$9.0 million
Crisis Care	$0.0 million	$0.0 million
Outpatient	$11.8 million	$5.1 million
Administration and Provider Tax	$2.5 million	$1.6 million
Total Budget for FY07	**$18.5** million	**$16.4** million

Any increases in actual costs in one area, must result in equivalent reductions in other service or administrative areas to remain solvent. Increased demand for service or increased service costs will not result in more revenue.

Outpatient

New Business Model Proposal
Verity's current business model allocates Outpatient revenue to providers on a formula that does not fluctuate if more or less service is provided to clients. This has resulted in a decline in the amount of service reported and possibly in the amount of service delivered. Verity needs to change its business model so that all services provided are reported to stop this trend.

A fee for service payment method is the most effective way to maximize the documentation of service delivery and it provides a financial incentive to provide billable treatment services. The downside is all of the financial risk resides with Verity's ability to design, implement and monitor a system within the resources available.
Verity has contracted with outside consultants to revise the clinical system and create a financial plan. That original plan was prepared in 2005 and has since been revised and updated[Plan Comparison Attachment 1]. The plan for the adult system deviates in total cost by about $5.3 million. We were unable to obtain a comparison for the Children's plan, but an initial review had a variation of about $2 million between the first draft plan, prepared a year ago, and the proposed plan.

FIRST DRAFT PLAN	CHANGE	PROPOSED PLAN
Outpatient Total Cost: **$15.8 million**	**$5.3 million**	Outpatient Total Cost: **$10.5 million**
Adult Outpatient Plan Cost Comparison (Program Offers 25062 and 25106)		

What Changed Between the Two Plans?
The average number of hours clients will need at the different treatment levels is the biggest change between the two models. The second model proposed more modest levels of intervention for members with low LOCUS scores. Both assume the elimination of Daily Structure and Support services, but the latter does not plan on funding a similar level of peer treatment. Certain inpatient and residential services were inadvertently included in the first draft. These services were removed from outpatient calculations in the second model. The second model utilized a more accurate case mix projection that had the effect of moving a body of clients into lower cost service areas. The reimbursement rates used in the first model were 'placeholders' used to build the conceptual framework. The second model used a finalized fee scheduled that was lower than the original. Verity staff and the expert consultants used believe both plans are clinically sound and result in more clinically appropriate service than the current system. In order to manage the financial risk presented in the proposed plan, the following controls need to be put into place:

o Verity will need to monitor the average hours of services projected by the LOCUS instrument compared to the actual amount delivered by the provider agencies. Monitoring and tracking the actual vs. planned average service hours will be essential to validate the financial integrity of the model.

o Verity will need to manage the penetration rate (number of enrolled members receiving service.) This will call for an active partnership between Verity and the provider agencies to limit duration and frequency of service to 'low-need' clients. For the Adult system, every 1 percent increase in penetration rate or about 500 additional adult clients could cost another $1.6 million per

year in outpatient costs. The current model projects serving about 300 more adult clients per month than those currently in services, at approximately the same cost as is currently experienced. Verity's current penetration rate for all services was 8.2 percent, which compares well to the statewide penetration rate for all MHO's of 6.9 percent.

o Verity will need to manage the case mix and monitor providers to ensure they are not upcoding (diagnosing clients as higher need than they really are.) Verity has established "caps" in all of its provider contracts to limit the total amount each provider can be reimbursed. This will be an effective cost containment tool only if the estimated average hours needed by all clients in all levels of care are accurate and monitored consistently.

o Under the proposed plan, 6,332 clients will be served at a cost of $10.5 million. This translates into an average cost of $1,658 per client compared to the average cost of $1,515 for uninsured and emergency hold clients.

To administer a fee-for-service outpatient system Verity has contracted with Performance Health Administrators to provide Third Party Administrative (TPA) claims processing services at an estimated cost of $400,000 per year. This is a TPA used by several other MHO's in the State.

Inpatient

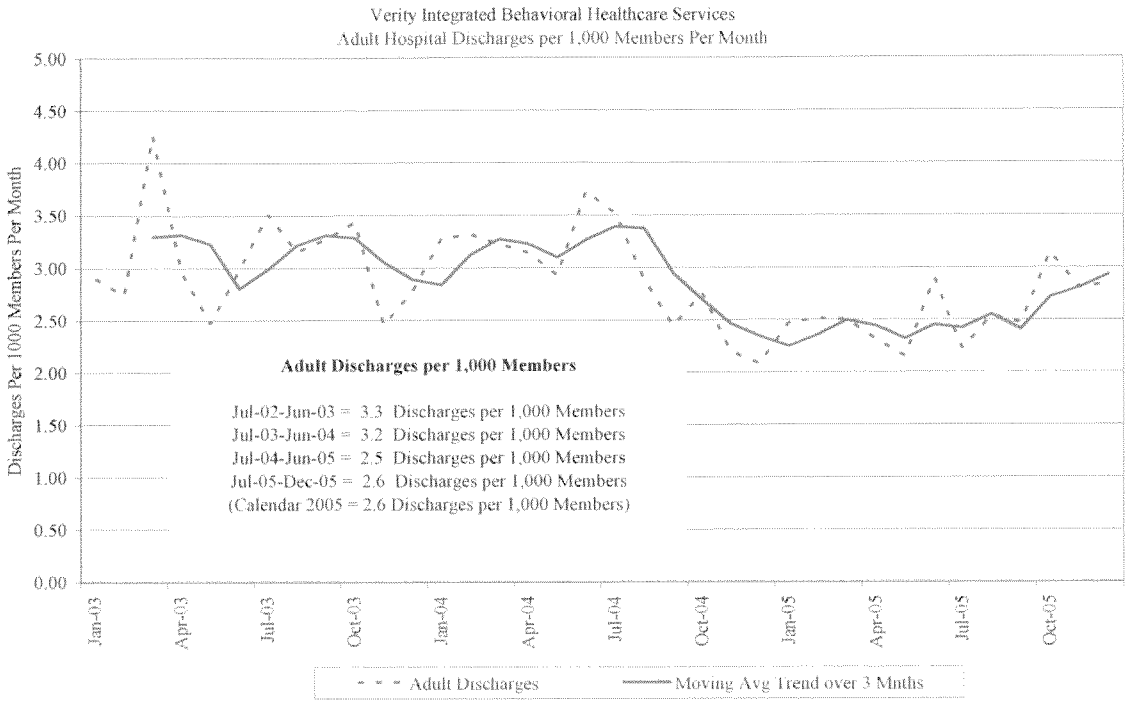
There is no plan to change the business model for Inpatient services. Hospitals are currently paid a daily rate of $700 per day, with Verity authorizing admission and length of stay on voluntary admissions (Emergency holds are addressed later in this document). Both local and regional hospital systems have taken the position that hospital rates should be increased to $750.00 - $800.00. Verity's weakened financial position suggests the opposite. Verity intends to offer a $650.00 per diem in this fiscal year. The current budget in FY06 set-aside for Inpatient treatment is $4.4 million for children and adults. Verity's total Inpatient costs were $4 million for FY 2005. In the first quarter of FY 2006, they have spent $999,619 on Inpatient services for children and adults.

All of the hospital contracts for Verity Inpatient and Emergency Holds are up for renewal. There is some effort by the hospitals to have the rates increased. Any rate increase or increase in the number of hospital days per month would exceed the Verity budget set-aside for hospital care.

The common wisdom is if the Outpatient system is not working Inpatient admissions and lengths of stay will increase. There are four high-level areas to monitor in the Inpatient area: total cost, admissions (generally, the discharges are counted, as they are more accurate), bed days, and average length of stay. While both Children and Adult hospitalizations should be monitored, by far adult inpatient is the biggest area of financial risk. Verity must monitor closely the trends in Inpatient services as it monitors its Outpatient redesign.

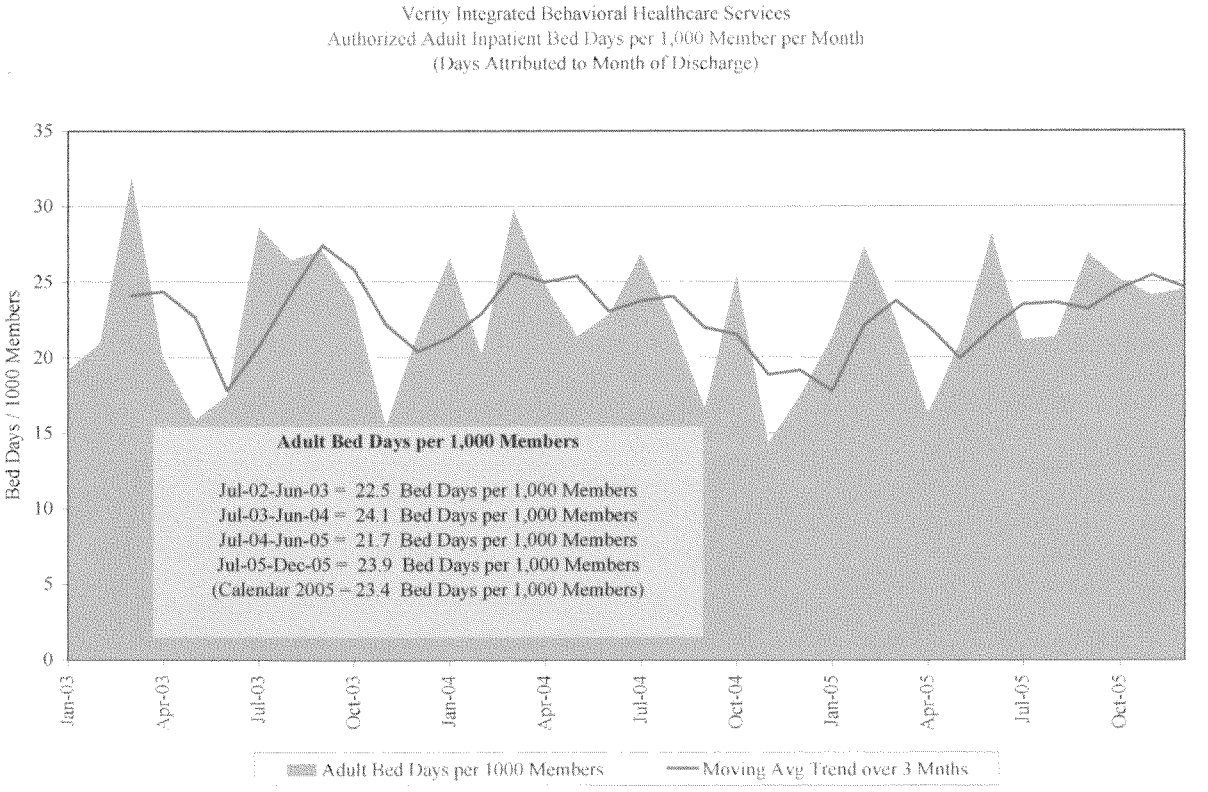
Hospital Admissions (Measured by Date of Discharge)

The adult hospital discharges per 1,000 members has been fluctuating around 2.5 to 2.6 discharges per 1,000 members. This is about 83 hospital discharges per month. The trend has been inching upward in 2005.



Adult Hospital Bed Days

The hospital bed days for adults has bumped around for the last five years. From a high in FY01 of 29.0 bed days per 1,000 members to a low in FY05 of 21.7. For calendar year 2005 it is 23.4, which is about 750 hospital bed days per month. This upward trend continues in the first six-months of FY06 and should be monitored.



Average Length of Stay

Finally, the average length of stay (LOS) is the average of admissions and total days, per 1,000 members. This measure has been nearly constant. The average LOS for the past 5 ½ years has been 8.1 days. The LOS for the first six-months of FY06 is 9.0 days. This is due to a slight up tic in the number of admissions in the last quarter and more bed days for the whole six-month period. This could be seasonal and smooth out in the last six months of the year.

Verity Inpatient Discharges / Days / Average Length of Stay

	Inpatient Discharges PTMPM			Inpatient Days PTMPM			Average Length of Stay		
Period	Adult	Child	All	Adult	Child	All	Adult	Child	All
Jul 00 to Jun 01 (Annual FY)	3.5	0.6	2.3	29.0	6.1	19.2	8.3	9.8	8.4
Jul 01 to Jun 02 (Annual FY)	3.6	0.5	2.3	28.0	4.6	18.1	7.7	9.0	7.8
Jul 02 to Jun 03 (Annual FY)	3.3	0.5	2.0	22.7	4.0	14.0	6.8	8.8	7.0
Jul 03 to Jun 04 (Annual FY)	3.2	0.4	1.6	24.1	3.4	12.5	7.6	7.9	7.6
Jul 04 to Jun 05 (Annual FY)	2.5	0.4	1.5	21.5	3.0	12.2	8.5	7.7	8.4
Jul 05 to Sep 05 (Quarter)	2.4	0.3	1.3	23.2	2.6	12.5	9.6	7.6	9.3
Oct 05 to Dec 05 (Quarter)	2.9	0.3	1.5	24.6	2.2	12.8	8.4	8.1	8.4

State Hospital

There is discussion about charging MHO's for their members in the State hospital who are awaiting discharge. This would be a new expense for Verity that would not come with any additional revenue to cover the cost. It would have to come out of the existing Inpatient bucket. The State has only just begun examining this issue and believes it would have little impact in this County.

Local Mental Health Authority (LMHA)

Crisis and Call Center Services

The Crisis and Call Center services provide a significant level of support and services to the Verity MHO. Many provider relation, service authorization, and member services occur through the Call Center. Roughly one quarter of the services provided by the urgent walk-in clinics, mobile outreach teams, and call center are for Verity members.

This support to the MHO is funded through a mix of County ITAX and State general fund, not MHO (Medicaid) resources.

Safety Net Crisis Services Proposed Budget for FY07: $6.3 million

Service	ITAX	State General Fund
Call Center	$1.1 million	$1.0 million
Urgent Care Walk-in Clinic and Mobile Outreach	$2.7 million	$1.5 million
Total Budget for FY07	**$3.8** million	**$2.5** million

The LMHA and Verity are critically dependent on the funding of these services. The MHO would face increased financial risk, because the $3.8 million in ITAX for Crisis Services would have to come out of its existing budget for services and administration. In addition, without the crisis system the County's Emergency Hold expenses would likely increase.

Emergency Holds and Involuntary Commitments

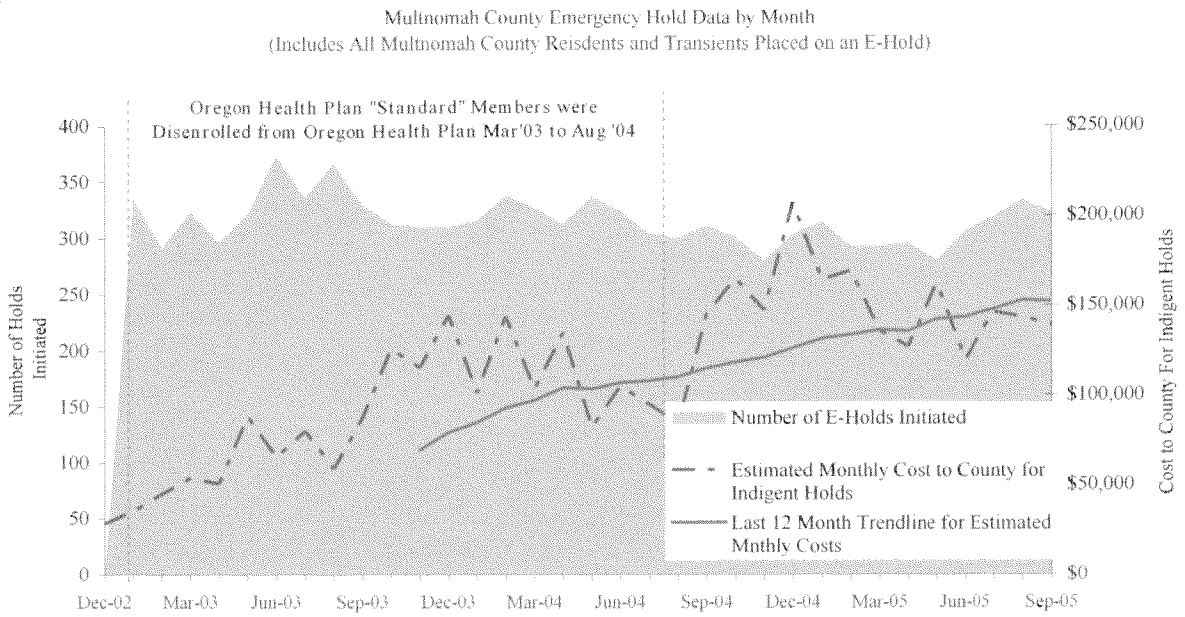
The other area of financial risk in the LMHA area is Emergency Holds and Involuntary Commitments (Program Offers 25075 and 25058). The County is responsible for paying the Emergency Hold hospital charges for indigent clients without Medicaid, Medicare or commercial insurance coverage. In the current year the County has $1.9 million budgeted in State General Fund for Emergency Holds. We are on a current trajectory to spend $1.7 million. For FY 2007, County Human Services has budgeted $1.3 million for Emergency Holds. Actual annual cost to the County for the last three years and estimate for FY 2006 is:

Fiscal Year	Amount Paid
FY 2002-2003	$408,988
FY 2003- 2004	$1,613,689
FY 2004-2005	$2,368,648
FY 2005-2006 (estimate)	$1,700,000

The actual amount paid and the estimated annual cost varies because of the timing and often extensive lag between when a hospitalization occurs and when the hospitals actually invoice the County for the hospital stay. The Division will employ several strategies to bridge the gap between the budgeted figure and claims experience.

- If the Division is successful in its intention to reduce hospital per diem reimbursement (see page 5, Inpatient), it will realize about $125,000 in savings.
- The Division has successfully reduced LOS for emergency holds from 4.5 days in FY03 to 3.7 days in FY05. If the year-to-date LOS in FY06 holds at the FY05 level, the Division could realize a savings larger than that necessary to close the $400,000 gap.

The estimated annual cost of $1.7 million and the data below is the estimated financial obligation based on the commitments by month. It provides a better understanding of the trends and patterns in Emergency Holds and Emergency hold costs.



The average number of emergency holds has remained constant over this three-year period at around 315 holds per month. The average length of the hold has also remained constant at 4.5 days. What has changed is the County's cost for the indigent care. The dis-enrollment of the Oregon Health Plan Standard members in March 2003 resulted in a nearly doubling of the indigent costs. Understandably, people who were previously enrolled in the Oregon Health Plan and had coverage (Verity) for their emergency holds, once dis-enrolled from the Oregon Health Plan were likely indigent.

What is not explained by the data is why when the standard members were re-enrolled in the Oregon Health Plan in August 2004, why didn't our indigent costs decline accordingly? Instead, the proportion of indigent care to the whole has increased three fold since 2002. Our average 12 month cost trend has gone from $50k per month to $150k per month.

Again, all the hospital contracts are up for renewal. Any increase in the daily rate paid for hospital care will aggravate the Emergency Hold cost projections. The projections above are based on the current rate of reimbursement to the hospitals.

The following table shows the estimated cost for the local Mental Health Authority and the number of clients served.

Cost of Local Mental Health Authority	$ 6,300,000
Uninsured receiving MH treatment (Program Offer 25063)	2,500
Uninsured receiving medication funding (Program Offer 25063)	1,000
Emergency holds (Program Offer 25075)	658

Total	4,158
Average cost per client	$ 1,515

In addition to having a lower cost per client, Mental Health Organization funds are leveraged to provide greater access to care for the uninsured, more services or better services. The following is how Oregon Health Plan funds are being leveraged:

- OHP provides 8% for local admin. This contributes about $3.1 million to system administration. The State mental health grant gives only 3% or $710,000 a year for local administration. MHASD's current administrative expenses (exclusive of Department contribution) make up 7.8% of the Division's global budget.
- Economies of Scale are achieved by having the same provider treat both sets of patients.
- The County uses the same reporting system for both groups of patients.
- County uses same employees to manage both service delivery systems.
- Quality of service is improved in that with greater number of patients, you can justify more specialists who are more expert in their field and therefore more efficient in providing necessary treatment.

Direct Service and Treatment

Again, in the area of direct treatment services the team was unaware of any financial risks or concerns. Many of these services are County sponsored and funded at the County's discretion, services like School Based Mental Health (Program Offer 25076A) and Early Childhood Services (Program Offer 25073).

Most of the services are entirely general fund supported or rely on a mix of general fund and Verity funds for the Medicaid insured clients. There are opportunities in this area to improve the revenue by providing and documenting billable services, then vigorously pursuing payment. There may also be ways to have County provided services relieve some of the pressure on the LMHA and MHO, if they are able to bring in additional resources as a Federally Qualified Health Center (FQHC.) There was not sufficient time during this review for the team to quantify the amount of potential revenue, if any.

Recommendations

- **Continue With Business Model Redesign** - The Mental Health Business model redesign should be implemented as soon as Verity has the systems for monitoring and oversight in place.

- **Evaluate MHO Contract (Board Policy Decision)** - The Board of County Commissioners could decide the risk to the general fund from cost overruns in the MHO is too great. This is an option contract which the County could choose to terminate. The State would need to either pay for the care directly, or open up the contract to HMO's like CareOregon.

This would eliminate the MHO financial risk, but limits the County's role in Medicaid service design, delivery, and implementation. It would also result in the loss of 19 FTE who are responsible

for administering the MHO and funded with MHO revenue. It is unclear what impact it that could have on LMHA responsibilities and financial obligations like Emergency Holds.

o **Provide Management and Support for Mental Health System Success -** Maybe the greatest risk, one not easily quantified, is the risk that MHASD will not adequately manage Verity and the associated risk. While implementing a new financial and clinical model hurdles will arise. If MHASD is slow to respond, what might have been a manageable risk becomes a significant financial issue.

This is especially critical knowing that MHASD has experienced high turnover in senior positions, a number of vacant positions and "interim" appointments. This makes it hard to judge the impacts and risks associated with funding downturns and business process changes. It is difficult to determine potential impact across the system from changes made in discrete silos of the mental health program.

The current Mental Health system is operating three very different and unique lines of business, an insurance company, a community safety net with monitoring and enforcement responsibilities, and they are a provider of clinical treatment services. These three lines of business often conflict, impact or overlap with each other. The Mental Health program needs to have directors and managers in place that can manage these very distinct operations, to protect against the financial risk inherent in implementing, monitoring and changing a large complex system.

o **Reports and Monitoring Tools -** The Finance Division will request the following financial data and indicators from MHASD. This should be provided monthly on a schedule provided by Mental Health. This is not an all-inclusive list for monitoring and implementing the system, only some leading markers to watch. MHASD may have some variations on this data, that they are already accumulating, which could substitute for the follow information.

MHO Verity

Outpatient - (All data in total and broken down by Children and Adult System)

o **Claims paid YTD compared to Budget**, based on actual claims paid with applied Incurred But Not Reported (IBNR) percentage. (Finance will approve the IBNR methodology for the first year, until actual IBNR is accumulated.)

o **Claims paid YTD compared against amounts authorized YTD** with claims matched against the appropriate authorization and the "amount" authorized being the average annual cost per LOCUS level of care. This will track on average how much of each authorization results in paid claims and how quickly the authorization is expended.

o **Average hours of service by LOCUS level compared to estimated hours of service.** This will gauge how closely the business plan is adhering to its average hour projections.

Inpatient

o **Total Cost YTD with applied IBNR compared to Budget.** An Inpatient IBNR should already exist since they have been paid Fee-for-Service for several years.

- **Total Cost YTD compared with cost of Authorized bed days YTD** with claims matched against the appropriate authorization. The cost of the authorizations should be the total daily rate, unless Verity can identify those with Medicare coverage and can accurately estimate the Medicaid share of the Authorization. This will measure how much of the Authorized days result in paid claims and test the accuracy of the applied IBNR.

- **Admissions, bed days, and length of stay.** The data included in this report should be updated and reported monthly.

Other MHO Data

- **Total Specialty and administrative YTD costs and revenue (accrual basis for both) compared to Budget.** This should be all other Verity cost and revenue data, not otherwise included in the reports above, compared to budget.

Local Mental Health Authority

- **Crisis and Call Center services YTD Budget to Actual** comparisons done monthly. Mental Health should confirm what program offers this would include.

- **Emergency Hold YTD Budget to Actual** the actual should be both costs basis actual and actual based on E-hold IBNR. (CFO should approve methodology for IBNR, since it will not be a traditional IBNR.)

- **Emergency Hold Admissions, bed days and lengths of stay,** presented in aggregate and broken out by Verity members and all others admissions.

Direct Service and Treatment

- **Budget to actual YTD revenue and expenditures** should be reported, especially progress on collecting revenue other than general fund.

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

Board Clerk Use Only	
Meeting Date:	04/18/06
Agenda Item #:	B-2
Est. Start Time:	9:50 AM
Date Submitted:	03/28/06

BUDGET MODIFICATION: -

Agenda Title: **Mental Health and Addictions Services Division Safety Net Briefing**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Date Requested:	April 18, 2006	**Time Requested:**	10 minutes
Department:	**County Human Services**	**Division:**	Mental Health & Addiction Svcs
Contact(s):	Chris Murphy		
Phone:	503 988-5464 **Ext.** 22458	**I/O Address:**	167/1/520
Presenter(s):	Rex Surface, Sandy Haffey and David Hidalgo		

General Information

1. **What action are you requesting from the Board?**
   At the budget work session held on March 2, 2006, the Board of County Commissioners requested a briefing on the Safety Net programs within MHASD, specifically emergency holds and involuntary commitments. The following topics will be covered with an emphasis on numbers and services for uninsured clients:
   - Safety net mental health services
   - Commitments for mental illness
   - Emergency holds
   - Demographics of mental health clients new to the system
   - Mental Health Organization (MHO) revenue/any use of County funds as subsidy
2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   The Safety Net programs are designed to keep safe those individuals who are at risk of harm to themselves or to others. These programs include the crisis call center, mobile outreach, urgent walk-in clinic, emergency holds (hospitalizations), and involuntary commitments.

3. **Explain the fiscal impact (current year and ongoing).**
   Although an important part of the mental health safety net system, emergency holds and involuntary commitments are expensive and very restrictive levels of care. It is important to monitor their usage and find ways to divert into less costly, less restrictive, clinically appropriate treatment that keep individuals safe in a crisis.

4. **Explain any legal and/or policy issues involved.**
   N/A

5. **Explain any citizen and/or other government participation that has or will take place.**
   N/A

Required Signatures

Department/ Agency Director: Pat Surface **Date:** **03/28/06**

Budget Analyst: _____ **Date:** _____

Department HR: _____ **Date:** _____

Countywide HR: _____ **Date:** _____

MULTNOMAH COUNTY

Access Points for Indigent Adult Mental Health Services in Multnomah County

MULTNOMAH COUNTY MENTAL HEALTH PROGRAMS

FOR PERSONS WHO ARE INDIGENT

Multnomah County Mental Health Call Center:
The Mental Health Call Center is the Mental Health "Information Hub" for Multnomah County and is available to all residents regardless of insurance status. The Call Center's team of 30 clinicians took 60,000 crisis calls last year ranging from mental health crisis and suicide intervention to information and referral.
Total number of calls in 2005: 60,000
Number of calls able to be identified by unique individual: 6,063
Number of individuals who were linked to persons who identified as indigent: 2811

Multnomah County Mental Health Mobile Outreach Team (Project Respond)
Project Respond is the county's mobile health outreach unit that does face-to-face crisis interventions in the community and helps provide diversion to individuals who would be otherwise hospitalized.
Total number of contacts in 2005: 12,700
Average number of contacts per unique individual: 7

Multnomah County Mental Health Urgent Walk-In Clinic
The Urgent Mental Health Walk-In Clinic is available to those individuals regardless of ability to pay who are experiencing a mental health crisis and can travel to a crisis clinic to be seen face-to-face. This clinic serves primarily indigent clients.
Total number of Walk-In visits for 2005: 5,000

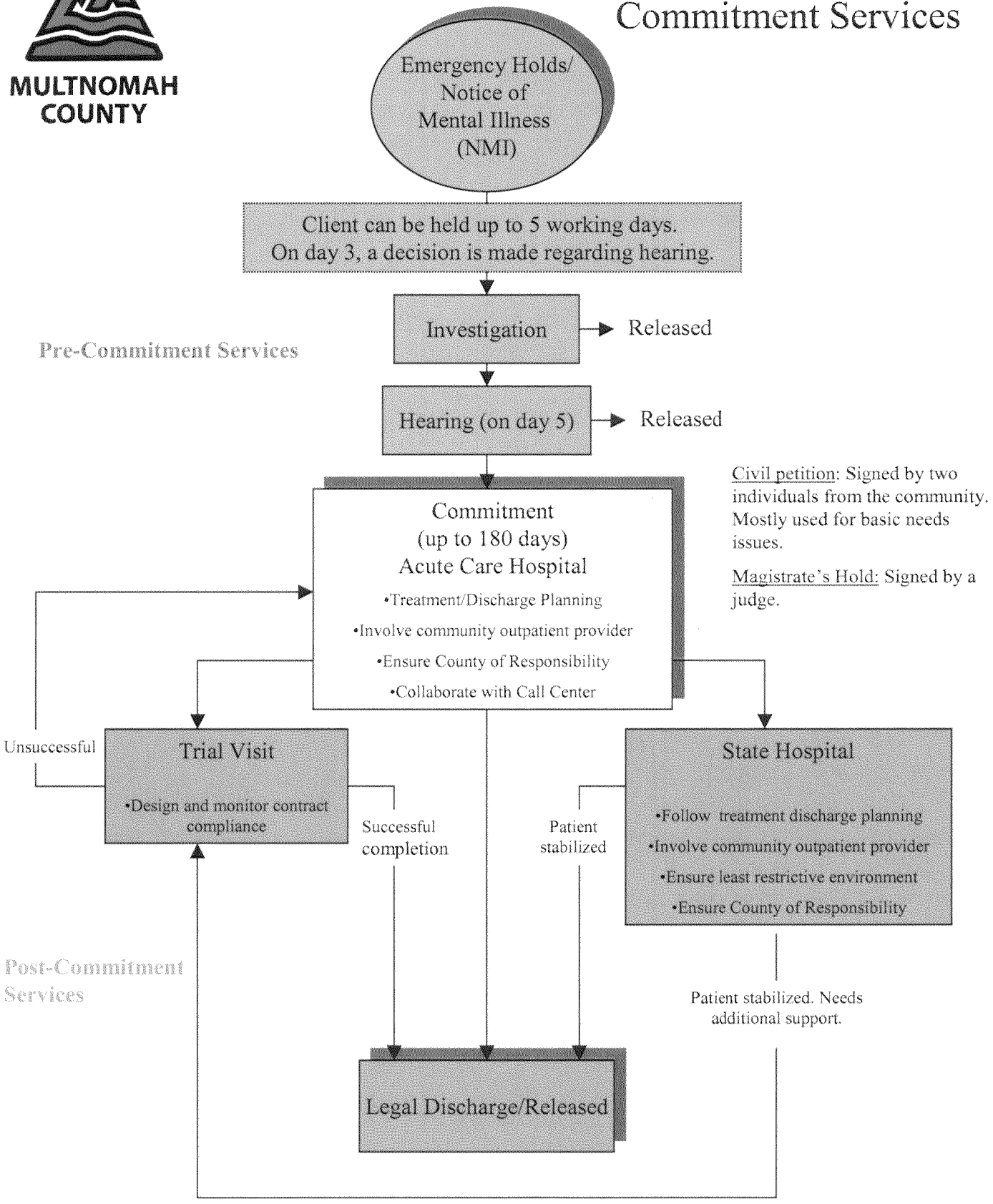
Multnomah County Mental Health Respite Care Services:
Multnomah County's Respite Care Program is a sub-acute community based residential setting where clients can be psychiatrically observed in a contained environment. This program serves persons who are indigent as well as Verity clients.
Total number of respite admits for 2005: 220
Number of admits for persons who identified as indigent: 92 clients

Multnomah County Verity Plus Program:
Coordinated from the Mental Health Call Center as of 2005. This is a last resort time-limited treatment fund for those who are indigent, at 200% of poverty level and at high risk of self-harm, hospitalization, incarceration, homelessness or loss of children in the context of a severe and persistent mental health disorder.
Total Number served last year is 2,500.

Multnomah County Indigent Medication Program:
Coordinated from the Mental Health Call Center as of 2005. This is a last resort time-limited medication fund for those who are indigent and meet 200% of poverty level and would otherwise go without medication that would dictate the need for use of other acute resources such as hospitalization.
Total number served in 2005: 1,000

MULTNOMAH COUNTY

Mental Health and Addiction Services Division
Commitment Services



E-HOLDS AND COMMITMENT SERVICES

E-Holds

- Total Emergency Holds for County Residents

FY 04-05	FY 05-06	FY 06-07
4080	4300 est.	4500 est.

*See last bullet for explanation of increase

- Total Emergency Holds for Indigent County Residents

FY 04-05	FY 05-06	FY 06-07
624	737 est.	850 est.

(Estimate for FY05-06 and FY06-07 based on 15% increase)

- Solutions to increasing cost of Emergency Holds
  a. Addition of Sunday staffing to Involuntary Commitment Program (ICP), with additional 2.0 FTE in February 2005

     Sunday staffing reduced the average length of stay (LOS) for indigent persons on Emergency Holds by .5 days. The decrease in LOS (.5) x # indigent Emergency Holds (737) x Hospital Cost/Day ($700.) = $257,950.00 decrease in Emergency Hold cost. This is a savings in the cost of indigent Emergency Holds.

     For each ICP Investigator hired, the savings is approximately the equivalent of their salary times 2. Salary savings are reflected in CGF.

  b. Addition of Saturday staffing to ICP in April 2006, utilizing 1 on-call staff.

     We will review data in June 2006 and September 2006 to determine if Saturday staffing decreases the average LOS, thus decreasing the Emergency Hold cost.

  c. Developed new Mental Health and Addiction Services Division ICP Policy and Procedure related to "payor of last resort" responsibility and processing of hospital indigent emergency holds claims.

- Requested Dr. Benston McFarland review data related to increases in number and cost of Emergency Holds since FY 02-03 to determine if there are factors that account for the increase in addition to:
  a. 2003 closure of Crisis Triage Center (CTC)
  b. Loss of 23-hours beds with closure of CTC
  c. 2003 closure of Ryles Center. (Sub-acute facility)
  d. 2004 OHP coverage changes, resulting in loss of benefits for numbers of clients
  e. Decrease in community resources

Commitment Monitoring/Discharge Planning

- Total County Commitments

FY 04-05	FY 05-06	FY 06-07
276	334 est.	350 est.

  Historically 7%-9% of Emergency Holds result in commitment.
- Per cent of County Commitments that are Indigent
  FY 04-05: Approximately 24%
- Improvements to Commitment Monitoring/Discharge Planning Services

  a. Addition of 2 FTE to provide additional Trial Visit capacity, increasing ability to discharge committed patients from acute care and State Hospital. Trial Visits have increased by approximately 66% in FY05-06. State dollars obtained for FTE.
  b. Waitlist Reduction Project provides 3 FTE ACT/CORE dedicated to community engagement and transition of committed patients discharging from acute care and State Hospital, increasing Commitment Services ability to discharge patients. State dollars obtained for FTE.
  c. Waitlist Reduction Project provides 1 FTE dedicated to discharge planning for Multnomah County residents at State Hospital or on the State Hospital waitlist. Average LOS on State Hospital waitlist decreased by 11 days for 7/01/05-12/31/05. Number of County residents on the State Hospital waitlist has dropped from double to single digits. State dollars obtained for FTE.
  d. Call Center, Utilization Review staff attend bi-weekly Commitment Services treatment/discharge planning meetings to coordinate discharge planning.
  e. Safety Net Services Manager provides weekly review of Call Center list of committed patients in acute care, for appropriateness of Length of Stay.
  f. Commitment staff instituted quarterly discharge planning visits to Blue Mountain Recovery Center (previously EOPC), due to the large number of Multnomah County residents committed to this State Hospital campus.

Multnomah County Mental Health and Addiction Services (COUNTY MHAS)
Involuntary Commitment Policy and Procedure Summary

As of 10/27/05:

* Multnomah County is payor of last resort per ORS 426.241.
* COUNTY MHAS has agreement to provide payment to providers within Multnomah County for ICP (Involuntary Commitment Program) patients who are indigent at rate of $700 per day, less any insurance or benefits available to them.
* The COUNTY MHAS does not require provider to obtain authorization to see patients before commitment.
* The COUNTY MHAS oversees the involuntary commitment and sends a MH investigator for each patient within 48 hours to determine if IC was appropriate and write up a report to the Court. Patients are dropped from E-hold after 6 days if not seen by the MH investigator. The MH investigator can recommend release of an E-Hold patient to the Court if circumstances warrant. If a patient is recommended for release, County will not pay for additional days after date of recommended release – even if provider has held the patient over.
* Hospitals must submit claims to the COUNTY MHAS for payment on E-Holds within 12 months from date of service to be eligible for processing for payment.
* Pursuant to ORS 426.241(1), hospitals are required to "charge to and collect from the person, third party payers or other persons or agencies otherwise legally responsible therefore, the costs of emergency care, custody and treatment, as it would for any other patient, and any funds received shall be applied as an offset to the cost of the services provided under this section".
* COUNTY MHAS will, pursuant to ORS 426.241 (5)(a), "deny payment for all or part of the emergency psychiatric services provided by a hospital or non-hospital facility under ORS 426.232 or 426.237 when the department finds, upon review, that the allegedly mentally ill person's condition did not meet the admission criteria in ORS 426.232 (1), 426.233 (1) or 426.237(1)(b)(A)."
* COUNTY MHAS pays several providers, although no current written contract is in place: Portland Adventist, Providence Hospitals (includes St. Vincent), OHSU, Legacy Emanuel & Good Samaritan, Salem Hospital, Mercy Medical, and Good Samaritan Hospital in Corvallis.
* COUNTY MHAS will use judicial days (M-F) for payment calculation and generally doesn't pay for weekend stays, unless there was a delay in filing paperwork due to holiday or Friday commitment. COUNTY MHAS will not pay for the date on which the emergency hold is dropped.
* Required documentation for E-Hold claim processing by the County will include:
    - HCFA 1450 (UB 92) form.
    - Multnomah County Payer of Last Resort Billing Verification Form
    - Notice of Mental Illness form (showing E-hold patient address & county of residence)
    - Drop Hold form from Physician or County Investigator
    - Admission Summary & Intake Information
    - Social Worker Patient Evaluation in Emergency Room
    - Emergency Department Patient Evaluation
    - Physician Orders
    - Physician Transport Hold documentation

Unit Notes from Social Worker
Urine Analysis & Lab reports if documentation reports suspicion of drug use
Discharge Summary Report
Explanation of Benefits (EOB) (if applicable)
Hospital Charity write off documentation (if applicable)
Due diligence bill payment collection documentation showing hospital collection efforts; i.e. payment plans, collection agency attempts, past due/collection correspondence.
Director/Police Custody Report copy (if applicable)
Release from Detention (if applicable)

* The County will return claims to the provider that do not contain the required documentation, accompanied by an Insufficient Documentation letter.
* The County will deny claims based on the following:
  > The claim was not received within 12 months from the date of service.
  > No record can be found of the original Notice of Mental Illness being filed with Multnomah
  > County Circuit Court (ORS 426.234)
  > Dates denied are dates that are not within the period of the hold.
  > Patient is or was a resident of another County within the State of Oregon at the time of the service.
  > Patient is or was a resident of another State at the time of the service.
  > Documentation indicates that the patient has income sources. Pursuant to ORS 426.241, providers must charge to and collect from the patient, third party payer or other persons or agencies legally responsible. If uncollectible, provider must provide detailed documentation of due diligence to recover the past due account subject to the NMI Claim appeal process.
  > First or third party payment was received by provider facility for the same hospital services.
  > The documentation provided for review of this claim does not support that client met the criteria for emergency psychiatric care, custody, and treatment pursuant to the requirements of ORS 426.232.

* COUNTY MHASD-ICP provides an appeal process only for denied hospital claims for inpatient mental health services provided to indigent persons. All hospital appeals must be submitted *in writing* and contain any required documents noted as missing from the original NMI claim, or contain additional documentation as needed to support the appeal. All hospital appeals must be initiated by mail, and filed within sixty (60) business days from the date of the Notice of Mental Illness (NMI) Claim-Provider Notice of Decision to: Multnomah County DCHS

Attn: MHASD – ICP Claims Appeal
421 SW Oak Street, Suite 520
Portland, OR 97204-1817

* Appeals received within the 60-business day timeframe, and include the required documentation, will be reviewed by COUNTY MHAS Quality Management. Appeals will either be denied or granted, and the results of the retrospective review of the appeal materials will be returned by mail to the provider within 60 business days of receipt. Any further appeal to the decisions made by COUNTY MHAS Quality Management will be referred to the Oregon Department of Human Services.
* Any hospital appeal received beyond 60 business days from the date of the Notice of Mental Illness (NMI) Claim-Provider Notice of Decision, or which does not contain sufficient documentation to support the appeal, will not be processed and will be returned. It is the responsibility of the hospital to submit appeals within the required timeframe and with appropriate documentation.

- If COUNTY MHAS denies an ICP claim for a patient a) who was an out of State resident, b) was an out of Multnomah County resident, or c) because the patient

was committed to the State, and the provider appeals the denial, COUNTY MHAS will take the following steps:

1) the provider's appeal and the original Provider Notice of Decision will be presented to the COUNTY MHAS Quality Management for retrospective review and decision;
2) COUNTY MHAS Quality Management will either uphold the original claim denial or approve payment if warranted;
3) if the provider appeals the COUNTY MHAS Quality Management decision, the claim, the original Provider Notice of Decision, and the Retrospective Review letter, will be sent to State Department of Human Services for a ruling.

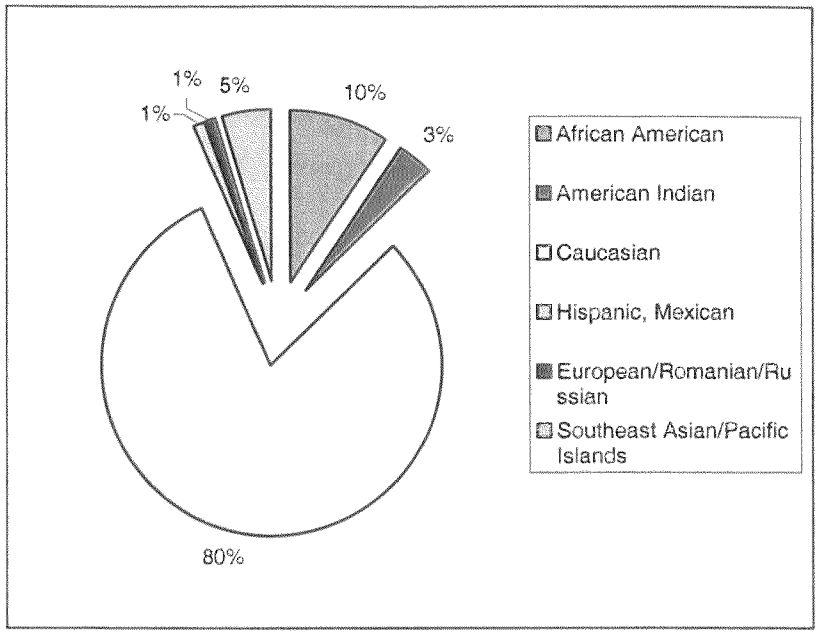
Change to Procedures for submission of ICP Emergency Hold claims 2/7/06:
Reason: Medicare's new rule that requires providers to combine charges into one account when less than 3 dates of service elapsed between two patient accounts, and Medicare issues one remittance for all charges.

In this situation, providers may combine into one ICP hold claim package, but separate the documents for each old (NMI, Drop Hold, etc) that support each hold period. They should include the remittance from Medicare to show how it was applied to the total of the combined holds. (Per Jean Dentinger, 2/7/06).

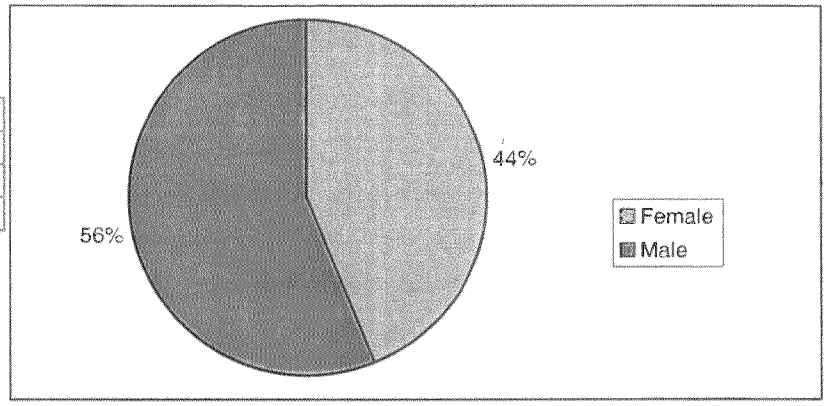
Multnomah County Commitment Monitoring Services

July 1, 2004 - June 30, 2005

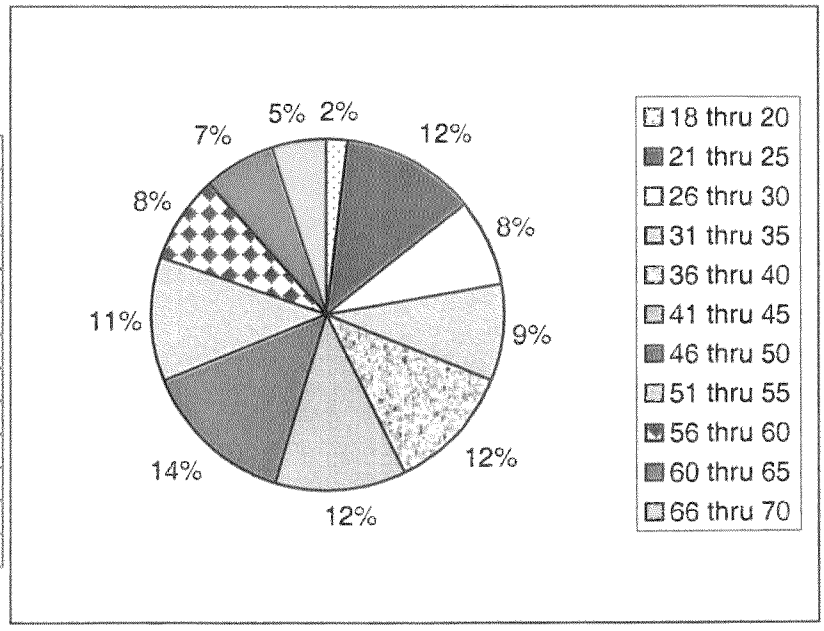
Ethnicity		
RaceDescription	Total	%
African American	29	9.57%
American Indian	10	3.30%
Asian, Pacific Islander	3	0.99%
Caucasian	244	80.53%
European	1	0.33%
Hispanic, Mexican	2	0.66%
Hispanic, Other	1	0.33%
Romanian	1	0.33%
Russian	1	0.33%
Southeast Asian	11	3.63%
Total	303	100.00%



Gender	Total	%
Female	133	43.89%
Male	170	56.11%
Grand Total	303	100.00%



Age At Commitment	Total	%
18 thru 20	6	1.98%
21 thru 25	37	12.21%
26 thru 30	24	7.92%
31 thru 35	27	8.91%
36 thru 40	36	11.88%
41 thru 45	36	11.88%
46 thru 50	43	14.19%
51 thru 55	34	11.22%
56 thru 60	25	8.25%
60 thru 65	20	6.60%
66 thru 70	15	4.95%
Total	303	100.00%



Patients In Acute Care Hospitals Committed In Multnomah County Court
From 07/01/2004 Through 06/30/2005

Insurance Coverage	Count Of Patients	Percent
Medicare A&B	121	18%
Verity Insurance	121	18%
Open Card	158	24%
Veteran	11	2%
No Insurance	85	13%
Verity Plus	7	1%
OHP Plus	135	20%
OHP Standard	11	2%
Medicaid Other State	1	0%
MHO Other County	11	2%
Total	661	100.00%

Partial 9%

Partial 1%

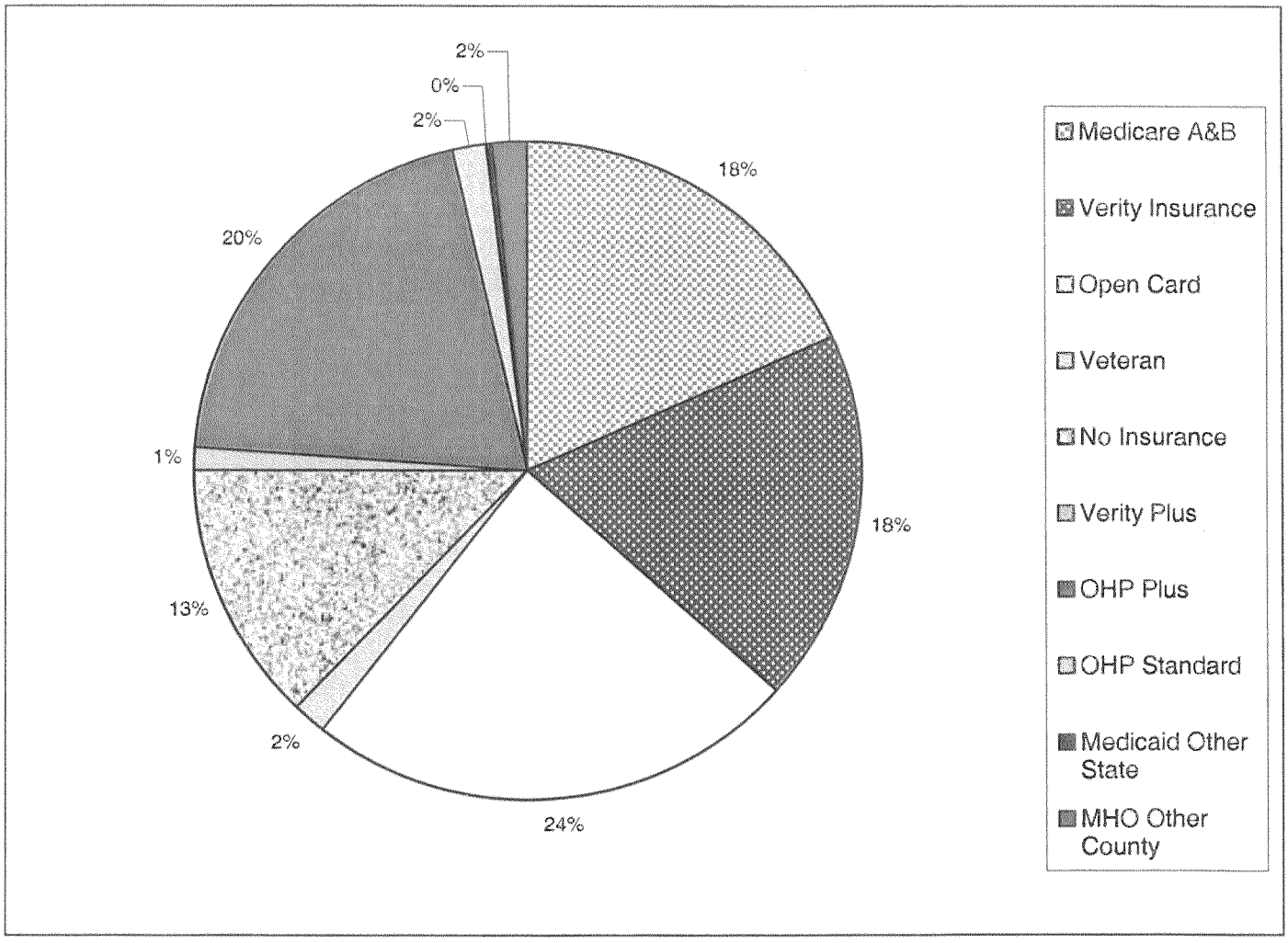
Verity + 13%

10%

24%

Total Client Episodes 317

Some clients have more than one type of coverage.



MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

Board Clerk Use Only	
Meeting Date:	04/18/06
Agenda Item #:	B-3
Est. Start Time:	10:00 AM
Date Submitted:	04/12/06

BUDGET MODIFICATION: -

Agenda Title:	**Briefing on the Fiscal Year 2007-2009 Mental Health and Addiction Services Division Biennial Implementation Plan**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Date Requested:	April 18, 2006	**Time Requested:**	10 minutes
Department:	**County Human Services**	**Division:**	Mental Health and Addiction Services
Contact(s):	Chris Murphy		
Phone:	503 988-5464 **Ext.** 22458	**I/O Address:**	167/1/520
Presenter(s):	Nancy Winters, Ray Hudson, Sandy Haffey and Godwin Nwerem		

General Information

1. **What action are you requesting from the Board?**
   Briefing of the Multnomah County Community Mental Health Program 2007 – 2009 Biennial Implementation Plan. This plan was approved on April 6, 2006 by the Board and this brieifng will allow for follow up to the document.

2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   Per Oregon Revised Statute 430.630 and 430.640, the State of Oregon Office of Mental Health and Addiction Services (OMHAS) has the responsibility for reviewing and approving the county Biennial Implementation Plan for the establishment and operation of county Community Mental Health Programs. Accordingly, OMHAS requests the County to submit a biennial plan encompassing treatment and prevention services for mental health, addiction, and problem gambling. The county plans will help guide OMHAS in the development of the 2007 -2009 County Financial Assistance Agreement (CFAA).

   The plan outlines how Multnomah County Mental Health and Addiction Services Division

(MHASD) will utilize state funding for 2007 – 2009 biennium. In the plan MHASD identifies any changes in needs, resources or other circumstances that might require alteration in the service delivery system.

3. **Explain the fiscal impact (current year and ongoing).**
   No fiscal impact in the immediate future. The biennial implementation plan will be used by OMHAS to develop the 2007 - 2009 OMHAS Budget Request, which attempts to influence the amount of funding available for mental health, addiction and gambling treatment services.

4. **Explain any legal and/or policy issues involved.**
   The County Biennial Implementation Plan is used by OMHAS to identify areas of need across the State. They use this information to request funding for services from the legislature.

5. **Explain any citizen and/or other government participation that has or will take place.**
   The Biennial Plan was distributed to the Adult Mental Health and Substance Abuse Advisory Committee (AMHSA), Child and Adolescent Mental Health and Substance Abuse Advisory Committee (CAMHSAC), Local Public Safety Coordinating Council (LPSCC), and County Commission on Children & Families (CCFC), for review and feedback.

Required Signatures

Department/ Agency Director: Pat Surface **Date:** 04/12/06

Budget Analyst: _____ **Date:** _____

Department HR: _____ **Date:** _____

Countywide HR: _____ **Date:** _____

Multnomah County

Biennial Implementation Plan

2007 - 2009

Contact Person:

Nancy Winters, LPC
Interim Director
Mental Health and Addiction Services Division
421 SW Oak St. Suite: 520
Portland OR 97204
Phone: 503-988-4055 Ext. 84055
nancy.winters@co.multnomah.or.us

For Additional Copies:

Chris Murphy
Mental Health and Addiction Services Division
421 SW Oak St. Suite: 520
Portland OR 97204
Phone: 503-988-5464 Ext. 22458
chris.murphy@co.multnomah.or.us

Multnomah County
2007-2009 Implementation Plan
Index

Narratives		Page
•	Executive Summary	4
•	County Planning Processes	5
•	Functional Linkages with State Hospital System	6
•	Priority Needs for Each Program Area	8
•	Allocation and Use of OMHAS Funding	12
•	A&D Prevention	20
•	Gambling Prevention and Treatment	25
•	Children's Mental Health Treatment	26
•	Description of Level of Need Determination Process and Protocol	29
•	Older Adult Mental Health & A&D Prevention & Treatment	32

Required Attachments		
	County Contact Information Form	33
1.	List of Subcontracted Services for Multnomah County	35
2.	Board of County Commissioners Review and Approval	41
3.	Local Alcohol and Drug Planning Committee Review and Comment	42
4.	Local Mental Health Advisory Board Review and Comment	43
5.	Multnomah Commission on Children and Families Review and Comment	44
6.	County Funds Maintenance of Effort Agreement	45
7.	Planned Expenditure of Matching Funds	46
8.	Service Delivery Area Manager Review and Comment	47
9.	Local Public Safety Coordinating Council	48
10.	Prevention Strategy Sheet	49

EXECUTIVE SUMMARY

The population served by Multnomah County's MHASD includes the chronically mentally ill; children, families and adults, and clients with a substance abuse and/or dual diagnosis disorders. MHASD provides mental health services to the frail elderly, developmentally disabled, and physically and mentally disabled that have a mental illness as well. We have outlined the programs and services that we feel can best meet these citizen's needs in this report. The development of this 2007-2009 Biennial Plan was accomplished in an era where a primary concern of this County is the shrinking availability of mental health and addictions funding, while the need for those services is growing.

Funding concerns:

- The Mental Health and Addiction Services Division (MHASD) provides over 1,100 outpatient A&D treatment slots per year, and spends just over $900,000 per month on A&D residential treatment. At those levels, we estimate we are meeting 50% – 60% of demand. Added to this concern is the loss of A&D funding resulting from the sunset of Multnomah County's temporary I-tax. These and other factors create the stage for a potential A&D crisis in Multnomah County. (More on this topic on page 10.)
- The Medicaid Mental Health System for Children has been reduced by 20% over the past four years, the next phase of this funding cut will be effective January 1, 2006. This will lead to a reduction of ongoing mental health treatment for at least 400 children who are Oregon Health Plan eligible. (More on this topic on page 28.)
- The severe inadequacy of funding for prevention, including substance abuse prevention, is well known across community sectors. There is general agreement that supports for children and families and comprehensive health promotion are critically important for long-term community health. However, federal, state, and local funding have not been balanced to adequately fund prevention. (More on this topic on page 20.)
- The percentage of all persons placed on an emergency hold that are identified as uninsured or indigent at the time of their hospital admission has increased each year since 2003. In 2003, 13.3% of all persons placed on a hold were uninsured or indigent; the number increased in 2004, and again in 2005 when up to 18% were uninsured or indigent. This increase in hospital use by unfunded residents is very costly. Over $1.5 million dollars were spent on emergency holds in 2005.

It is, therefore, the primary goal of this County to make the best possible strategic choices in procuring and managing our mental health and our alcohol and addiction services, in an effort to create the greatest possible impact with our available social service dollars.

Multnomah County
2007 – 2009 Implementation Plan

Planning Process used to Update Biennial Plan

As part of the planning used to update the biennial plan, numerous public meetings were held to obtain provider and consumer feedback on the then projected new system of care for children and families as well as the adult system of care. Community meetings were held for child and adult services, and a wide variety of providers, stakeholders, consumers and County residents participated in providing input. The proposed adult system changes were also presented at provider agency consumer meetings. Presentations on the new system took place at consumer advisory meetings, including the Adult Mental Health and Substance Abuse Advisory Committee (AMHSA) and Children's Mental Health and Substance Abuse Committee (CMHSAC).

Internal data was also used to determine what the new systems of care should look like. Underserved populations were identified and utilization trends examined. Regulatory changes and funding requirements were also considered when creating the new systems of care.

Utilization information and the input from these meetings were used to develop the adult system of care and child and family system of care Requests for Programmatic Qualifications (RFPQ). The intent of the RFPQs was to procure the types of services the planning process had determined would make the best use of available funds. Each respondent to the RFPQs was asked how they would incorporate culturally specific practices into their provided services so underserved populations could and would access treatment.

Additionally, to further address the problem of culturally competent treatment, the County has been meeting with representatives of the underserved populations to find out how they can best be assisted in building infrastructure. County General Funds will be used to procure culturally competent services with this information.

Multnomah County
2007 – 2009 Implementation Plan
Functional Linkages with State Hospital & Inpatient Providers

Task: Provide a description of current functional linkages with the State Hospital System and mental health acute care inpatient providers.

Multnomah County Mental Health and Addiction Services Division (MHASD) maintains current functional linkages with local acute care inpatient mental health providers through the Mental Health Call Center, Involuntary Commitment Program, and through relationships maintained at the administrative level.

The Multnomah County Mental Health Call Center is the clinical resource hub for the county crisis network and provides a first point of contact with local acute care facilities and other crisis providers in the community such as emergency departments, mobile mental health outreach, police and community corrections. The Mental Health Call Center is consulted before admission of any Verity MHO member to consider medical necessity for acute care services and clinically appropriate diversion alternatives. Pre-authorization for acute care services is required by Verity for the purpose of community coordination, utilization management and payment. The Mental Health Call Center is available 24 hours a day, 7 days per week to be called by any Multnomah County resident (regardless of OHP eligibility) who presents at local acute care hospitals needing psychiatric treatment. The Call Center has a dedicated line for police and community corrections. When police interact with a mentally ill person, they can work with the Call Center to avoid a potential incarceration when treatment is more appropriate.

MHASD presents regularly to crisis providers in the community in an effort to foster closer relationships with the community emergency services/crisis network. These presentations solidify the Mental Health Call Center's role as the leader in the mental health crisis system. It also provides a forum for acute care providers and other crisis providers to discuss resources and strategies for keeping consumers in need of community based mental health services in the least restrictive community setting.

Additionally, by having regular communication and case consultation, the Mental Health Call Center aims to decrease the number of unnecessary emergency department visits and unnecessary jail bookings for persons who can be best served in the community mental health system. The Call Center has access to wraparound services, mobile outreach services, or flexible funds if housing is needed. Additionally, the Mental Health Call Center has access to the network of Verity clinical providers in the community who can assist in creating safe community based diversion plans.

As part of the Waitlist Reduction Project, the Call Center can dispatch the County's contracted mobile crisis services, Project Respond, to evaluate persons for other, less restrictive, community treatment resources when appropriate. For all admissions, the Call Center identifies whether the person has a Primary Provider in our mental health system. For persons with Primary Providers, the Primary Provider is notified of the admission and works with the Call Center to coordinate care and discharge planning. For persons without a Primary Provider, the Call Center coordinates a referral for a Primary Provider who begins to offer outpatient mental health services, usually prior to discharge from acute care.

Commitment Services at Multnomah County is a second point of linkage with local acute care hospitals. Multnomah County Involuntary Commitment Program (ICP) is responsible for investigating all Notices of Mental Illness filed in Multnomah County to determine whether or not persons held involuntarily for mental health treatment should be referred for civil commitment. This work unit has daily contact with staff and patients of all local acute care hospitals in the process of investigating these Notices. In the process of conducting an investigation, ICP staff also provide a link between the inpatient treatment providers and the outpatient providers as less restrictive treatment options are explored.

For persons who are civilly committed in Multnomah County, the MHASD Commitment Monitors are able to connect individuals with community treatment providers upon discharge. A commitment monitor is assigned to each local acute care hospital to work with the hospitals in the planning and treatment for all Multnomah County committed persons. These commitment monitors have daily contact with the hospitals in the oversight of the treatment of committed patients. They provide a linkage to community resources, monitor referrals to the State Hospital, and oversee the discharge planning process.

Multnomah County MHASD also maintains relationships with local acute care hospitals in the administrative venue. MHASD administrative staff participates in the monthly Metro Acute Care Advisory Council (MACAC). This meeting is comprised of representatives of all local acute care hospitals, all Metropolitan Area Counties and contracted providers as well as representatives from the State Hospital and the State Office of Mental Health and Addiction Services. Issues related to the overall Metropolitan Area system of care are discussed. MHASD is also represented at the monthly Regional Emergency Department meeting. Hospital emergency departments are often the point of entry to inpatient mental health treatment. MHASD, in partnership with medical staff from contracted outpatient providers, has also initiated a bi-monthly meeting involving inpatient and outpatient physicians and clinical administrators to facilitate consistent, functional communication between inpatient and outpatient treatment providers.

Multnomah County
2007 – 2009 Implementation Plan
High Priority Needs for All Program Areas

The needs assessment performed by Multnomah County MHASD identifies the following needs as critical:

1. To Improve the Mental Health of its Citizens:

As an urban area, Multnomah County serves both a large population base and more chronically and severely ill residents. According to the Department of Human Services Office of Mental Health and Addiction Services MHO Utilization Report, Multnomah County provides a higher percent of services to individuals with schizophrenia and other psychotic disorders (21%) than the State average (17%). Multnomah County also serves a disproportionately large number of adult individuals whose mental illness is severe enough to require residential care in thirty residential treatment homes and facilities licensed, totaling 284 beds. The County is also home to multiple residential treatment facilities for children.

Multnomah County's Mental Health System Redesign in 2001 provided better access to care, improved service coordination through the call center and crisis services. Sustaining the gains made in these areas continues to be a top priority in the upcoming Biennium. Walk-In clinics providing no appointment assessments and screening services, access to licensed practitioners, and crisis intervention, are more necessary now than in 2001 when more residents had Oregon Health Plan coverage. Mobile Crisis Teams initiated with the last redesign are still available twenty-four hours per day. Success of future system improvements is contingent upon maintenance of these critical system components.

In an effort to best serve and improve the mental health of these large numbers of clients, MHASD has redesigned its mental health system to create a system of services that are integrated and comprehensive. MHASD has qualified local mental health providers to provide a full array of mental health services for adults and children. Services include care coordination and acute care management, which is provided to children and families and adults who are in need of high acuity treatment services. These services are built on a Recovery based model that includes active front door/back door policies. These are clear procedures designed for allowing clients to enter treatment when they are ill and exit treatment when they are no longer in need of treatment.

MHASD is increasing access to services by providing Community-Based Services for people who cannot or will not access services on their own but who are in obvious and urgent need of mental health and addictions treatment services. This includes providing well-integrated community support to ensure that basic living needs are met.

MHASD is improving its quality management and using the services of a third party administrator to better track client treatment and outcomes. It is also ensuring accountability from providers based on the use of evidence practices and the monitoring of treatment outcomes in order to better incorporate a cause and effect theory aimed at *improving the level of functioning* and producing measurable results.

Assertive Community Treatment (ACT) and Dialectical Behavior Therapy (DBT) will be provided for consumers who are at high risk of needing acute care services and have not done

well in traditional outpatient programs. These services are both shown to decrease adult acute hospitalizations. One of the criteria for qualifying for ACT services includes risk of incarceration.

In a report published by the Public Safety Coordinating Council of Multnomah County "A Study of People With Mental Illness In The Criminal Justice System", over-representation of people with mental illness in the jail is cited as a key issue. "Although approximately 5% of the national population is estimated to have a serious mental illness, a figure that holds across economical and racial groups, the prevalence of mental illness among the population in jail or prison is estimated at 16% nationwide. Multnomah County is ahead of the national average, with about 13.8 % of people booked into jail having a mental illness. In 2004: 24,759 people (unduplicated) were booked into the Multnomah County jail during the year, some more than once, for a total of 41,139 bookings. Corrections Health placed 3,413 of these people on a medical psychiatric alert at some time during the year. A psychiatric alert is placed when an initial health assessment reveals a history of mental illness, suicidal thought, or disruptive or bizarre behaviors. These 3,413 people represented 13.8% of the total booked population. These 3,413 people were booked 5,009 times, representing 12.7% of all bookings. Such over-representation of people with mental illness in jail illustrates the unfortunate fact that jails have become de facto treatment facilities. For most people with a mental illness, treatment is more effectively provided in community settings, ranging from secure facilities, to residential services, to supported or independent living. Co-occurring substance abuse disorders are also a major concern, affecting an estimated three quarters of people booked into jail nationwide who have a serious mental illness. In Multnomah County, the County Jail's drug-use forecasting data show that over half (54 to 76% of men and 51 to 88% of women) test positive for at least one illegal drug when booked, and that inmates with addiction issues are most likely to have frequent incarcerations."

All MHASD contracts with mental health and addiction services providers require that culturally competent and/or specific services are provided. In recognition of the County's growing ethnic diversity, it is a requirement in all county contracts that culturally specific needs are met through providing culturally and linguistically appropriate treatment to high-risk clients.

2. To Increase Economic Independence (Employment part of Adult System of Care and A&D programs)

Multnomah County has experienced an unemployment rate that is higher than the national unemployment rate. Financial difficulties resulting from prolonged unemployment add to the level of demand for county services. Housing and employment are both integral parts of recovery, which is why the County is making these services a priority. Supported employment is one of the evidence-based practices that MHASD is purchasing through its Adult System of Care RFPQ. All respondents were asked to identify ways they would assist individuals in gaining and maintaining employment. Those who wish to provide Assertive Community Treatment (ACT) are required to have a vocational specialist on the team to assist the most severely ill in finding and keeping jobs in the community.

3. To Create Partnerships

The number of arrestees who test positive for drugs in Multnomah County is very high: 82.2% of all females and 71.5% of all males. Multnomah County MHASD has improved its efforts to help address alcohol or drug abuse and dependence in the mentally ill. They have done this by

requiring that A&D and mental health providers provide integrated assessments and treatment planning. They are also requiring that providers create closer integrated partnerships with DCJ, jails, health care, and other community partners. MHASD believes that creating partnerships with business, law enforcement and health care agencies can provide better outcomes than a single agency working alone. MHASD is also contractually requiring that providers work strategically with other community partners in order to expand services beyond what government is able to do to support vulnerable populations

4. To Provide Readily Available and Easily Accessible Crisis Services.

The mental health call center receives a total number of calls of approximately 4,300 per month at the 24-hour crisis line that is staffed by master's level practitioners. A large amount of the calls are not crises, but are requests for information and case management among Verity enrollees. This program is highly effective and saves money because it allows clients to get contact and advice without going for more expensive treatment. The mental health call center operates 24/7, 365 days a year and is staffed by mental health professionals. They respond to mental health crises, requests for mental health services, and are responsible for the coordination of crisis and inpatient mental healthcare. There is also a phone line dedicated for corrections, so that if police are called to intercede with a mentally ill individual, the Call Center can assist in finding services that can prevent a jail stay.

5. To Provide Prevention Services

Through the redesign of its mental health system and its continued efforts in A&D, MHASD is working to provide prevention efforts that are well coordinated and have agreed upon, shared, and well-articulated goals.

6. To Provide Alcohol and Drug Treatment:

MHASD provides an array of Addiction Treatment services, including case management, transitional housing, and relapse prevention designed to assist clients in their struggle to achieve and maintain their sobriety. These include:

- Addiction Services – Detoxification, Residential, Outpatient, Methadone Treatment, Supported Housing, and Support and Education.
- Mentorship programs for clients with substance abuse problems to support them in recovery group participation as well as other services.
- Providing culturally and linguistically appropriate treatment to high-risk clients with a substance abuse disorder.

MHASD provides over 1,100 outpatient treatment slots per year, and spends over $900,000 per month on residential treatment. At those levels, we estimate we are meeting 50% - 60% of demand. There are two major factors currently influencing the future of A&D programs in Multnomah County. The first of these involves Multnomah County's implementation, two years ago, of a temporary income tax (the "I-Tax".) As a result of this tax we were able to double the number of methadone treatment slots available to the county's residents and these slots were filled immediately. Secondly, MHASD just received wait lists, as of December 1, 2005, from all of our residential providers. After collating these lists and eliminating duplicates, we were able to identify that there are over 500 county residents waiting for residential services. These two factors speak of a potential pending crisis in A&D in Multnomah County. The temporary

income tax referred to above has just ended, and because of the loss of funding we are being forced to reduce our current methadone treatment slots by 50%. Add to this the impact of the residential service wait lists and it is obvious that a potential crisis is looming.

Multnomah County is currently not meeting its citizens' need for A&D treatment. Approximately 15,000 treatment episodes are recorded in the County each year (a number greater than the entire population of many Oregon counties.) A reasonable estimate of what is needed indicates that at least another 8,000 to 10,000 treatment episodes need to be made available to meet our residents' needs. According to recent information from the Office of Mental Health and Addiction Services, the County can expect an 8% reduction in Service Element 66: A&D funding, effective in July 2007.

7. To Provide Gambling Services:

The Gambling Program services are provided for problem gamblers and their families, providing prevention and treatment services. More information on this service is available on page twenty-five of this document.

9. To Increase Access To Stable, Affordable and Decent Housing

Housing First is a part of all A&D and is included in Adult Mental Health System of Care programs. In addition to supported employment, housing is a system priority for the County.

10. To Provide Services to Homeless Youth

Homeless youth receive services through Outside In, which does outreach to these at-risk children. Outside In has experience with this population and provides treatment, care coordination, and links youth to other appropriate social services.

Multnomah County
2007 – 2009 Implementation Plan
Allocation and Use of OMHAS Resources

Funding from OMHAS is allocated to programs provided by Multnomah County MHASD or by our sub-contractors as follows:

Service Element	Service Provision
LA01	Mental Health and Addiction Services Division Administrative Expenses.
MHS 20	Adult CMI case management/care coordination, trial visit monitoring, abuse investigation, residential case management, and other services designed to prevent hospitalization.
MHS 22	Children and adolescent mental health services including early childhood, school aged, intensive in-home treatment, treatment foster care, and care coordination.
MHS 24	Acute mental health services including inpatient hospitalization.
MHS 25	Adult and Child non-OHP community crisis services including crisis walk-in clinic, mobile outreach, and crisis line.
MHS 28	Mental health residential services.
MHS 30	PSRB
MHS 35	Older adult mental health services, including the multi-disciplinary team.
MHS 38	Residential
MHS 39	Transitional housing
A&D 60	Special projects including the housing conference, family involvement team and services to Latino youth.
A&D 61	Residential alcohol and drug treatment, including services to pregnant African American women.
A&D 62	Housing for dependent children whose parents are in alcohol and drug residential treatment.
A&D 66	Outpatient alcohol and drug treatment
A&D 70	Prevention/Early intervention services
A&D 71	Youth alcohol and drug residential treatment
A&D 80	Gambling prevention services
A&D 81	Gambling treatment services
A&D 83	Gambling treatment enhancement including brochures and gambling awareness week.

Decision making, in terms of the allocation and use of OMHAS funding, was determined in concurrence with a major redesign of Multnomah County's Mental Health System. As a primary first step in this redesign, Multnomah County's MHASD released its first Request for Programmatic Qualifications (RFPQ) in March 2005. This first step was designed to begin the implementation of plans to create a comprehensive system of care for children, families and for adults in Multnomah County. The Children and Family System of Care and the Adult System of Care changes were developed as a result of a belief that standards for quality of care and the implementation of services with proven efficacy were lagging behind current research and system of care findings. We also believed a functional system of care could not be developed from a series of uncoordinated contracts that significantly vary in quality of service. Therefore, the County's goal in the redesign was to ensure that the services it purchased were evidenced based and that the system was as integrated from a management and clinical perspective as possible and to ensure that the System of Care could provide services in a seamless manner for OHP and non-OHP children, families and adults.

An RFP or RFPQ is a legal procurement procedure, which is viewed as the formal end of an involved planning process. This planning process incorporates a five-year cycle, largely because the maximum legal life span of any Multnomah County RFP or RFPQ is five years. MHASD's choice to use an RFPQ instead of an RFP allows the county greater flexibility in adjusting the provision of Mental Health and A&D treatment services in the community. It allows the system to qualify many providers and then adjust contract awards and services on a yearly basis, if necessary, based on the following criteria:

- County and Department strategic priorities
- Overall system of care needs and deficiencies
- RFPQ proposal information and evaluation input from the RFPQ Raters
- Provider/system stability
- Provider experience
- Number and type of funded slots/beds
- Funder-imposed requirements or restrictions (i.e. non-profit, etc.)
- Specific population coverage
- Geographic service coverage
- Coverage of specific modalities
- Client needs and trends
- Provider economy of scale
- Past performance
- Certification status
- Other factors as deemed appropriate by the system of care.

To assist MHASD in making the funding allocations, the providers responding to all of the RFPQs were required to complete a "Bed/Slot Request Form." They specified the minimum and maximum capacity or amount of service they could provide. MHASD and the Department of Community Justice, and other major funders of alcohol and drug treatment services, have worked together to make funding and service decisions for the fiscal year beginning July 1, 2006. By coordinating allocations, the County is making every effort to maintain and strengthen the continuum of treatment services in the County.

Three major RFPQs have been released by MHASD since March 2005, these include:

1. The System of Care for Children and Families: Children's Intensive Mental Health Treatment and Special Populations Services RFPQ (March 2005)
2. The System of Care for Children and Families: Services for School-Aged Children RFPQ (July 2005); and
3. The Adult System of Care RFPQ (September 2005.)

Each of these RFPQs was designed to move the County's mental health system to the next level of competency and gain greater control over the quality and cost of mental health services provided.

An intense planning process was utilized to develop each of these RFPQs. Numerous community meetings were held for children's and for adult services and a wide variety of providers, stakeholders, consumers and County residents participated in providing input. The resulting RFPQs allowed Multnomah County MHASD to qualify agencies that could provide comprehensive mental health services for OHP and non-OHP children and families and for adults.

Intensive Community Based Services for children:

Currently the county has qualified mental health providers to supply the following Intensive Community based services for children. These include:

- Screening
- Assessment and treatment planning
- Family involvement and supports including wraparound service delivery tailored to individual child and family needs
- Family education and support
- Skill training
- Mental health consultation
- Care coordination
- Supports and interventions in school-based setting whenever possible
- Psychiatry and medication management
- In-home and office-based individual and family therapy
- Respite services
- Crisis services
- Psychiatric day treatment
- Psychiatric residential treatment
- Inpatient hospitalization

Providers of Intensive Community based services qualified to supply services in two categories and nine service areas:

Category I: Intensive Mental Health Treatment Services

1. Psychiatric Residential Treatment Facility
2. Psychiatric Day Treatment Services

Category II: Special Populations Services

Part A: Intensive Family Search and Preservation Services and Treatment Foster Care

3. Intensive Family Search & Preservation Services
4. Treatment Foster Care

Part B: Intensive In-Home Family Services

5. Intensive In-Home Family Services

Part C: Individually Tailored Mental Health Outpatient Services including Behavioral Rehabilitation Services (BRS)

6. Individually Tailored Mental Health Services
7. Behavioral Rehabilitation Services

Part D: Crisis Respite

8. Foster Care Crisis Respite

Part E: Transition Aged Services

9. Transition Aged Services for 17 to 21 year olds and Homeless Youth Outreach

School-aged services for Children:

The County has qualified providers, through the System of Care for Children and Families: Services for School-Aged Children RFPQ, to supply mental health services to School-Aged children. These services include:

a. Mental Health Assessment
b. Case management and Coordination of Care
c. Family Therapy
d. Integrated Adult Mental Health and Addiction Services including case management, supported housing and employment, psychiatry and addiction services)
e. Individual Therapy and Skill Building
f. Parent Coaching and Support
g. Respite
h. Flexible and Wraparound Services
i. Extensive In Home and In School Services
j. 24/7 Intensive Response to High Risk/High Needs Families within Caseload. This includes being available by phone and in person to de-escalate crisis situations by someone who is familiar with the child and the family.
k. Psychiatric Assessment and Medication Management
l. Foster Family In Home Supports
m. Other Necessary Services

Evidenced Based Practices (EBP) for Children:

The children's contracts for Intensive Treatment Community Services, School-age children and Early Childhood, require providers to use at least the following EBP's:

- Incredible Years

- Wraparound Services
- Multi-Systemic Therapy
- Oregon Social Learning Center, Multidimensional Treatment Foster Care.

Within the System of Care for Families, MHASD is also in the process of integrating an evidence based family readiness assessment tool into the outpatient intake process. The Family Check Up (FCU) model consists of an initial interview, an assessment session, and a motivational feedback session (Dishion & Kavanagh, in press). The Family Check Up model is designed to build parental motivation and to engage families in the most appropriate family-centered intervention. Motivational interviewing provides the foundation for the Family Check Up based on the work of Miller and Rollnick (1991). In the feedback session, the therapist collaborates with the parent in selecting one or more intervention options from the family-centered intervention menu. MHASD is currently negotiating a contract with Kate Kavanaugh to provide training for school-aged mental health providers. She is also actively working with local mental health providers who are in the process of implementing this tool.

MHASD requires, in its contracts, that all children's mental health providers who provide service to Multnomah County residents will follow the State statute regarding evidence based practices (EBP). The statute requires that, for the 2005-07 biennium, 25% of state funds be used to treat people with mental illness who use or have a propensity to use emergency mental health services. In the 2007-09 biennium, the percentage of funds to be spent on EBPs increases to 50% and in the 2009-2011 biennium to 75%.

The Adult System of Care

The Adult System of Care is based on the following goals:

- All service delivery is culturally relevant with the involvement of the consumer, family members, and other members of the consumers' natural support system.
- An effective front door is in place to provide timely access to the system, with front door workers that are properly trained to triage clients to the appropriate service.
- Crisis services are in place to divert people from higher levels of care and connect them with appropriate inpatient alternatives.
- Inpatient services are focused on stabilization and discharge planning to ensure that adequate care is available upon discharge.
- Stable and supported housing is a system priority.
- Individuals with low to moderate need are provided appropriate evidence-based outpatient services including brief treatment, psycho-education, support groups, etc.
- Individuals with moderate to high need receive appropriate evidence-based services with adequate case management, which promote illness management and recovery and reduce the need for higher levels of care.
- Intensive wrap around community integrated services are available for very high need clients including Assertive Community Treatment (ACT) teams.
- Active back doors are in place with developed aftercare programs.
- The system will be able to address and serve those mentally ill individual with specialized heath care needs such as medical and psychiatric co-morbidity, developmental disabilities and chronic homelessness.
- The goal of the initial contact is to do the assessment, triage individuals whose needs can be addressed by social service agencies and to refer those individuals accordingly.

Implementing all aspects of this program should help to manage the flow of quality services and funds in a far more effective manner.

Adult System of Care Services:

Currently the county has qualified mental health providers to supply adult mental health services. These include:

a. Treatment readiness and community based engagement services
b. Mental Health Assessment and treatment planning
c. Case Management and Coordination of Care
d. Individual, group and family therapy based on established Evidenced Based Practices
e. Integrated Adult Mental Health and Addiction Services including case management, supported housing, education and employment, psychiatry and addiction services
f. Flexible and Wraparound Services
g. Recovery Model Mental Health Services
h. In home and community based services
i. Crisis Services during business hours and 24/7 response by phone and/or in person to de-escalate crisis situation by someone who is familiar with a consumer
i. On-site hospital discharge planning coordination and treatment planning
j. Psychiatric Assessment and Medication Management
k. Mental health support services to adult residential facilities and transitional housing programs
l. Other necessary services

Adult System of Care consists of five service categories:

Category I: Assertive Community Treatment
(2 ACT teams to serve 100 individual Verity members each)
Category II: Dialectical Behavior Therapy (DBT)
Category III: Services for Severely Mentally Ill (SMI)
Category IV: General Outpatient Mental Health Services
Category V: Respite and Sub-Acute Services

Adult System of Care Evidence-Based Practices:

During the 2007-2009 biennium it is expected that a minimum of six fidelity models will be implemented in the adult mental health system. They are:

Supported Employment
Co-Occurring Disorders: Integrated Dual Diagnosis Treatment
Illness Management and Recovery
Family Psychoeducation
Assertive Community Treatment
Medication Management Approach in Psychiatry.

Through the Adult System of care RFPQ, the County purchased through mental health service providers, Assertive Community Treatment and Dialectical Behavior Therapy. These two EBP's will comprise 25% of funding in the 2005-2007 biennium in accordance with the SB 267. These two EBP's were selected based on inpatient and outpatient data, which identified a service need

for consumers needing intensive outpatient services to reduce higher and more restrictive levels of care.

The County requires in its contracts that all adult mental health providers who provide service to Multnomah County residents will follow the State statute regarding evidence based practices (EBP). The statute requires that, for the 2005-07 biennium, 25% of state funds be used to treat people with mental illness who use or have a propensity to use emergency mental health services. In the 2007-09 biennium, the percentage of funds to be spent on EBPs increases to 50% and in the 2009-2011 biennium to 75%.

Mental Health and Addiction Services Division's Alcohol and Drug Treatment programs

Beginning in July 2007, the Mental Health and Addiction Services Division's Alcohol and Drug treatment programs will be in the third year of a five-year procurement. The RFPQ described successful providers as programs that will:

- Utilize case management services;
- Utilize evidence based practices;
- Offer manual guided therapies;
- Employ motivational enhancement techniques;
- Use an integrated treatment model;
- Are dually licensed as an A&D and Mental Health Provider.

The RFPQ further focused on manual-guided programs such as: A program that has adopted an evidence-based practice, in which its intervention is codified in a written protocol or manual. The manual defines the theory, active components, duration, intensity, and procedures of treatment, which can be used to assure that treatment is of a consistent quality and approach. Program manuals lay out guidelines for staff-client ratio, details of clinical supervision, and require that staff adherence to the manual-based therapy be monitored. Program staff may codify their practice and compose their own manual, but many exist already. Examples include three NIAAA Project Match manuals, five NIDA manuals (including four treating cocaine addiction), five CSAT Cannabis Youth Treatment manuals, and nine Adolescent Treatment Models manuals developed by Chestnut Health Systems.

The respondents to the RFPQ were evaluated using the following criteria:

- The provision of an integrated treatment model of the implementation of an integrated treatment model by a specific date;
- The utilization of evidenced based practices or specifies what evidenced based practices will be in place by a specific date;
- The utilization of manual guided group treatment services or specifics when all group services will be manually guided and how this will be achieved;
- The utilization of motivational enhanced techniques or specifies what motivational enhanced techniques will be in place by a specified date; and
- The utilization of case management services.

In addition to the standards and criteria included in the RFPQ, an inventory of the evidence based practices listed as being implemented by each provider has been developed. This inventory has been compared to the National and State OMHAS lists of evidence-based practices

and the three categories of evidence based practices – Gold Standard, Second Tier, and Third Tier.

The RFPQ and subsequent funding allocations were developed and implemented jointly with the County Department of Community Justice and the Mental Health and Addiction Services Division. The allocation of OMHAS and County General Funds to the providers and services selected through the RFPQ was done in such a way as to maximize resources and provide as broad an array of A&D services as possible. This allocation is evaluated annually based on the criteria in the RFPQ but primarily on the resources available.

Multnomah County
2007 – 2009 Implementation Plan
A&D Prevention

Overview

This A&D Prevention Implementation Plan describes how Multnomah County proposes to allocate OMHAS A/D 70 prevention funding for the 2007-09 Biennium. It updates the current *2005-07 Prevention Implementation Plan* and reflects planning for the County's *Coordinated Plan for Children, Families and Community (2002, revised 2004).* In addition, this plan incorporates related planning work including prevention and treatment procurements and the annual County budget allocation process.

The Multnomah County *Coordinated Plan for Children, Families & Community* (also called the "SB 555 Comprehensive Plan") identified priorities and strategies addressing three High Level Outcomes: Reducing Adult Substance Abuse, Reducing Youth Alcohol Use, and Reducing Youth Drug Use. Priorities and strategies listed in the plan spanned the continuum of treatment and prevention services. One of the two A&D logic models developed during Phase II of SB 555 planning (2002) was replaced (in 2004) with a new model describing the Housing Authority of Portland (HAP) collaborative prevention project partially funded by A/D 70 funds.

Multnomah County Planning Processes

Long-Range County system planning for mental health and addiction services is driven by procurement requirements. County-funded services must be procured every five years. A majority of A&D treatment service elements were procured in Winter 2004 in a joint procurement undertaken by Mental Health and Addiction Services (a division of the Department of County Human Services) and the Department of Community Justice. Procurement planning included a series of community meetings attended by clients, family members, community members, and treatment provider staff held in Fall 2003. Prevention system comments were also solicited during this input period. Results of this public input process were incorporated into the 2005-2007 Biennial Implementation Plan (BIP). Since this is a 5-year procurement cycle, the 2007-2009 BIP can be viewed as essentially a mid-course correction to the 2005-2007 plan.

The largest funding commitment in the A/D 70 prevention plan is to the Housing Authority of Portland (HAP) collaborative effort. This effort, managed by HAP, involves multiple funders and multiple planning processes, including competitive procurement through the City of Portland's Children's Investment Fund (CHIF). In administering the various planning and procurement processes involved, HAP updates and revises details of the program. For example, additional staffing has been provided in East County to serve increasing low income and minority populations there. Also, an office has been opened in New Columbia to serve low-income families moving into that large project. (The old Columbia Villa was the original site for this prevention project.)

The Multnomah County Commission on Children, Families and Community (CCFC) leads the state-mandated Coordinated Comprehensive Plan process (SB 555 plan). A major plan was developed in 2002, was updated in 2004, and will undergo a major rewrite in 2007-2008. For the 2004 minor update, a logic model of the collaboratively funded Prevention Services in Public Housing program coordinated by Housing Authority of Portland (HAP), which is partially funded by A/D 70 funds, replaced an A&D treatment logic model. This raises the collaborative HAP program to the status of a major Comprehensive Plan strategy. The CCFC also plans three "frameworks" that guide County social services: Early Childhood Framework, School-Aged

Services Policy Framework, and Poverty Elimination Framework. CCFC conducts needs assessment and resource inventory work to support these planning efforts, including community input, public comment, and focus groups including culturally specific focus groups. Results from these planning efforts also inform the BIP process.

The Portland-Multnomah Progress Board tracks local indicators and produces occasional "benchmark audits." They have produced several relevant audits in collaboration with the Commission on Children, Families, and Communities, including Educational Success (2000) and Children's Readiness to Learn (updated by CCFC in 2005).

Due to the difficulty in creating strong, consistent inter-jurisdictional coordination and planning of prevention interventions, a study is being undertaken during 2005-2007 by University of Oregon to summarize existing research findings about key characteristics and critical intervention points of an effective comprehensive prevention program for Multnomah County and conduct a comprehensive scan to determine which of the key characteristics and critical intervention points are currently implemented by government, education, non-profit, and community organizations in Multnomah County. The team will also inventory the relationships among programs and organizations and the tools and approaches in place for coordinating services and programs.

Workshops involving experts and service delivery staff from a range of organizations will review the findings and develop specific recommendations. This will allow the ongoing selection and implementation of strategies that coordinate most effectively and interact synergistically with prevention efforts throughout Multnomah County.

Community Action to Reduce Substance Abuse (CARSA) is expanding to include major business partners and draft a Portland Drug Strategy. A Methamphetamine Congress held in June 2005 developed law enforcement, treatment, and prevention recommendations and presented them to the area's elected officials. Prevention and treatment recommendations were comprehensive. They will inform future planning efforts.

Prevention Funding Inadequacy

The severe inadequacy of funding for prevention, including substance abuse prevention, is well known across community sectors. There is general agreement that supports for children and families and comprehensive health promotion are critically important for long-term community health. While there is consensus that substance abuse programs stand on three legs – prevention, treatment, and law enforcement - the prevention leg is nearly non-existent. However, federal, state, and local funding have not been balanced to adequately fund prevention. Law enforcement and treatment become over-emphasized in times of fiscal crisis and of drug emergencies such as the meth crisis. The obvious big pieces of prevention are not being funded at anything close to needed levels. Best-Practice prevention and comprehensive health curricula, which have been shown to be extremely effective over several decades of research and implementation, have not been implemented comprehensively throughout school districts, and are not routinely provided with good fidelity.

Major increases in prevention funding are needed. New, strong, focused, dedicated policy level leadership is required to advocate for increased prevention and upstream public health. This leadership would include major media efforts to foster prevention and upstream public health as a major component of the health care system.

Requirements and Goals

This Plan incorporates the following OMHAS requirements and major prevention goals:

OMHAS requirements

- Assume current A/D 70 funding level for planning purposes ($600,000 per biennium).
- Maintain alcohol and drug prevention services for minorities at the 2005-07 level.
- Support one (1.0) FTE Prevention Coordinator with A/D 70 funding.
- Prevention Coordinator must attend two OMHAS sponsored meetings using A/D 70 funding.
- Include priorities and strategies from the County's SB 555 Comprehensive Plan.
- Continue to maintain and/or support the ongoing development of community coalitions.
- Follow outcome-based and evidence-based funding approaches.

Major Multnomah County Prevention Goals

- Stabilize and/or strengthen existing prevention initiatives and collaborations. Continue intersystem collaboration and integration efforts.
- Incorporate best-practice approaches, including family-strengthening strategies/services across the continuum of prevention and treatment services.
- Increase access to services for very high risk and/or under-served populations.

Potential Additional OMHAS Prevention Funding

Multnomah County received a $100,000 competitive one-year Safe and Drug Free Schools Project Grant from OMHAS for FY 05-06.. This award funds Department of Community Justice best-practice family therapy utilizing Multi-Systemic Therapy and Multidimensional Treatment Foster Care. Proposals will be submitted to continuation funding of this project at current levels. Multnomah County also received $100,296 Enforcing Underage Drinking Laws (EUDL) funding for FY 05-06 to fund minor decoy operations and strategic media advocacy. Requests for continuation of this work will be submitted as directed, with ongoing funding levels estimated at $35,000 per year.

Fund Allocation

Multnomah County Mental Health and Addiction Services recommends supporting the following A/D 70 prevention program elements (details in narrative below):

- Maintain a full-time (1.0 FTE) A&D Prevention Coordinator plus $500 in travel funding.
- Maintain A&D prevention spending level to minority services by continuing support for two culturally specific community-based organizations and the Housing Authority of Portland youth services program, a long-term collaborative prevention initiative which serves a high proportion of people of color in public housing communities.
- Maintain technical assistance support for existing and new prevention community coalitions.
- Provide training opportunities for implementing evidence-based prevention programs.
- Fund an evidence-based prevention program to address gaps identified by a University of Oregon study.

County Plan Oversight—Prevention Coordinator

A/D 70 prevention funding will provide the personnel costs of a full-time A&D Prevention Coordinator and travel expenses to at least two DHS-sponsored prevention meetings per year.

The County Prevention Coordinator is responsible for development, monitoring, and oversight of the Biennial Prevention Funding Plan. The Prevention Coordinator is also responsible for providing prevention input for other planning and coordination efforts including the comprehensive (SB 555) plan and County budget allocation planning, collecting and entering

monthly Minimum Data Set (MDS) data from prevention providers, writing Prevention Annual Reports, and providing technical assistance to providers on prevention planning, grant writing, and MDS training. DHS Implementation Plan guidelines also specify that the County Prevention Coordinator attend up to two designated DHS meetings each year. In addition, the County is expected to "plan for and provide access to ongoing professional development training for prevention staff and providers." In the past, the County has created prevention workshops on engaging parents and community mobilization and sponsored staff and provider attendance to State prevention trainings and conferences. The County will continue to budget for sponsoring training opportunities and encourage providers and coalition members to obtain prevention expertise and certification.

One of the priorities for the Prevention Coordinator will be providing technical assistance to, and participation in, the substance abuse prevention coalition, Community Action to Reduce Substance Abuse (CARSA), which was formed as part of the ONDCP "Major Cities Initiative." This coalition is implementing a Drug-Free Communities grant, adding major business partners and writing a Portland Drug Strategy.

Other priorities are:

1) Monitoring and reporting outcomes for the County *Coordinated Plan for Children, Families and Community* and participating in the 2007-2008 major revision,
2) Preparing the County's response to the Statewide competitive prevention RFPs,
3) Preparing and participating in County procurements for new prevention and related programs,
4) Developing grant and other funding opportunities, and
5) Developing collaborative efforts to foster prevention and public health as priority issues.

Community Mobilization/Engagement

As indicated above, the Multnomah County Prevention Coordinator will continue to be a participant in the activities of the substance abuse prevention coalition, CARSA. Multnomah County staff also participated in the development of a new A&D trends index, the Portland Profile, modeled on the former Regional Drug Initiative *Drug Impact Index*. Staff will continue work on updating and improving the quality and utilization of this product.

A/D 70 funding will also continue to support culturally specific coalitions/community-based organizations at the current level. These are the Latino Youth Network and the TUNE - Teens Uniting for a New Era - project through Asian Family Center.

Prevention Services to Public Housing Communities

A long-term intersystem collaborative initiative between Multnomah County and the Housing Authority of Portland (HAP) will be continued. Despite the loss of Federal Drug Elimination (HUD) funding, Multnomah County has maintained Youth Prevention Services in collaboration with HAP and other funders. The program will continue to implement an after-school program offering after-school "clubs" and core services to youth and their families including school liaison services, individual tutoring and mentoring, and home visits. In addition, the program offers a "Reading Together" program and monthly alumni group. The "Reading Together" program is based on the best practice "Families and Schools Together" program (FAST) adapted to focus on the identified need of improving reading readiness. The comprehensive HAP program will be submitted in the next few months for OMHAS certification as an evidence-based program. The provider also plans an evaluation program sufficient to qualify the program for national recognition as a model program.

Attachments

A&D prevention programs, outputs, and outcomes are listed in Attachment 10. Subcontract information is provided in Attachment 1.

Multnomah County
2007 – 2009 Implementation Plan
Gambling Prevention and Treatment

The primary focus of Multnomah County's Problem Gambling and Prevention program is early identification, access to, and provision of, problem gambling treatment. The focus of this program, in the 2007-2009 biennium, is not expected to change.

Demand for problem gambling and treatment services during the FY 2004 - 2005 exceeded funded treatment levels. As a result of this performance level, Multnomah County Problem Gambling and Treatment program received a significant increase in treatment funds. As a direct result of this funding, gambling treatment and prevention services will be expanded. The expansion of the program is opportune, as current State Help Line data has shown that western Multnomah County and adjacent zip codes currently have the highest volume of calls to the Help Line. The future direction of the Problem Gambling and Treatment program could be dependent, in part, upon the viability of this expansion. Treatment enhancement funds will be used to support and expand the treatment services through added outreach and early intervention. Problem gambling research has shown that easy geographic access (treatment services located less than seven miles from home) increases treatment engagement.

If current providers are not able to expand as hoped, Multnomah County will go outside the current RFPQ to seek short-term providers to provide expanded outreach, early intervention and treatment services until the full system can be procured.

In FY 2006 - 2007, MHASD will enter into its next planning and procurement cycle for Multnomah County A&D programs. This program will be included in that cycle. This planning and procurement process will guide and focus the priorities and funding allocations for the 2007 – 2009 Biennium. The procurement process will be a Request for Provider Qualifications (RFPQ.) An RFPQ qualifies one or more eligible agencies to provide problem gambling treatment and prevention services for a five-year period beginning July 1, 2007. This process allows MHASD the ability to award and renew contracts annually, at the sole discretion of the County, pending continued satisfactory performance, continuing need, and the availability of funding.

Problem gambling treatment staff, from Multnomah County providers, participate in the State sponsored trainings as required. The State sponsored trainings and courses are statewide sources of the most current evidence based practices. The State sponsored training is also used by providers and their staff as a primary source in filling the mandated continuing education units (CEU).

Subcontractor funding allocations and treatment slots are adjusted annually based on their previous year's performance. Encounter data, provided by providers is used as the primary tool in making these provider allocation adjustments. It is not anticipated that there will be any significant changes in the percentages of funds allocated to our three current providers: Cascadia Behavioral Healthcare, Lifeworks NW, and Oregon Health Sciences Behavioral Health Clinic.

Multnomah County
2007 – 2009 Implementation Plan
Children's Mental Health Treatment

Description of actions taken to develop Intensive Community-based Services at a local level:

In order to ensure community involvement and support of its planned children's mental health system redesign, Multnomah County's MHASD held a community meeting to gather input from all interested System of Care stakeholders. The first community meeting was held on February 1, 2005. Dale Jarvis and MHASD staff facilitated the meeting and participants included representatives from DHS Child Welfare, Portland Public Schools, Centennial School District, Gresham Barlow School District, local community mental health providers and Early Childhood mental health providers. The consensus of those present was that it would be more beneficial and less disruptive to the system to make the proposed changes to the system in stages rather than in one large redesign effort. It was agreed that an initial System of Care for Children and Families: Children's Intensive Mental Health Treatment and Special Populations Services RFPQ would be released first as the need for its implementation was eminent and imperative. It was agreed that that effort would then be followed by a System of Care for Children and Families for Services for School-Aged Children RFPQ, and a System of Care for Children and Families RFP for Early Childhood Services. It was also agreed by those present that additional meetings would be beneficial and should be held in the very near future to gather input for the School-Aged and Early Childhood portions of the redesign. These further community meetings were held for stakeholders interested in mental health services for the School-aged population on March 29, 2005, April 13, 2005 and May 2, 2005. Community meetings were also held on March 30, 2005 and April 14, 2005 for stakeholders interested in mental health services for the Early Childhood population.

In March of 2005 The Multnomah County Department of County Human Services Mental Health Addiction Services Division released an RFPQ (Request for Programmatic Qualification) for the System of Care for Children and Families: Children's Intensive Mental Health Treatment and Special Populations Services. This RFPQ was a first step in the procurement of services designed to implement the plan to create a System of Care for Children and Families (SOCCF) sponsored by County Commissioner Lisa Naito.

On July 1, 2005 the System of Care for Children and Families: Services for School-Aged Children RFPQ, was released

System of Care Changes

The Multnomah County System of Care for Families and Children is currently entering the next phase of redesign with the goal of creating an integrated system to ensure that the provision of service occurs in a seamless, developmentally appropriate manner across the continuum of families, children, and youth who present with mental health needs. Contracts have been negotiated with those who qualified to provide services for Special population and School-aged services. Changes made to the service delivery system through these RFPQs should ensure that 1) there is provider ownership for the highest need families and their children and 2) services are streamlined, effective and delivered in a family friendly manner. High intensity family preservation teams (Family Care Coordination Teams) have been developed and are actively working to prevent unnecessary utilization of facility-based care.

Multnomah County Department of County Human Services, MHASD Intensive Community Based Services Design

Children's Intensive Mental Health Treatment Services and Special Populations Services are available to high risk, high need youth who have scored at a Level 4, 5 or 6 on the Child & Adolescent Service Intensity Inventory (CASII) and meet County criteria for "Intensive Community Based Treatment Services and Supports."

Multnomah County's MHASD Children's Intensive Mental Health Treatment Services and Special Populations Services consist of the following two categories and nine service areas and the following design changes are being implemented:

Description of Level of Need Determination Process and Protocol

Referrals for Intensive Community Based services for the children of Multnomah County will be received from several sources. These include, but are not limited to: families, mental health providers, private and public schools, child welfare, juvenile services, hospitals, and residential treatment centers. The level of need determination and protocol and policies are attached. (See attachments for detailed policies and procedures) In brief, a referent will call the intake line, a referral packet will be sent or faxed to be completed by referent w/ accompanying clinical documentation, a CASSI level of care will be completed by an FCC and depending on outcome will proceed w/ treatment planning from the ISA (Intensive Service Array) or provide alternate service options.

Category I: Intensive Mental Health Treatment Services

1. Psychiatric Residential Treatment Facility
2. Psychiatric Day Treatment Services

Category II: Special Populations Services

Part A: Intensive Family Search and Preservation Services and Treatment Foster Care

3. Intensive Family Search & Preservation Services
4. Treatment Foster Care

Part B: Intensive In-Home Family Services

5. Intensive In-Home Family Services (FAST) & Multisystemic Therapy (MST)

Part C: Individually Tailored Mental Health Outpatient Services including Behavioral Rehabilitation Services (BRS)

6. Individually Tailored Mental Health Services
7. Behavioral Rehabilitation Services

Part D: Crisis Respite

8. Foster Care Crisis Respite

Part E: Transition Aged Services for 17 to 21 year olds and Homeless Youth Outreach

Evidence Based Practices

MHASD expects that all children's mental health providers who provide service to Multnomah County residents will follow the State statute regarding evidence based practices (EBP). The

statute requires that, for the 2005-07 biennium, 25% of state funds be used to treat people with mental illness who use or have a propensity to use emergency mental health services. In the 2007-09 biennium, the percentage of funds to be spent on EBPs increases to 50% and in the biennium 2009-2011 to 75%.

Family and Stakeholder Involvement and Input in System of Care

Family and Stakeholders are fully represented in the following meetings to assure education, input, and problem solving regarding the development and utilization of mental health service options and to address system barriers.

C-4 (Community Care Coordination Committee) meets weekly to review cases and problem solve cases that have encountered system barriers. The meeting includes DHS, DCJ, OYA, MHO, Schools, family advocates, Oregon Advocacy Center and Juvenile Rights Project.

CMHSAC (Children's Mental Health System Advisory Council) meetings monthly to review system issues, provide instruction, act as a sounding board, and review Policies and Procedures for approval. Families are regular participants and now meet one week prior to the Council meeting to review agenda items and prioritize issues for review.

SIC (System Improvement Committee) formed to meet monthly to address system barriers and to increase the effective use of the C-4 meeting.

The Family Care Coordination Team ensures family involvement by arranging the Child and Family Team Meetings to develop individualized community based mental health services with the providers and other stakeholders.

Family Advocates also participate in the FCCT clinical reviews with the medical director and or clinical supervisor.

Wraparound Oregon

MHASD has also partnered with Portland State University (as researcher) and Albertina Kerr (as granting agency) to test the efficacy of Wraparound Milwaukie in Multnomah County. It is a parallel process to the System of Care for Children and Families Redesign. The pilot project will follow services for 25 clients using the Wraparound Milwaukie model. It also emphasizes community based mental health services.

Budget Concerns

The Medicaid Mental Health System for Children has been reduced by 20% over the past four years, the next service cut starting January 1, 2006. This will lead to a reduction of ongoing mental health treatment for at least 400 children who are Oregon Health Plan eligible. The State and Federal mandate requires that all Managed Care Organizations minimally provide a mental health assessment when requested and medically necessary mental health services. However, the prioritization process for who actually receives services is shifting so that children with significant mental health needs will receive the majority of services. While this runs contrary to the notion of early intervention as a means to prevent crisis down the road, the availability of funding will always dictate providing services to those most in need.

Multnomah County
2007 – 2009 Implementation Plan

Children's Mental Health Treatment
Description of Level of Need Determination Process and Protocol

Referrals for Intensive Community Based Services for the children of Multnomah County will be received from several sources. These include, but are not limited to, families, mental health providers, private and public schools, child welfare, juvenile services, hospitals, and residential treatment centers. The level of need determination and protocol and policies are listed below:

Initial Contact: Upon initial contact for request for level of care (LOC) determination the Family Care Coordinator will send out a referral packet to the requesting party.

1. Referring party must complete the Referral Information Form, obtaining and attaching supporting documentation requested on the form. Documentation required for the packet to be considered complete includes:

    a. Completed Referral Information Form

    b. A comprehensive Mental Health Assessment within the last 60 days that includes a 5-axis diagnosis with a psychiatrist's or psychologist's recommendation for residential level of care.

    c. A signature on an Authorization to Release of Information form attached to the Referral Information Form. A separate Authorization Form for each referring agency, community partner etc. is required. This signature must be from not only the parent/guardian, but from the child if 14 years of age or older.

2. Completed referral forms with the accompanying Authorizations can be mailed or delivered to: **Multnomah County MHASD**
   C/O FCCT TEAM
   421 SW OAK St., Suite 520
   Portland, Oregon 97204

   Or it can be faxed to 503-988-3328. It must be directed to the FCCT team.

3. Upon receipt of a completed referral packet, the Family Care Coordination Team representative will administer a CASII to determine the level of service that the child and family need within 3 working days.

4. Referral packets that are incomplete will not be processed. The FCCT team will contact the referring parties to clarify missing elements and assist them in the completion of the referral process.

5. For completed packets, and after the completion of the CASII the FCCT team will refer the client to the appropriate level of care and assist them in accessing these services including care coordination. If they are enrolled in Intensive treatment Services (ITS) they will have an FCC assigned to them.

6. Completed packets that are scored using the CASII and do not meet level of care criteria, the FCCT will send a "Notice of Action" and grievance and appeal process will be sent to the referring party and the parent or legal guardian on the day of the action informing them of the denial decision.

7. FCCT members will assist those not eligible for ISA services with appropriate referrals and help them access alternative services.

Care Determination:

1. If approved, care coordination will be assigned to a Family Care Coordinator (FCC).

2. FCC will assemble a single, separate and individualized clinical record for each client and family served. These records will meet all criteria listed in the medical records policy.

3. FCCT will identify members of the child and family team jointly with the family.

4. The FCC will write a letter to the family, educational representative and all other team members notifying them of the client's acceptance into ISA services.

5. FCC will write a note in the Raintree and/or progress note section of the client's clinical record confirming the admission.

6. FCC will explain to the client and their family, the nature and goals of the treatment program, and present them with copies of the FCCT program description and member's handbook.

7. The FCC will give a copy of the Notice of Privacy Practices to the parent or legal guardian, or minor over 14 years of age and have the person sign a receipt acknowledging receipt and understanding of the notice. The FCC will also fully inform the child in developmentally appropriate language of their rights and obtain informed consent from the child's parent(s) or guardian, and client themselves when appropriate, about the proposed care. FCC will document in the child's clinical record that the following information has been reviewed, discussed and agreed to by the participants:
    a. Active treatment and other interventions to be undertaken;
    b. Alternative treatment s or interventions available, if any;
    c. Projected time to complete the treatment process;
    d. Indicators by which progress will be measured;
    e. Benefits which can reasonably be expected;
    f. Risks of treatment, if any;
    g. Prognosis for treatment; and
    h. Discharge plans.

8. FCC will obtain appropriate authorizations from the legal guardian, parent or youth over 14, to obtain and exchange information with team members and other community agencies or stakeholders involved with the client.

9. FCC will convene a child and family team meeting and develop an initial service coordination plan, including any necessary crisis prevention and intervention planning, no later than 14 calendar days from the date the client is accepted into ISA services. FCC

will insure that the meeting occurs when both the family and educational representative can be present in person.

10. The FCC will develop a Plan of Care (POC) that clinically supports the level of care to be provided and is developed and implemented no later than 14 treatment days after admission by an interdisciplinary team in consultation with the child, the parent(s), or guardian and the provider to which the child will be assigned for services. The FCC will insure that the meeting occurs when both the family and educational representative can be present in person.

Multnomah County
2005 – 2007 Implementation Plan
Older Adult Mental Health Treatment

According to SAMHSA's article, ***Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities,*** "mental disorders are not a normal part of aging, yet a significant number of older adults have these serious but treatable diseases. Currently, 35 million people age 65 and older reside in the United States, of which 7 million (20 percent) have a psychiatric illness (Jeste et al., 1999; U.S. Census Bureau, 2000). This number is expected to double to 15 million over the coming three decades (Jeste et al., 1999).

Projections of a rapid growth in the number of older adults with psychiatric disorders over the coming decades are largely due to the maturation of the "baby boomer" cohort, which has 76 million members. The first group of this cohort will reach age 65 in 2011. Greater longevity associated with improved health care and other social factors also will add to the anticipated population of older adults with mental disorders."

MHASD is aware that its primary population of adults who have serious mental health and addiction issues is aging. The Governor and Oregon Sate Legislature created SB781which establishes that county mental health and developmental disability programs, subject to the availability of funds, include preventive mental health services and early identification of problems for older adults. Below are Multnomah County demographics from the 2000 Census.

General Multnomah County Population:

▪ Total County Population	660,486	100.0 %
▪ Persons Age 60+	94,567	14.3% of County
▪ Persons Age 65+	73,607	11.1% of County
▪ Persons Age 16 –64 with disability	78,831	11.9% of County
▪ Persons, 16-64 w/disability& unemployed	29,583	4.5% of County

County Age Groups:

- Ages 60 – 74	55,469	**16% *decrease*** (10,740 people, 1990 – 2000)
- Ages 75 - 84	28,320	**5% *increase*** (1,052 people, 1990 – 2000)
- Ages 85+	10,778	**18% *increase*** (1,649 people, 1990 – 2000)

MHASD currently provides services for all of its consumers aged 18 and older in our outpatient provider agencies. Our current and future planning will take into account that the number of aging adults with mental illness and addiction issues will continue to grow.

MHASD contributes all of our Service Element 35 money to the MDT (multi-disciplinary team) team, which is a program at Cascadia designed specifically for "older" adults. Those monies are passed directly down to that program. Mental health services for older and disabled adults are delivered as part of this multi-disciplinary team that includes aging and disability staff and sub-contractors. This service provides 5 treatment slots that are specifically used for approximately 600 older and disabled adults whose services are coordinated by the multi-disciplinary team and include consultation, assessment, and case management.

Office of Mental Health and Addiction Services

County Contact Information Form

1. County Contact Information

County: Multnomah

Address: 421 SW Oak St., Suite 520

City, State, Zip: Portland, Oregon 97204

Name and title of person(s) authorized to represent the County in any negotiations and sign any Agreement:

Name Rex Surface Title DCHS Interim Director

Name _____ Title _____

2. Addiction Treatment Services Contact Information

Name Ray Hudson

Agency Multnomah County Mental Health and Addiction Services Division

Address 421 SW Oak St. Suite 520

City, State, Zip Portland, OR, 97204

Phone Number 503-988-5018 Fax 503-988-5870

E-mail Ray.Hudson@co.multnomah.or.us

3. Prevention Services Contact Information

Name Larry Langdon

Agency Multnomah County Mental Health and Addiction Services Division

Address 421 SW Oak St. Suite 520

City, State, Zip Portland, OR, 97204

Phone Number 503-988-5464 Fax 503-988-5870

E-mail Larry.Langdon@co.multnomah.or.us

4. Mental Health Services Contact Information

Name Nancy Winters

Agency Multnomah County Mental Health and Addiction Services Division

Address 421 SW Oak St. Suite 520

City, State, Zip Portland, OR, 97204

Phone Number 503-988-4055 Fax 503-988-5870

E-mail nancy.winters@co.multnomah.or.us

5. Gambling Treatment Prevention Services Contact Information

Name John Pearson

Agency Multnomah County Mental Health and Addiction Services Division

Address 421 SW Oak St. Suite 520

City, State, Zip Portland, OR, 97204

Phone Number 503-988-5464 Fax 503-988-5870

E-mail john.f.pearson@co.multnomah.or.us

6. State Hospital/Community Co-Management Plan Contact Information

Name Sandy Haffey

Agency Multnomah County Mental Health and Addiction Services Division

Address 421 SW Oak St. Suite 520

City, State, Zip Portland, OR, 97204

Phone Number 503-988-5464 Fax 503-988-5870

E-mail sandy.j.haffey@co.multnomah.or.us

Office of Mental Health and Addiction Services – Attachment 1
Mental Health page 1 of 2

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your treatment provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Lifeworks NW	24221	MHS20	800,000	
Cascadia Behavioral	23776	MHS 20	700,000	
Morrison Center Child & Family	23755	MHS 22	100,000	Youth
Trillium Family	23742	MHS 22	100,000	Youth
Cascadia Behavioral	23776	MHS 22	50,000	Youth
Lifeworks NW	24221	MHS 22	100,000	Youth
Albertina Kerr	23746	MHS 22	50,000	Youth
Providence Health	43996	MHS 24	500,000	
Portland Adventist	24084	MHS 24	1,600,000	
Legacy Emanuel Hospital	12226	MHS 24	400,000	
Legacy Good Samaritan	40420	MHS 24	600,000	
University Hospital	12072	MHS 24	250,000	

Office of Mental Health and Addiction Services – Attachment 1
Mental Health page 2 of 2

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your treatment provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Trillium Family	23742	MHS 25	2,800,000	Mobile crisis has a culturally specific team for outreach to minorities.
Cascadia Behavioral	23776	MHS 25	600,000	
Cascadia Behavioral	23776	MHS 30	500,000	
Providence Medical	12241	MHS 30	250,000	
Comprehensive Options	10569	MHS 30	100,000	
Cascadia Behavioral	23776	MHS 38	130,000	
Cascadia Behavioral	23776	MHS 39	410,000	

Office of Mental Health and Addiction Services – Attachment 1 – A/D 60-62

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Cascadia (ASAP)	90770054	A/D 60	89,538	Women
Central City Concern	93-0728816	A/D 60	89,538	Women
Central City Concern	93-0728816	A/D 60	352,176	NA
Comprehensive Options for Drug Abusers	93-0716860	A/D 60	232,484	Women
Lifeworks	93-0502822--	A/D 60	114,612	Women
Morrison Center	93-0354176	A/D 60	240,000	Youth
Biennial Total 07-09			1,118,348	
Central City Concern	93-0728816	A/D 61	1,168,000	Women
Central City Concern	93-0728816	A/D 61	175,200	NA
Comprehensive Options for Drug Abusers	93-0716860	A/D 61	1,927,200	NA
Comprehensive Options for Drug Abusers	93-0716860	A/D 61	408,800	Women
DePaul Treatment Centers	93-0706892	A/D 61	934,400	Minority
DePaul Treatment Centers	93-0706892	A/D 61	2,044,000	NA
Lifeworks	93-0502822	A/D 61	1,343,200	Women/Minority
Lifeworks	93-0502822	A/D 61	116,800	NA
To be determined	NA	A/D 61	2	
Biennial Total 07-09			8,117,602	
Central City Concern	93-0728816	A/D 62	350,400	NA
Comprehensive Options for Drug Abusers	93-0716860	A/D 62	109,500	NA
Lifeworks	93-0502882	A/D 62	21,900	NA
Biennial Total 07-09			481,800	

Office of Mental Health and Addiction Services – Attachment 1 – A/D 66

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Cascadia Behavioral Health	97-0770054	A-D 66	782,856	NA
Central City Concern	93-0728816	A-D 66	111,807	Women
Central City Concern	93-0728816	A-D 66	2,810,821	NA
Changepoint	93-1229222	A-D 66	381,996	NA
Changepoint	93-1229222	A-D 66	200,838	Minority
Changepoint	93-1229222	A-D 66	53,662	Youth
Comprehensive Options for Drug Abusers	93-0716860	A-D 66	749,094	NA
DePaul Treatment Centers	93-0706892	A-D 66	37,728	NA
DePaul Treatment Centers	93-1229222	A-D 66	68,994	Youth
DePaul Treatment Centers	93-1229222	A-D 66	70,740	Minority
NTN/Allied Health Belmont	20-2081662	A-D 66	323,666	NA
InAct	51-0145008	A-D 66	28,296	NA
Lifeworks	93-0502822	A-D 66	235,800	Minority
Lifeworks	93-0502822	A-D 66	1,054,982	Youth
Lifeworks	93-0502822	A-D 66	165,060	NA
OHSU	93-1176109	A-D 66	117,900	NA
Multnomah County Department of County Human Services	93-0712083	A-D 66	8,642	NA
Multnomah County Department of Community Justice	93-0706892	A-D 66	423,894	NA
To be Determined	NA	A-D 66	884	NA
Biennial Total 07-09			7,627,620	

Office of Mental Health and Addiction Services – Attachment 1 – A/D 67-80

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Central City Concern	93-0728816	A-D 67	292,000	Women
Central City Concern	93-0728816	A-D 67	43,800	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 67	481,800	NA
Comprehensive Options for Drug Abusers	93-0716860	A-D 67	102,200	Women
DePaul Treatment Centers	93-0706892	A-D 67	233,600	Minority
DePaul Treatment Centers	93-0706892	A-D 67	511,000	NA
Lifeworks	93-0502822	A-D 67	335,800	Women/Minority
Lifeworks	93-0502822	A-D 67	29,200	NA
Lifeworks	93-0502822	A-D 67	109,500	Youth
Biennial Total 07-09			2,138,900	
Housing Authority of Portland	93-6001547	A-D 70	347,798	Youth
IRCO-Asian Family Center	93-0806295	A-D 70	20,360	Youth
Latino Network	73-1675402	A-D 70	20,360	Youth
To be Determined	NA	A-D 70	22,482	Youth
Biennial Total 07-09			411,000	
Lifeworks	93,0502822	A-D 71	302,950	Youth
Biennial total 07-09			302,950	
Lifeworks	93-0502822	A-D 80	62,134	NA
OHSU Behavioral Health Clinic	93-1176109	A-D 80	9,574	NA
To be determined	93-1229222	A-D 80	34,292	NA
Biennial Total 07-09			106,000	

Office of Mental Health and Addiction Services – Attachment 1 – A/D 81-83

LIST OF SUBCONTRACTED SERVICES FOR MULTNOMAH COUNTY

For each service element, please list all of your provider subcontracts on this form. In the far right column indicate if the provider delivers services specific to minorities, women, or youth.

Provider Name	Approval/License ID Number	Service Element	OMHAS Funds in Subcontract	Specialty Service
Cascadia Behavioral Healthcare	97-0770054	A-D 81	1,323,866	NA
Lifeworks	93-0502822	A-D 81	24,000	NA
OHSU Behavioral Health Clinic	93-1176109	A-D 81	188,000	NA
To be Determined	NA	A-D 81	20,134	NA
Biennial Total 07-09			1,556,000	
Cascadia Behavioral Healthcare	97-0770054	A-D 83	60,000	NA
Direct Pay/Printing Vendors	To be Determined	A-D 83	6,000	NA
Biennial Total 07-09			66,000	
Total Biennial Total A&D			21,926,220	

State Mental Health Subcontract Funding	
A&D 60 Special Projects	1,118,348
A&D 61 Adult Residential	8,117,602
A&D 62 Housing for Dependent Children	481,800
A&D 66 Continuum of Care	7,627,620
A&D 67 A&D Residential Capacity	2,138,900
A&D 70 Prevention	411,000
A&D 71 Youth Residential	302,950
A&D 80 Problem Gambling Prevention	106,000
A&D 81 Outpatient Problem Gambling Treatment	1,556,000
A&D 83 Problem Gambling Treatment Enhancement	66,000
Grand Total	$21,926,220

Office of Mental Health and Addiction Services – Attachment 2

BOARD OF COUNTY COMMISSIONERS REVIEW AND APPROVAL

County: Multnomah

In accordance with ORS 430.258 and 430.630, the Board of County Commissioners has reviewed and approved the mental health and addiction services County Biennial Implementation Plan for 2007-2009. Any comments are attached.

Name of Chair: Diane Linn

Address: _____

_____

Telephone Number: _____

Signature: _____

Office of Mental Health and Addiction Services – Attachment 3

LOCAL ALCOHOL AND DRUG PLANNING COMMITTEE
REVIEW AND COMMENTS

County: Multnomah

Type in or attach list of committee members including addresses and telephone numbers. Use an asterisk (*) next to the name to designate members who are minorities (ethnics of color according to the U.S. Bureau of Census).

Adult Mental Health and Substance Abuse Advisory Committee performs this function for MHASD.

In accordance with ORS 430.342, the Multnomah County LADPC recommends the state funding of alcohol and drug treatment services as described in the 2007-2009 County Implementation Plan. Further LADPC comments and recommendations are attached.

Name of Chair: _____

Address: _____

_____

Telephone Number: _____

Signature: _____

LOCAL MENTAL HEALTH ADVISORY COMMITTEE REVIEW AND COMMENTS

County: Multnomah

Type in or attach a list of committee members, including addresses and telephone numbers.

The Multnomah County Local Mental Health Advisory Committee, established in accordance with ORS 430.630(7), recommends acceptance of the 2007-2009 Biennial County Implementation Plan. Further comments and recommendations of the Committee are attached.

Name of Chair: Patricia Backlar

Address: Portland State University, POB 751, Portland, OR 97207

Telephone Number: 503-725-3499

Signature: Patricia Backlar 1 March 2006

AMHSA Membership Roster

Members (Office)	Position Number - MH or A&D, Category, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
ANDERSON, ELISE	E.3. – MH Housing Authority of Portland 11-2004	elisea@hapdx.org	Housing Authority/Ptld 135 SW Ash St. Portland, OR 97204	802-8574
BACKLAR, TRISH	B.1. – MH Parent/Advocate 11-2004	backlarp@pdx.edu	PSU-Philosophy Dept. POB 751 Portland, OR 97207	725-3499
BARBISAN, KYLE			5077 SW Evelyn St. Portland, OR 97219	
BORDERS, GREG	C.7. – MH Crisis Response System	gregb@cascadiabhc.org	Cascadia Behavioral HealthCare 2130 SW 5th Avenue, #210 Portland, OR 97201	238-0769
BOTSFORD, PATRICE	G.1. - DDSD Developmental Disabilities Services Division (ongoing term)	patrice.a.botsford@co.multnomah.or.us	Multnomah County Developmental Disabilities Division 421 SW Oak., Ste. 600 Portland OR 97204	988-3272
BROOKS, MALIK	Consumer 10-2007	putitinyamouth69@yahoo.com	2415 SE 43rd Ave. Portland OR 97206	232-8503
BUCKLEY, MARY CLAIRE	E.4. - MH PSRB 11-2004	mcb@oregonvos.net	PSRB 620 SW 5th, #907 Portland, OR 97204	229-5596

Members (Office)	Position Number - MH or A&D, Category, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
BURROW, GAYLE		gayle.f.burrow@co.multnomah.or.us	Corrections Health 1120 SW 3rd Ave Portland, OR 97204-2828	988-3720
CHILD, BECKIE	Consumer 10-2007	beckie@quik.com	333 NW 4th Ave. #227 Portland OR 97209	227-8496
COSGROVE, PAT	C.5. – Acute Care Service Agency	cosgropi@ah.org	10123 SE Market St. Portland, OR 97204	251-6266 x4109
DIAMATA, DONITA		donita@cascadiabhc.org	Cascadia Behavioral HealthCare 2130 SW 5th Avenue, #210 Portland, OR 97201	
FITTS, KEVIN	A.1. - MH Consumer 09-2005	limbicsystems@yahoo.com	2330 NE Everett Portland, OR 97232	235-0794
FORD, LESLIE	C.1. - MH Outpatient Service Agency 12-2004	leslie@cascadiabhc.org	Cascadia Behavioral HealthCare 2130 SW 5th Avenue, #210 Portland, OR 97201	238-0769 x12
FORTNER, ROSS	A.3. - MH Consumer 11-2004	fortner_ross@hotmail.com or fortner_ross@msn.com	Fortner Recruiting Services 1419 SE 17th Ave. Portland, OR 97214	234-6302
GODSCHALX, SUSAN		susan.m.godschalx@co.multnomah.or.us	Health Dept. 426 SW Stark St 8th fl. Portland, OR 97204-2347	988-3663 x22661
GRANT, HUGH	A.4. – A&D Consumer 11-2004	ishipishi@ipns.com	16590 SE 84th Milwaukie, OR 97267	655-5822

Members (Office)	Position Number - MH or A&D, Category, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
GREEN, DAVID	Consumer 10-2007	none yet	510 SW 76th Ave. #8 Portland OR 97206	771-5535
HOLMES, JOHN	B.2. – MH Parents/Advocates 11-2004	jholmes@nami.org	NAMI 524 NE 52nd Ave. Portland OR 97213	228-5692
HURLBERT, JENNIFER	Consumer 10-2007	hurlbert@coho.net	17376 NE Couch #102 Portland OR 97230	254-6287
LEEB, ROBERT		robert@leebarc.com		228-2840 (w) 246-1798 (h)
MCCULLOUGH, KATHY	E.2. – MH Sheriff's Office 11-2004	kathleen.mccullough@mcso.us	Mult Co Sheriff Office 14540 NE Inverness Drive Portland OR 97220	988-5230
MERCER, JACKIE	C.8. – A&D Structured Residential Services 11-2004	narajam@aol.com	NARA NW 1776 SW Madison Portland OR 97205	224-1044 x227
MORPHIS, ESSIE	Consumer		5025 NE 8th Ave. #23 Portland OR 97211	282-0823
POTTER, PAUL	C.4. – A&D Outpatient Service Agency (PAADMA) 4-2003	paul@cascadiabhc.org	Cascadia Behavioral HealthCare PO Box 8459 Portland, OR 97207	238-0769 x132 963-7756 (direct)

Members (Office)	Position Number - MH or A&D, Category, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
ROBERTSON, JEANNE		jeanneliz711@att.net	3914 NE Laurelhurst Portland OR 97232	232-3441
ROMPREY, DAVID	Consumer 10-2007	davidromprey@aol.com	826 N. Emerson Portland OR 97217	930-5710
SHATOKIN, JOHN	Consumer		6423 SE 73rd Portland OR 97206	771-5480
STRONG, JACKIE	C.3. – A&D Outpatient Service Agency (PAADMA) 11-2006	jackies@lifeworksnw.org	LifeWorks 14600 NW Cornell Rd. Portland OR 97229	617-3826
SURFACE, REX	G.1. - DDSD Developmental Disabilities Services Division (ongoing term)	rex.b.surface@co.multnomah.or.us	Senior Manager Multnomah County Developmental Disabilities Division 421 SW Oak., Ste. 600 Portland OR 97204	988-3272 x26353
TRAN, TAN AM	Consumer 10-2007	taman_kinh@yahoo.com	7339 N. Willamette Blvd. Portland OR 97203	866-7974 285-8897 (cell)
TREB, KATHLEEN	E.6. – A&D Community Justice	kathleen.a.treb@co.multnomah.or.us	Multnomah County Dept. of Community Justice 2nd Floor 501 SE Hawthorne Portland, OR 97214-7214	988-6131
WAITE, SUE	H.1. – ADSD Aging and Disabilities Services Div. 11-2004	rorysuewaite@msn.com	6304 SE 41st Ave. Portland OR 97202	774-6260

Members (Office)	Position Number - MH or A&D, Category, Term Exp. Date	Email Address	Mailing Address	Phone (area code 503 unless noted)
WARE, PAUL	E.1. – MH Portland Police 11-2004	cit@police.ci.portland.or.us	CIT Coordinator Portland Police Bureau 1111 SW 2nd Ave. #1552 Portland OR 97204	823-0183
YOUNG, ADRIENNE	Consumer 10-2007	ayoung@chooseempowerment.com	4370 NE Halsey #223 Portland OR 97213	249-1413
YOUNG, CAROL		cyoung2005@msn.com	4175 SW Crestwood Drive Portland OR 97045	297-5234

Please update as necessary. Thanks!

Children's Mental Health System Advisory Council (CMHSAC)
Member Roster
March 2006

Name	Representing	Address	Phone Number	Email Address
Abrams, Rob	State Department of Human Services	2446 SE Ladd Ave. Portland OR 97214	503-872-5588	rob.abrams@state.or.us
Botsford, Patrice	Developmental Disabilities			
Boring, Kathy	Families	6612 SE 89th Ave. Portland OR 97266	503-771-7872	katbportland@netzero.net
Boyer, Stephanie	Families	6522 SE 66th Ave. Portland, OR 97206	503-777-2421	sboyer@orclinic.com
Camarena, Angie	Families	NAMI 524 NE 52nd Ave. Portland OR 97213	503-228-5692	acamarena@qwest.net
Checkley, Sherry	Families	2328 SW Dolph Ct. Portland OR 97219		
Hansen, Debbie	Oregon Youth Authority	123 NE 3rd Suite 105 Portland OR 97232	503-731-4971 x233	debbie.hansen@oya.state.or.us
Henderson, Jimi	Families	5249 NE 45th Place Portland OR 97218	503-249-8265	jimihsr@hotmail.com
Hill, Cris	Families	12224 SE Carlton St. Portland OR 97236	503-760-1889	robyoo2000@comcast.net

Name	Representing	Address	Phone Number	Email Address
Hoffer, Vern	PPS	BESC Special Education Dept. 501 N. Dixon Portland OR 97227	503-916-2000	vhoffer@pps.k12.or.us
Holmes, John	National Alliance for the Mentally Ill-Multnomah	524 NE 52nd Ave. Portland OR 97213	503-228-5692	jholmes@nami.org
Johnson, Joan	Families	514 NE Stanton St. #1 Portland OR 97227	503-286-1157	joan1561@aol.com
Johnson, Mary Lou	East County School Districts	Centennial School Dist. 18135 SE Brooklyn Portland OR 97236	503-760-7990	marylou_johnson@centennial.k12.or.us
Kibble, Rachel	Families	NAMI 524 NE 52nd Ave. Portland OR 97213	503-228-5692	rkibble@qwest.net
Linfoot, Ally	Families			Ally.Linfoot@morrisonkids.org
May-Watson, Samantha	Families	17524 SE Pine St. #B1 Portland OR 97233	503-253-3024	
McKechnie, Mark	Juvenile Rights Project	123 NE 3rd Ste. 310 Portland, OR 97232	503-232-2540	mark@jrplaw.org
Sauer, Rick	Families	7331 SE 113th Portland OR 97266	503-957-4298 (c)	ricksauer@virco.com
Scott, Wayne	Juvenile Justice	1401 NE 68th Ave Portland, OR 97213	503-988-6904 x86904	wayne.scott@co.multnomah.or.us

Name	Representing	Address	Phone Number	Email Address
Surface, Rex	Developmental Disabilities	Multnomah County Developmental Disabilities Division 421 SW Oak St., Ste. 610 Portland OR 97204	503-988-3658 x26353	rex.b.surface@co.multnomah.or.us
Torres, Ivon	Families	12243-B SE Harold St. Portland OR 97236	503-309-1379	ivonne503@yahoo.com
Wallick, Elaine	State Department of Human Services	2446 SE Ladd Ave. Portland OR 97214	503-872-5588	elaine.e.wallick@state.or.us
Wells, Diane	Families	570 NW Birdsdale Ave. Gresham OR 97030	503-665-2197	dwells@trilliumfamily.org
Yedzmiak, Jay	FamilyCare, Inc.	2121 SW Broadway Ste. 300 Portland OR 97201	503-471-2116	jayy@familycareinc.org

Office of Mental Health and Addiction Services – Attachment 4

LOCAL MENTAL HEALTH ADVISORY COMMITTEE REVIEW AND COMMENTS

County: Multnomah

Committee: Children's Mental Health System Advisory Council (CMHSAC)

Type in or attach a list of committee members, including addresses and telephone numbers.

See attached.

The Multnomah County Local Mental Health Advisory Committee, established in accordance with ORS 430.630(7), recommends acceptance of the 2007-2009 Biennial County Implementation Plan. Further comments and recommendations of the Committee are attached.

Name of Chair: Stephanie Boyer

Address: c/o Multnomah County MHASD

421 SW Oak St., Suite 520

Portland OR 97204

Telephone Number: 503-777-2421 (home)

Signature: Stephanie C. Boyer

Comments from Children's Mental Health System Advisory Council (CMHSAC):

Clarification is requested regarding the details of the "Transition Age Youth" services. The Biennial Plan should define this set of services and who is eligible to receive them. For youth within this age group (18-21) who are not eligible for this level of care, it should be explained what other services are available to them and how those with less acute/chronic mental health needs access appropriate treatment and support (for example, through the adult system).

Office of Mental Health and Addiction Services - Attachment 5

COMMISSION ON CHILDREN & FAMILIES REVIEW & COMMENTS

County: Multnomah

The Multnomah County Commission on Children & Families has reviewed the alcohol and drug abuse prevention and treatment portions of the county's Biennial Implementation Plan for 2007-2009. Any comments are attached.

Name of Chair: Wendy Lebow

Address: 421 SW Oak St. Suite 200

Portland, Oregon 97204

Telephone Number: 503-988-6981

Signature: Wendy Lebow

Office of Mental Health and Addiction Services – Attachment 6

COUNTY FUNDS MAINTENANCE OF EFFORT ASSURANCE

County: Multnomah

As required by ORS 430.359(4), I certify that the amount of county funds allocated to alcohol and drug treatment and rehabilitation programs for 2005-2007 is not lower than the amount of county funds expended during 2003-2005.

Nancy Winters, LPC
Name of County Mental Health Program Director

Nancy Winters
Signature

3/20/06
Date

Office of Mental Health and Addiction Services – Attachment 7

PLANNED EXPENDITURES OF MATCHING FUNDS (ORS 430.380) AND CARRYOVER FUNDS

County: Multnomah

Contact Person: Keith Mitchell

Matching Funds

Source of Funds	Amounts	Program Area

Carryover Funds

OMHAS Mental Health Funds Carryover Amount from 2003-2005	Planned Expenditure	Service Element
$1,028,264.	Walk in Clinic & Empowerment Initiatives	MHS20
$188,090.	Severely Mentally Ill Special populations	MHS 22
$509,509.	Involuntary Commitment Program, Emergency holds	MHS 24
$1,932,100.	Crisis Call Center	MHS 25
$12,035.	Supported Employment	MHS 38
$3,744.	PSRB	MHS 30
$12,100.	Older Disabled Adult MH Services	MHS 35

OMHAS Alcohol & Drug Funds Carryover Amount from 2003-2005	Planned Expenditure	Service Element
$20.24	A&D Residential	A&D 61
$47,744	A&D Continuum of Care	A&D 66
$209	A&D Prevention	A&D 70
$1	A&D Youth Residential Treatment	A&D 71

Effective 6/30/05, carryover amounts confirmed as of 03/05 settlement report.

Office of Mental Health and Addiction Services – Attachment 8

REVIEW AND COMMENTS BY THE LOCAL SERVICE DELIVERY AREA MANAGER FOR THE DEPARTMENT OF HUMAN SERVICES

County: Multnomah

As Service Delivery Area Manager for the Department of Human Services, I have reviewed the 2007-2009 Biennial County Implementation Plan and have recorded my recommendations and comments below or on at attached document.

Name of SDA Manager: Jerry Burns

Signature: Jerry Burns

Date: 3/23/06

Office of Mental Health and Addiction Services – Attachment 9

REVIEW AND COMMENTS BY THE LOCAL PUBLIC SAFETY COORDINATING COUNCIL

County: Multnomah

The Local Public Safety Coordinating Council has reviewed the 2007-2009 Biennial County Implementation Plan. Comments and recommendations are recorded below or are provided on an attached document.

Name of Chair: Commissioner Lisa Naito

Address: 501 SE Hawthorne, Room 600
Portland, OR 97214

Telephone Number: 503 988-5217

Signature: Lisa Naito

Date: 3/22/06

Office of Mental Health and Addiction Services – Attachment 10
2007-2009 County Biennial Implementation Plan

PREVENTION STRATEGY SHEET

County Multnomah County, Prevention Coordinator: Larry Langdon

Using the grid below, list all the proposed programs for which the County is requesting funding. Include all the Program Outcomes (process objectives) and Intermediate-Level Outcomes (educational, attitudinal & behavioral objectives) for each of the proposed programs. All outputs and outcomes must be measurable.

Proposed Programs	**Proposed Outputs**	**Proposed Outcomes**
County Prevention Plan Oversight (1.0 FTE Prevention Coordinator)	Provide technical assistance on prevention work plan development, grant opportunities, Minimum Data Set training and reporting, and provider annual reports.	(Process only) Prevention work plans, County prevention annual report completed. MDS reports and annual report submitted to OMHAS. Proposal(s) submitted to OMHAS for Statewide competitive prevention grant.
Community Mobilization/Coalition Support (1.0 FTE Prevention Coordinator)	Provide technical assistance to A&D prevention coalition (CARSA) and Drug-Free Communities Grant implementation. Provide A&D prevention technical assistance to other community coalitions. Process objectives: technical assistance provided (at meetings).	# Community partners' grants received # Prevention materials produced # Prevention programs sponsored by community partners
County Prevention Program Planning & Development (1.0 FTE Prevention Coordinator)	Prevention procurement planning. Prevention implementation planning. Revise/update Comprehensive (SB555) Plan Monitor and report as required on Prevention High Level Outcomes; revise and report on County "SB 555" prevention logic models as needed.	Procure, contract prevention programs. Develop and update 2009-11 Prevention Implementation Plan as required by OMHAS. Report outcomes, revise prevention portion of County Coordinated Plan as required by SB 555 timelines.

Latino Youth Network (Outputs are per year)	Recruit on-going participation of 15 youth. Hold at least 6 meetings throughout calendar year. Implement at least two projects as determined by prior annual retreat. Participate in at least 3 additional community events. Participate in a leadership development program. Hold planning retreat – develop next year activity plan.	Leaders do under 50% of event coordination effort. 80% of youth feel they have increased their leadership skills and feel more empowered.
TUNE Asian Youth Program (Outputs are per year)	Recruit on-going participation of 12 youth. Hold at least 6 meetings throughout calendar year. Implement at least two projects as determined by prior annual retreat. Participate in at least 3 additional community events. Hold a planning event to develop an activity plan for the next year.	Leaders do under 75% of event coordination effort in year 1, under 50% in year 2. 80% of youth feel they have increased their leadership skills and feel more empowered.
Prevention Services to Public Housing Communities (Outputs are per year for entire program, funded by AD-70, Children's Investment Fund, and Housing Authority of Portland.)	Serve 400 unduplicated youth. Provide 500 After School Club sessions. Identify & engage 60 youth & their families in core group services, including school liaison, individual tutoring and mentoring, as identified through individual family goals. Provide 225 home visits with core group. Provide six 6-session "Reading Together" groups.	75% of Core Group show increased academic achievement and 75% demonstrate decreased behavioral problems. 50% of middle school children in after school clubs participate in community service projects. 75% of families will report reading together regularly 6 months after "Reading Together" program completion.
New Evidence-Based Prevention Program – As determined by U of O work during 05-07 and procured in 06-07	As determined during program development phase and finalized during procurement	As determined by procurement.

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

Board Clerk Use Only	
Meeting Date:	04/18/06
Agenda Item #:	E-1
Est. Start Time:	10:10 AM
Date Submitted:	04/12/06

BUDGET MODIFICATION: -

Agenda Title: **Executive Session Pursuant to ORS 192.660(2)(h)**

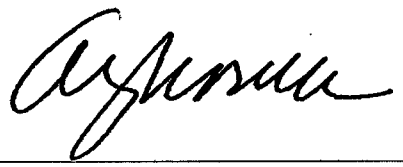
Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title.

Date Requested:	April 18, 2006	**Time Requested:**	15-30 mins
Department:	**Non-Departmental**	**Division:**	County Attorney
Contact(s):	Agnes Sowle		
Phone:	503 988-3138 **Ext.** 83138	**I/O Address:**	503/500
Presenter(s):	Agnes Sowle and Invited Others		

General Information

1. **What action are you requesting from the Board?**
   No Final Decision will be made in the Executive Session.
2. **Please provide sufficient background information for the Board and the public to understand this issue.**
   Only Representatives of the News Media and Designated Staff are allowed to Attend. Representatives of the News Media and All Other Attendees are Specifically Directed Not to Disclose Information that is the Subject of the Executive Session.
3. **Explain the fiscal impact (current year and ongoing).**
4. **Explain any legal and/or policy issues involved.**
   ORS 192.660(2)(h).
5. **Explain any citizen and/or other government participation that has or will take place.**

Required Signatures

Department/ Agency Director:  **Date:** 04/12/06

Budget Analyst: _____ **Date:** _____

Department HR: _____ **Date:** _____

Countywide HR: _____ **Date:** _____