ANNOTATED MINUTES

Tuesday, May 15, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFING

Interim-Chair Bill Farver convened the meeting at 9:36 a.m., with Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present, and Vice-Chair Lisa Naito arriving at 9:38 a.m..

Interim Chair Bill Farver read a statement from Laddie Read regarding mental health.

B-1 Public Affairs Office Update on the 2001 Oregon Legislature. Presented by Gina Mattioda and Stephanie Soden.

GINA MATTIODA AND STEPHANIE SODEN LEGISLATIVE UPDATE PRESENTATION ON ISSUES INCLUDING REVENUE FORECAST, GOVERNOR'S NEW PROPOSED BUDGET, PORTLAND HARBOR CLEAN UP BILL AND SCHOOLS. STAFF TO DRAFT FLOOR LETTER REFLECTING BOARD POSITION. DIANA BIANCO PRESENTATION REGARDING HB 3245A-ENG MENTAL HEALTH BILL AND REQUEST FOR POLICY DIRECTION. BOARD DISCUSSION WITH STEVE WEISS ON OREGON ADVOCACY BILL IN RESPONSE TO RECENT SUICIDE AND THE NEED FOR THOROUGH, UNBIASED, INDEPENDENT INVESTIGATION, NOT BY COUNTY AGENCY WHO MONITORS PROGRAM. MS. MATTIODA TO TRACK BILL AND KEEP BOARD AND MS. BIANCO INFORMED. MS. MATTIODA, MS. SODEN AND HAROLD LASLEY PRESENTATION ON ISSUES INCLUDING HB 3953A-ENG, REGIONAL TRANSPORTATION AUTHORITY HB 3048, PERS OMNIBUS BILL AMENDMENTS, DEPARTMENT OF HUMAN RESOURCES REORGANIZATION, OREGON HEALTH PLAN, MENTAL HEALTH,

EARLY CHILDHOOD BUDGET, SCHOOL BASED HEALTH CLINIC, AFFORDABLE HOUSING, COMMUNITY LEARNING CENTER, COLUMBIA RIVER GORGE, COMMUNITY CORRECTIONS, CUSTODY UNITS, DEPARTMENT OF CORRECTIONS BUDGET, BILL TO EXPAND SCHOOLS IN JUVENILE DETENTION FACILITIES, OREGON YOUTH AUTHORITY BUDGET, LIVING WAGES, AND CHRISTMAS TREE BILL.

The briefing was adjourned at 10:30 a.m.

Tuesday, May 15, 2001 - 10:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

Interim-Chair Bill Farver convened the meeting at 10:40 a.m., with Commissioner Lonnie Roberts and Interim Commissioner Pauline Anderson present, Commissioner Serena Cruz arriving at 10:44, and Vice-Chair Lisa Naito excused.

B-2 **DEPARTMENT OF AGING AND DISABILITY SERVICES** Fiscal Year 2001-2002 Budget Presentation. Presented by Jim McConnell, Director; Mary Shortall, Deputy Director; Rey España , Planning Manager; Tanya McGee, Long Term Care Manager; Nancy Harp, Community Services Manager; Fran Landfair, Elders in Action CBAC; and Steve Weiss, Disability Services CBAC.

I. Who We Are at ADS
II. How Services Are Accessed
III. How We Are Organized
IV. How Well We Deliver Services
V. FY 2002 Budget
VI. Issues and Challenges
VII. CBAC Report and Recommendations

JIM MCCONNELL PRESENTATION. STEVE WEISS AND FRAN LANDFAIR PRESENTED CBAC REPORTS AND RESPONSE TO BOARD

QUESTIONS. JIM MCCONNELL, MARY SHORTALL, TANYA COLIE MCGEE, NANCY HARP, DON CARLSON AND REY ESPAÑA PRESENTATIONS AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING FUNDING TO RETAIN MULTIDISCIPINARY TEAM NURSES, NEED TO WORK WITH LEGISLATORS TO SEE THAT OREGON PROJECT INDEPENDENCE GETS FEDERAL FUNDING, AND BOARD DIRECTION TO THE DIRECT REPORT MANAGERS FOR DEVELOPMENT OF A COUNTYWIDE POLICY FOR THE BOARD'S FUTURE CONSIDERATION, TO ADDRESS STATE FUNDING FORMULA ISSUES SUCH AS GRANTS IN AID AND AGING AND DISABILITY SERVICES EQUITY ISSUES IN COLLABORATION AND PARTNERSHIP WITH THE DEPARTMENT OF HUMAN RESOURCES REORGANIZATION EFFORTS, AND LATINO ELDERS SERVICES SUCH AS ADDITIONAL HOUSING AND MULTI-GENERATIONAL COMMUNITY CENTER.

There being no further business, the meeting was adjourned at 11:48 a.m.

Tuesday, May 15, 2001 - 2:30 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

Interim-Chair Bill Farver convened the meeting at 2:35 p.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present.

B-3 Discussion on Proposed Direction of Mental Health Redesign. Presented by Jim Gaynor and Staff.

LOLENZO POE AND JIM GAYNOR PRESENTATION OF MENTAL HEALTH SYSTEM REDESIGN ACTION PLAN FOR MULTNOMAH

COUNTY, PHASE I: RESOLVING THE ACUTE CARE CRISIS, AND RESPONSE TO BOARD QUESTIONS, DISCUSSION AND BOARD DIRECTION ON ISSUES INCLUDING TIMELINE FOR BUDGET DETAILS; PRIMARY ROLE OF PROVIDER; ALTERNATIVES OR TRADE OFFS IF PROPOSAL TOO EXPENSIVE; NEED TO NEGOTIATE PLAN FOR RAPID DEPLOYMENT OF CRISIS STABILIZATION SERVICES WITHIN 60 DAYS, IDENTIFY WHO WILL BE DEPLOYED TO DO THE WORK; COUNTY RISK TO PROVIDE SERVICES; NEED FOR COUNTY TO CONTINUE MANAGING SERVICES AND MAINTAIN GATE-KEEPING CONTROL FOR AUTHORIZING CARE; LANE COUNTY MODEL AND SHARING RISKS; AND NEED FOR THOUGHTFUL PLANNING. STAFF TO SET UP A MEETING WITH COMMISSIONER ANDERSON FOR FURTHER BRIEFING. BOARD DIRECTION FOR STAFF TO CLARIFY DIFFERENCES AND COSTS BETWEEN TODAY'S PLAN AND LANE COUNTY MODEL; ADDRESS BOARD CONCERN WHERE TODAY'S PLAN DOESN'T FOLLOW RESOLUTION CASE MANAGEMENT; COST ANALYSIS CONSISTENT WITH CASE MANAGEMENT FUNCTION; AND PROVIDE A WANTS COLLABORATIVE PROCESS UTILIZING COUNTY EXPERTISE AND THE PROVIDER NETWORKS. STAFF DIRECTED TO COME BACK WITH SPECIFIC CASE MANAGEMENT SCENARIOS WITHIN 30 DAYS. BOARD CONSENSUS ON BUDGET NOTE THAT STAFF COME BACK WITH PACKAGE OF BUDGET AMENDMENTS, OR REVISED MENTAL HEALTH BUDGET ON THE REDESIGN OF THE MENTAL HEALTH SYSTEM. CHAIR DIRECTED STAFF TO COME BACK IN LATE MAY OR EARLY JUNE FOR FURTHER BUDGET DISCUSSIONS.

There being no further business, the meeting was adjourned at 3:24 p.m.

Wednesday, May 16, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

Interim-Chair Bill Farver convened the meeting at 9:35 a.m., with Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present, and Vice-Chair Lisa Naito arriving at 9:40 a.m.

B-4 **HEALTH DEPARTMENT** Fiscal Year 2001-2002 Budget Presentation

1. **Introduction: Lillian Shirley, Department Director**
   Department Mission and three Public Health goals: setting the framework for the Health Department's Budget
2. **Citizens Budget Advisory Committee Report: Bill Hancock, Community Health Council President and Sonia Manhas, Director's Office**
3. **Budget Summary: Lillian Shirley**

   Restorations and cuts. How department decisions were made
   Revenues and Expenditure Summaries
4. **Federal Financial Participation: Tom Fronk, Director's Office**

   Health Department, County, and State work.
5. **Budget and Operations Review: Dave Houghton, Bonnie Kostelecky, Patsy Kullberg, Gary Oxman, Consuelo Saragoza, and Jane Spence.**
   - Assuring Access To Necessary And Dignified Health Care
   - Promoting The Health Of All County Residents
   - Protecting The Health Of All County Residents
6. **Addressing Community Health Disparities**
7. **Final BCC Questions & Answers; Closing: Lillian Shirley**

CHAIR FARVER CONGRATULATIONS TO CHAIR-ELECT DIANE LINN AND COMMISSIONER-ELECT MARIA ROJO DE STEFFEY ON THEIR SUCCESSFUL ELECTION YESTERDAY AND ADVISED THEY WILL BE SWORN IN ON JUNE 5, 2001.

LILLIAN SHIRLEY INTRODUCED SONIA MANHAS, ANNE POTTER AND BILL HANCOCK. BILL HANCOCK PRESENTED THE CBAC REPORT. LILLIAN SHIRLEY, CAROL FORD, TOM FRONK, CONSUELO SARAGOZA AND BONNIE KOSTELECKY PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING CAREOREGON; FEDERAL FINANCIAL PARTICIPATION; OCHIN TRANSITION; OLDS TEAM FUNDING CONCERNS; OREGON CHILDRENS PLAN; STARS PROGRAM; CARES CHILD CARE GRANT; WORK WITH AGING AND DISABILITY SERVICES TO CONTINUE FUNDING 4 MULTI-DISCIPLINARY TEAM NURSES.

The meeting was recessed at 10:55 a.m. and reconvened at 11:07 a.m.

DAVE HOUGHTON AND GARY OXMAN PRESENTATION AND RESPONSE TO BOARD QUESTIONS REGARDING VECTOR CONTROL, DISEASE PREVENTION AND TREATMENT SERVICES CAPACITY, HIV/AIDS REPORTING, AND LEAD POISONING EDUCATION AND SCREENING SERVICES. LILLIAN SHIRLEY, GORDON EMPEY, JANE SPENCE, PATSY KULLBERG AND GARY OXMAN PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING EAST COUNTY SERVICE CENTER; PRIMARY CARE SERVICES AND REDESIGN; OREGON ACTION COALITION; CHARITABLE CARE RULES; LOW INCOME/UNINSURED CLIENTS; CORRECTIONS HEALTH; NEED FOR CORRECTIONS HEALTH STAFF TO BE INVOLVED WITH LOCAL PUBLIC SAFETY COORDINATING COUNCIL; AND MENTAL HEALTH ISSUES. BOARD CONSENSUS TO ADD BUDGET NOTE DIRECTING STAFF TO MONITOR CLIENT FLOW AND ACCESS ISSUES AND TO PROVIDE BOARD UPDATES ON PRIMARY CARE CLINIC REVENUES. BOARD CONSENSUS TO ADD BUDGET NOTES LOCAL

PUBLIC SAFETY REVIEW OF COUNTY'S PRE-TRIAL RELEASE SYSTEM FOR INCREASED EFFICIENCES, EFFECTIVENESS AND POTENTIAL COST SAVINGS. JANE SPENCE, CONSUELO SARAGOZA, JOY BELCOURT AND BONNIE KOSTELECKY PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING MENTAL HEALTH AND DISABILITY DISCRIMINATION AND LACK OF FEDERAL REIMBURSEMENT FOR VETERANS AND SOCIAL SECURITY CLIENTS WHO ARE INCARCERATED; SCHOOL BASED HEALTH CENTERS; PHARMACEUTICAL COSTS, OUTREACH AND TREATMENT MODELS AND PARTNERSHIPS; EFFORTS TO PARTNER ON MATCHING FUNDS GRANTS TO ADDRESS AFRICAN AMERICAN INFANT MORTALITY AND OTHER HEALTH ISSUES. STAFF DIRECTED TO HAVE COUNTY ATTORNEY PROVIDE BOARD WITH LEGAL OPINION REGARDING VETERANS ADMINISTRATION POSITION NOT TO REIMBURSE COUNTY FOR SERVICES TO INCARCERATED VETERANS.

There being no further business, the meeting was adjourned at 12:15 p.m.

Wednesday, May 16, 2001 - 1:30 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

Interim-Chair Bill Farver convened the meeting at 1:35 a.m., with Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present, and Vice-Chair Lisa Naito arriving at 1:40 p.m.

B-5 **DEPARTMENT OF COMMUNITY AND FAMILY SERVICES** Fiscal Year 2001-2002 Budget Presentation

I.	**Introduction**	Lolenzo T. Poe, Jr., Director
II.	**CBAC Report**	Doug Montgomery, CBAC Chair
III.	**Department Overview**	Denise Chuckovich & Kathy Tinkle

- Vision, Mission and Values
- Organizational Structure
- Expenditures, Revenues and FTE
- Efficiencies and Other Budget Reductions
- DCFS Services

IV. FY 2002 Issues and Challenges

• Developmental Disabilities	Howard Klink
• Behavioral Health	Janice Gratton
• SUN	Kathy Turner
• Community Programs & Partnerships	Mary Li

V. Board Questions

LOLENZO POE INTRODUCTIONS. BILL MONTGOMERY PRESENTED CBAC REPORT. DENISE CHUCKOVICH, KATHY TINKLE, HOWARD KLINK, JANICE GRATTON AND KATHY TURNER PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING DEPARTMENT OVERVIEW; LETTER FROM LADDIE READ; DEVELOPMENTAL DISABILITIES PROGRAM BUDGET; SKIP SCREENING; BEHAVIORAL HEALTH DIVISION BUDGET; EARLY INTERVENTION PROGRAM FUNDING; SUN INITIATIVE AND CASEY GRANT, STRATEGIC INVESTMENT PROGRAM REVENUES; NEED TO WORK WITH SCHOOL BOARD; BUCKMAN AND CLEAR CREEK SCHOOLS.

The meeting was recessed at 3:05 p.m. and reconvened at 3:15 p.m.

MARY LI AND JIM CLAY PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION ON ISSUES INCLUDING COMMUNITY PROGRAMS AND PARTNERSHIPS BUDGET; WEATHERIZATION PROGRAM AND COMMJNITY ACTION FUNDING SOURCE; MULTNOMAH COMMISSION ON CHILDREN AND FAMILIES BUDGET CUTS.

There being no further business, the meeting was adjourned at 3:40 p.m.

Thursday, May 17, 2001 - **9:00 AM**
Multnomah Building, First Floor Commissioners Conference Room 112
501 SE Hawthorne Boulevard, Portland

EXECUTIVE SESSION

Interim-Chair Bill Farver convened the meeting at 9:03 a.m., with Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present, and Vice-Chair Lisa Naito arriving at 9:05 a.m.

E-1 The Multnomah County Board of Commissioners will meet in executive session authorized pursuant to ORS 192.660(1)(f) to discuss confidential information that is protected under Federal and State housing provisions and other laws from disclosure and therefore exempt under either ORS 192.502(8) or (9) or both. 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. No final decision will be made in the executive session.

EXECUTIVE SESSION HELD.

There being no further business, the executive session was adjourned at 9:25 a.m.

Thursday, May 17, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

Interim-Chair Bill Farver convened the meeting at 9:30 a.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present.

CONSENT CALENDAR

UPON MOTION OF COMMISSIONER NAITO, SECONDED BY COMMISSIONER CRUZ, THE

CONSENT CALENDAR (ITEMS C-1 THROUGH C-6) WAS UNANIMOUSLY APPROVED.

DISTRICT ATTORNEY'S OFFICE

C-1 Renewal of Intergovernmental Agreement 500167 with Tri-Met for the Continued Funding of 1 FTE Deputy District Attorney to the Tri-Met Neighborhood Based Prosecution Office

SHERIFF'S OFFICE

C-2 Budget Modification MCSO 5 Appropriating $45,000 from Portland Police Bureau Block Grant Revenue to Purchase 7 Mobile Data Centers for County Law Enforcement Vehicles

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES

C-3 Budget Modification CFS 50 Transferring $15,021 Great Start Revenue from the Commission on Children, Families and Community Budget to Fund a .21 FTE Program Development Specialist Senior Position

C-4 Budget Modification CFS 51 Adding a .13 FTE Program Development Specialist for the Victims' Panel Coordinator from DUII Victims Panel Fees

C-5 Budget Modification CFS 52 Adjusting Expenditure and Revenue Budgets in Community Programs and Partnerships to Reflect Additional Unanticipated Low Income Energy Assistance Program Funds from the State

C-6 Budget Modification CFS 53 Adjusting Expenditures and Revenues for SUN Schools to Reflect Actual Expenditures and Revenue Agreements, and Appropriating a $1,000 Donation from the Oregon Community Foundation via the City of Portland

REGULAR AGENDA
PUBLIC COMMENT

Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.

NO ONE WISHED TO COMMENT.

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES

R-1 PUBLIC HEARING on the 2000 Affordable Housing Development Program Property Transfer Recommendations and Consideration of a RESOLUTION Approving the Transfer of Tax-Foreclosed Properties to Non-Profit Housing Sponsors for Low Income Housing Purposes

COMMISSIONER NAITO MOVED AND COMMISSIONER ANDERSON SECONDED, APPROVAL OF R-1. HC TUPPER EXPLANATION AND RESPONSE TO BOARD QUESTIONS. LOREA ALBA, REPRESENTING POWERHOUSE, AND DENNY WEST REPRESENTING THE HOUSING AUTHORITY OF PORTLAND, TESTIMONY IN SUPPORT. HC TUPPER AND MATT RYAN RESPONSE TO BOARD QUESTIONS REGARDING MERGER OF NE CDCS AND COUNTY LOAN DOCUMENTS. BOARD COMMENTS IN SUPPORT. RESOLUTION 01-061 UNANIMOUSLY ADOPTED.

R-2 NOTICE OF INTENT to Apply for a "Build Mentally Healthy Communities" Grant from the Center for Mental Health Services for the Multnomah County Incredible Years Program

COMMISSIONER NAITO MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-2. JANICE GRATTON, BARBARA BRADY, MARGIE MCCLOUD AND LINDA CASTILLO EXPLANATION AND RESPONSE TO BOARD QUESTIONS AND COMMENTS IN SUPPORT. NOTICE OF INTENT UNANIMOUSLY APPROVED.

DEPARTMENT OF HEALTH

R-3 PROCLAMATION Designating the Week of May 20 through 26, 2001 as EMERGENCY MEDICAL SERVICES WEEK

COMMISSIONER NAITO MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-3. BILL COLLINS EXPLANATION AND INTRODUCTION. RANDY LAUER OF AMR READ PROCLAMATION AND INTRODUCED LUCY DRUM IN AUDIENCE. PROCLAMATION 01-062 UNANIMOUSLY ADOPTED.

NON-DEPARTMENTAL

R-4 RESOLUTION Designating the Multnomah County Public Affairs Office to Coordinate the Public Involvement Processes for Siting of County-Owned and County-Leased Facilities and Repealing Resolution No. 98-164

COMMISSIONER NAITO MOVED AND COMMISSIONER ANDERSON SECONDED, APPROVAL OF R-4. GINA MATTIODA AND ALTHEA MILECHMAN EXPLANATION. BOARD COMMENTS IN SUPPORT. RESOLUTION 01-063 UNANIMOUSLY ADOPTED.

DEPARTMENT OF SUPPORT SERVICES

R-5 RESOLUTION Authorizing Issuance and Sale of Short-Term Promissory Notes, (Tax and Revenue Anticipation Notes), Series 2001 in the Amount of $20,000,000

COMMISSIONER NAITO MOVED AND COMMISSIONER NAITO SECONDED, APPROVAL OF R-5. HARRY MORTON EXPLANATION AND RESPONSE TO QUESTION OF COMMISSIONER ROBERTS. RESOLUTION 01-064 UNANIMOUSLY ADOPTED.

DEPARTMENT OF SUSTAINABLE COMMUNITY DEVELOPMENT

R-6 RESOLUTION Approving Authorization for Facilities and Property Management Division to Utilize North Portland Health Clinic Project Contingency Funds to Assist the St. Johns Boosters Renovate and Improve Community Neighborhood Sign Adjacent to the North Portland Health Clinic Parking Lot

COMMISSIONER CRUZ MOVED AND COMMISSIONER NAITO SECONDED, APPROVAL OF R-6. PETER WILCOX EXPLANATION. JOE BEULLER, VICE-PRESIDENT OF ST. JOHN'S BOOSTERS, EXPLANATION AND COMMENTS IN SUPPORT. BOARD COMMENTS IN SUPPORT. RESOLUTION 01-065 UNANIMOUSLY ADOPTED.

AGING AND DISABILITY SERVICES DEPARTMENT

R-7 RESOLUTION: Acceptance of the Report of Contract Policy Team; Adoption of Policies Governing Human Service Contracting

COMMISSIONER NAITO MOVED AND COMMISSIONER CRUZ SECONDED, APPROVAL OF R-7. JIM MCCONNELL AND FRANNA HATHAWAY EXPLANATION AND RESPONSE TO BOARD QUESTIONS AND COMMENTS IN SUPPORT. CHAIR FARVER ASKED THAT THE BOARD CONTINUE SUPPORTING THIS EFFORT. RESOLUTION 01-066 UNANIMOUSLY ADOPTED.

The regular meeting was adjourned at 10:50 a.m.

Thursday, May 17, 2001 - 10:55 AM
(OR IMMEDIATELY FOLLOWING REGULAR MEETING)
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFING

Interim-Chair Bill Farver convened the meeting at 10:55 a.m., with Vice-Chair Lisa Naito, Commissioners Serena Cruz and Lonnie Roberts and Interim Commissioner Pauline Anderson present.

B-6 Portland Development Commission's Gateway Regional Center Urban Renewal Area Plan. Presented by Kenny Asher and Don Mazzioti.

ABE VARGAS, KENNY ASHER AND DICK HOOLIE PRESENTATION AND RESPONSE TO BOARD QUESTIONS AND DISCUSSION. STAFF TO PREPARE RESOLUTION FOR BOARD CONSIDERATION ON THURSDAY, MAY 31, 2001.

There being no further business, the meeting was adjourned at 11:56 a.m.

Thursday, May 17, 2001 - 6:00 PM
North Portland Branch Library, Upstairs Meeting Room
512 N Killingsworth, Portland

PUBLIC HEARING

Interim-Chair Bill Farver convened the meeting at 6:03 a.m., with Vice-Chair Lisa Naito and Interim Commissioner Pauline Anderson present, Commissioner Serena Cruz arriving at 6:04 p.m., and Commissioner Lonnie Roberts excused.

PH-1 Opportunity for Public Input on the 2001-2002 Multnomah County Budget. Testimony Limited to Three Minutes Per Person.

CHAIR FARVER ANNOUNCED CHAIR-ELECT DIANE LINN AND COMMISSIONER-ELECT MARIA ROJO DE STEFFEY WILL BE SWORN IN ON JUNE 5, 2001. DONNA PURDY AND DEANNA LYNN CALEF OF JEFFERSON CARING COMMUNITY TESTIMONY IN SUPPORT OF FUNDING FOR EARLY CHILDHOOD, READINESS TO LEARN, NATIVE AMERICAN AND VIOLENCE PREVENTION PROGRAMS. JACKIE MERCER, GEOFF ROTH, NORREEN SMOKEY-SMITH, SUE ZIGLINSKI AND MISOKE ALEX STONE OF NARA AND NW NATIVE RESPONSE TEAM TESTIMONY IN SUPPORT OF FUNDING FOR SERVICES TO NATIVE AMERICANS, INCLUDING CHILD CARE, NAYA ALTERNATIVE SCHOOL, YOUTH ALCOHOL PROGRAMS AND HEALTH CARE. ROBERT BERNSTEIN PRESENTED STUDENT LETTERS AND TESTIMONY IN SUPPORT OF FUNDING FOR NORTH PORTLAND YOUTH AND FAMILY CENTER PROGRAMS AND SERVICES. LANITA DUKE, LARINDA RODRIQUEZ, MARQUINDA BARBER, SASHA BELL, SANDRA JOHNSON, ANJEANETTE BROWN, LETICIA PERRY, DEANNA BROWN AND CHANTANAY PERRY TESTIMONY IN SUPPORT OF FUNDING FOR THE NORTH PORTLAND COMPONENT OF THE GIFT PROGRAM. CHIP SHIELDS, PATTY KATZ AND ROOSEVELT JOHNSON REPRESENTING BETTER PEOPLE, TESTIMONY IN SUPPORT OF $40,000

BUDGET AMENDMENT FOR TRANSITIONAL EMPLOYMENT SERVICES FOR EX-OFFENDERS. PATRICIA WELCH AND NIA GRAY TESTIMONY IN SUPPORT OF GIFT PROGRAM FUNDING. JAY SWEDBLOM, LARRY JOHNSON, ARWEN BIRD AND ANETTE JOLIN REPRESENTING BETTER PEOPLE, TESTIMONY IN SUPPORT OF $40,000 BUDGET AMENDMENT FOR TRANSITIONAL EMPLOYMENT SERVICES FOR EX-OFFENDERS. PAMELA TEMBURINO, VALUENT WHITE, DOROTHY CLARK, BARABARA BALSERO TESTIMONY IN SUPPORT OF FUNDING FOR MULTIDISCIPLINARY TEAM NURSES FOR SENIORS. MARILYN MILLER, JOSETTE HERRERA AND DEB MEADOWS-WEST TESTIMONY IN SUPPORT OF FUNDING FOR COMMUNITY AND FAMILY CENTER PROGRAMS. SUSAN MASIN AND JEYLEEN TORANZO TESTIMONY IN SUPPORT OF FUNDING FOR YWCA AND JOLANDA HOUSE. DIANE FELDT TESTMONY IN SUPPORT OF FUNDING FOR NORTH PORTLAND COMMUNITY AND FAMILY CENTER, GIFT AND TEEN CONNECTIONS PROGRAMS. MS. FELDT READ A LETTER OF SUPPORT FROM MIKE VERBOUT. GAIL ALBERS TESTIMONY IN SUPPORT OF FUNDING FOR EAST COUNTY AGING SERVICES. JANICE BOOKER, CHEKAYA OLIVER, LACONDRA BROWN, DEBRA KNAPPER AND SARA STUMP TESTIMONY IN SUPPORT OF FUNDING FOR YWCA YOUNG FAMILIES PROGRAM. CAROL FORD EXPLANATION IN RESPONSE TO A QUESTION OF COMMISSIONER NAITO. WENDY MATTESON, LAURA LYBRAND, AMBER BARTON, MANI CANNON, TAMMY RAUSCHL, SHELLEY BRADLEY AND KRISTINE ELDRIDGE TESTIMONY IN SUPPORT OF FUNDING FOR COMMUNITY AND FAMILY CENTER PROGRAMS, TEEN CONNECTIONS, YWCA HOMELESS SHELTER PROGRAMS. JEAN DEMASTER EXPLANATION OF STATE BUDGET CUTS IN RESPONSE TO QUESTION OF CHAIR FARVER.

WILLIAM ROBINSON TESTIMONY IN SUPPORT OF ADULT COMMUNITY CORRECTIONS PROGRAM FUNDING. IN RESPONSE TO A QUESTION OF COMMISSIONER NAITO, CHAIR FARVER ADVISED THE PROGRAM IS FUNDED IN THE DEPARTMENT BUDGET. CHARLES JENNINGS OF BETTER PEOPLE TESTIMONY IN SUPPORT OF FUNDING FOR AFRICAN AMERICAN PROGRAM WITHIN ADULT COMMUNITY CORRECTIONS. TINA RUSSELL TESTIMONY IN SUPPORT OF FUNDING FOR THE YWCA SAFE HAVEN SHELTER AND COMMUNITY AND FAMILY SERVICE CENTER PROGRAMS. LARISSA WILLIAMS TESTIMONY IN SUPPORT OF FUNDING FOR RICHMOND PLACE AND YWCA PROGRAMS.

There being no further business, the meeting was adjourned at 8:25 p.m.

BOARD CLERK FOR MULTNOMAH COUNTY, OREGON

Deborah L. Bogstad

Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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ANY QUESTIONS? CALL BOARD CLERK DEB BOGSTAD @ (503) 988-3277
Email: deborah.l.bogstad@co.multnomah.or.us

INDIVIDUALS WITH DISABILITIES PLEASE CALL THE BOARD CLERK AT (503) 988-3277, OR MULTNOMAH COUNTY TDD PHONE (503) 988-5040, FOR INFORMATION ON AVAILABLE SERVICES AND ACCESSIBILITY.

MAY 15, 16 & 17, 2001 BOARD MEETINGS

FASTLOOK AGENDA ITEMS OF INTEREST

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
(Saturday Playback for East County Only)
Sunday, 11:00 AM, Channel 30

Produced through Multnomah Community Television

Tuesday, May 15, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFING

B-1 Public Affairs Office Update on the 2001 Oregon Legislature. Presented by Gina Mattioda and Stephanie Soden. 1 HOUR REQUESTED.

Tuesday, May 15, 2001 - 10:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

B-2 **DEPARTMENT OF AGING AND DISABILITY SERVICES** Fiscal Year 2001-2002 Budget Presentation. Presented by Jim McConnell, Director; Mary Shortall, Deputy Director; Rey España , Planning Manager; Tanya McGee, Long Term Care Manager; Nancy Harp, Community Services Manager; Fran Landfair, Elders in Action CBAC; and Steve Weiss, Disability Services CBAC.

I. Who We Are at ADS
II. How Services Are Accessed
III. How We Are Organized
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V. FY 2002 Budget
VI. Issues and Challenges
VII. CBAC Report and Recommendations

Tuesday, May 15, 2001 - 2:30 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

B-3 Discussion on Proposed Direction of Mental Health Redesign. Presented by Jim Gaynor and Staff.

Wednesday, May 16, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

B-4 **HEALTH DEPARTMENT** Fiscal Year 2001-2002 Budget Presentation

1. **Introduction: Lillian Shirley, Department Director**
   Department Mission and three Public Health goals: setting the framework for the Health Department's Budget
2. **Citizens Budget Advisory Committee Report: Bill Hancock, Community Health Council President and Sonia Manhas, Director's Office**
3. **Budget Summary: Lillian Shirley**

   Restorations and cuts. How department decisions were made
   Revenues and Expenditure Summaries
4. **Federal Financial Participation: Tom Fronk, Director's Office**

   Health Department, County, and State work.
5. **Budget and Operations Review: Dave Houghton, Bonnie Kostelecky, Patsy Kullberg, Gary Oxman, Consuelo Saragoza, and Jane Spence.**
   - Assuring Access To Necessary And Dignified Health Care
   - Promoting The Health Of All County Residents
   - Protecting The Health Of All County Residents
6. **Addressing Community Health Disparities**
7. **Final BCC Questions & Answers; Closing: Lillian Shirley**

Wednesday, May 16, 2001 - 1:30 PM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BUDGET DELIBERATIONS

B-5 **DEPARTMENT OF COMMUNITY AND FAMILY SERVICES** Fiscal Year 2001-2002 Budget Presentation

I.	**Introduction**	Lolenzo T. Poe, Jr., Director
II.	**CBAC Report**	Doug Montgomery, CBAC Chair
III.	**Department Overview**	Denise Chuckovich & Kathy Tinkle

- Vision, Mission and Values
- Organizational Structure
- Expenditures, Revenues and FTE
- Efficiencies and Other Budget Reductions
- DCFS Services

IV. FY 2002 Issues and Challenges

• Developmental Disabilities	Howard Klink
• Behavioral Health	Janice Gratton
• SUN	Kathy Turner
• Community Programs & Partnerships	Mary Li

V. Board Questions

Thursday, May 17, 2001 - **9:00 AM**
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 authorized pursuant to ORS 192.660(1)(f) to discuss confidential information that is protected under Federal and State housing provisions and other laws from disclosure and therefore exempt under either ORS 192.502(8) or (9) or both. 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. No final decision will be made in the executive session. 15 MINUTES REQUESTED.

Thursday, May 17, 2001 - 9:30 AM
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

REGULAR MEETING

CONSENT CALENDAR - 9:30 AM
DISTRICT ATTORNEY'S OFFICE

C-1 Renewal of Intergovernmental Agreement 500167 with Tri-Met for the Continued Funding of 1 FTE Deputy District Attorney to the Tri-Met Neighborhood Based Prosecution Office

SHERIFF'S OFFICE

C-2 Budget Modification MCSO 5 Appropriating $45,000 from Portland Police Bureau Block Grant Revenue to Purchase 7 Mobile Data Centers for County Law Enforcement Vehicles

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES

C-3 Budget Modification CFS 50 Transferring $15,021 Great Start Revenue from the Commission on Children, Families and Community Budget to Fund a .21 FTE Program Development Specialist Senior Position

C-4 Budget Modification CFS 51 Adding a .13 FTE Program Development Specialist for the Victims' Panel Coordinator from DUII Victims Panel Fees

C-5 Budget Modification CFS 52 Adjusting Expenditure and Revenue Budgets in Community Programs and Partnerships to Reflect Additional Unanticipated Low Income Energy Assistance Program Funds from the State

C-6 Budget Modification CFS 53 Adjusting Expenditures and Revenues for SUN Schools to Reflect Actual Expenditures and Revenue Agreements, and Appropriating a $1,000 Donation from the Oregon Community Foundation via the City of Portland

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

Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.

DEPARTMENT OF COMMUNITY AND FAMILY SERVICES - 9:30 AM

R-1 PUBLIC HEARING on the 2000 Affordable Housing Development Program Property Transfer Recommendations and Consideration of a RESOLUTION Approving the Transfer of Tax-Foreclosed Properties to Non-Profit Housing Sponsors for Low Income Housing Purposes

R-2 NOTICE OF INTENT to Apply for a "Build Mentally Healthy Communities" Grant from the Center for Mental Health Services for the Multnomah County Incredible Years Program

DEPARTMENT OF HEALTH - 10:10 AM

R-3 PROCLAMATION Designating the Week of May 20 through 26, 2001 as EMERGENCY MEDICAL SERVICES WEEK

NON-DEPARTMENTAL - 10:15 AM

R-4 RESOLUTION Designating the Multnomah County Public Affairs Office to Coordinate the Public Involvement Processes for Siting of County-Owned and County-Leased Facilities and Repealing Resolution No. 98-164

DEPARTMENT OF SUPPORT SERVICES - 10:30 AM

R-5 RESOLUTION Authorizing Issuance and Sale of Short-Term Promissory Notes, (Tax and Revenue Anticipation Notes), Series 2001 in the Amount of $20,000,000

DEPARTMENT OF SUSTAINABLE COMMUNITY DEVELOPMENT - 10:35 AM

R-6 RESOLUTION Approving Authorization for Facilities and Property Management Division to Utilize North Portland Health Clinic Project Contingency Funds to Assist the St. Johns Boosters Renovate and Improve Community Neighborhood Sign Adjacent to the North Portland Health Clinic Parking Lot

AGING AND DISABILITY SERVICES DEPARTMENT - 10:40 AM

R-7 RESOLUTION: Acceptance of the Report of Contract Policy Team; Adoption of Policies Governing Human Service Contracting

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Thursday, May 17, 2001 - 10:55 AM
(OR IMMEDIATELY FOLLOWING REGULAR MEETING)
Multnomah Building, First Floor Commissioners Boardroom 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFING

B-6 Portland Development Commission's Gateway Regional Center Urban Renewal Area Plan. Presented by Kenny Asher and Don Mazzioti. 30 MINUTES REQUESTED.

Thursday, May 17, 2001 - 6:00 PM
North Portland Branch Library, Upstairs Meeting Room
512 N Killingsworth, Portland

PUBLIC HEARING

PH-1 Opportunity for Public Input on the 2001-2002 Multnomah County Budget. Testimony Limited to Three Minutes Per Person.

2001-2002 Multnomah County Budget Deliberations Schedule
All sessions to be in held in the Multnomah Building, Commissioners Boardroom 100, 501 SE Hawthorne Boulevard, except as noted

Thur, April 26, 2001	9:30 to noon	Executive Budget Overview Presentation to Board and Regular Board Meeting
Tue, May 1, 2001	9:00 to 3:00 p.m.	Board Budget Work Session on Issues
Thur, May 3, 2001	9:30 to noon	Executive Budget Message and Board Approval of Budget for Transmission to Tax Supervising and Conservation Commission, Regular Board Meeting
Tue, May 8, 2001	9:30 to noon	**Central Citizen Budget Advisory Committee Report & Department of Library Services** Budget Hearing
Tue, May 8, 2001	1:30 to 4:00 p.m.	**Department of Sustainable Community Development** Budget Hearing
Wed, May 9, 2001	1:30 to 4:00 p.m.	**Non-Departmental** and **Special Service Districts** Budget Hearings
*Thur, May 10, 2001	**6:00 to 8:00 p.m.**	**Public Hearing and Testimony on the Multnomah County Budget, Midland Branch Library, 805 SE 122nd Avenue, Portland**
Tue, May 15, 2001	9:30 to noon	Public Affairs Office Legislative Update discussion, followed by **Department of Aging and Disability Services** Budget Hearing

2001-2002 Multnomah County Budget Deliberations Schedule
All sessions to be in held in the Multnomah Building, Commissioners Boardroom 100, 501 SE Hawthorne Boulevard, except as noted

Tue, May 15, 2001	2:30 to 4:00 p.m.	**Mental Health System Briefing**
Wed, May 16, 2001	9:30 to noon	**Health Department** Budget Hearing
Wed, May 16, 2001	1:30 to 4:00 p.m.	**Department of Community and Family Services** Budget Hearing
*Thur, May 17, 2001	**6:00 to 8:00 p.m.**	**Public Hearing and Testimony on the Multnomah County Budget, North Portland Branch Library, 512 N Killingsworth, Portland**
Tue, May 22, 2001	9:30 to noon	**District Attorney's Office** Budget Hearing
Tue, May 22, 2001	1:30 to 4:00 p.m.	**Department of Juvenile and Adult Community Justice** Budget Hearing
Wed, May 23, 2001	9:30 to noon	**Sheriff's Office** Budget Hearing
Wed, May 23, 2001	1:30 to 3:00 p.m.	**Department of Support Services** Budget Hearing
*Wed, May 23, 2001	**6:00 to 8:00 p.m.**	**Public Hearing and Testimony on the Multnomah County Budget, Gresham Branch Library, 385 NW Miller, Gresham**
Tue, May 29, 2001	9:30 to noon	**Capital Program** Budget Hearing

2001-2002 Multnomah County Budget Deliberations Schedule
All sessions to be in held in the Multnomah Building, Commissioners Boardroom 100, 501 SE Hawthorne Boulevard, except as noted

Tue, May 29, 2001	1:30 to 4:00 p.m.	**Mental Health Council Briefing** and Discussion, Follow-up Info, Review Budget Amendments Work Session
Wed, May 30, 2001	9:30 to noon	Discussion, Follow-up Info, Review Budget Amendments Work Session
Wed, May 30, 2001	1:30 to 4:00 p.m.	Discussion, Follow-up Info, Review Budget Amendments Work Session
Tue, June 5, 2001	9:30 to noon	Discussion, Follow-up Info, Review Budget Amendments Work Session
Tue, June 5, 2001	1:30 to 4:00 p.m.	Discussion, Follow-up Info, Review Budget Amendments Work Session
Wed, June 6, 2001	9:30 to noon	Discussion, Follow-up Info, Review Budget Amendments Work Session
Thur, June 7, 2001	**1:30 to 3:00 p.m.**	**Tax Supervising and Conservation Commission Public Hearing and Testimony on Multnomah County Budget** (quorum of BCC to attend)
Thur, June 7, 2001	**6:00 to 8:00 p.m.**	**Public Hearing and Testimony on the Multnomah County Budget**
Thur, June 14, 2001	9:30 to noon	**Public Hearing and Testimony and Adoption of Budget and Amendments** and Regular Board Meeting

MEETING DATE: May 15, 2001
AGENDA NO: B-3
ESTIMATED START TIME: 2:30 PM
LOCATION: Boardroom 100

(Above Space for Board Clerk's Use ONLY)

AGENDA PLACEMENT FORM

SUBJECT: Mental Health Redesign

BOARD BRIEFING: DATE REQUESTED: May 15, 2001
REQUESTED BY: Lolenzo T. Poe Jr.
AMOUNT OF TIME NEEDED: 1.5 hours

REGULAR MEETING: DATE REQUESTED:

AMOUNT OF TIME NEEDED

DEPARTMENT: Community & Family Services DIVISION: Behavioral Health

CONTACT: Jim Gaynor TELEPHONE #: (503) 988-3339
BLDG/ROOM #: 166/500

PERSON(S) MAKING PRESENTATION: Jim Gaynor and Staff

ACTION REQUESTED:

[ ] INFORMATIONAL ONLY [x] POLICY DIRECTION [ ] APPROVAL [ ] OTHER

SUGGESTED AGENDA TITLE:

Proposed Direction of Mental Health Redesign

SIGNATURES REQUIRED:

ELECTED OFFICIAL:
(OR)
DEPARTMENT MANAGER: Lolenzo T. Poe Jr.

ALL ACCOMPANYING DOCUMENTS MUST HAVE REQUIRED SIGNATURES

Any Questions: Call the Board Clerk @ (503) 988-3277 or email
deborah.l.bogstad@co.multnomah.or.us

BOGSTAD Deborah L

From: FARVER Bill M
Sent: Tuesday, April 10, 2001 12:21 PM
To: #MULTNOMAH COUNTY ALL EMPLOYEES
Subject: Update on County Mental Health System

Dear Multnomah County employees:

I am writing today to update you on the progress we are making towards improving the County's mental health system. As you may know, there has been a great deal of activity focused on redesigning the County's mental health system over the course of the past few months. Following are a couple of highlights:

- The Board of County Commissioners created the Mental Health Coordinating Council to oversee the implementation of the redesign effort. The Council is comprised of a variety of stakeholders including mental health consumers, family members and mental health professionals. John Ball, the President of Worksystems Inc, chairs the Council. Commissioner Pauline Anderson serves as the vice-chair.

- The Department of Community and Family Services recently hired Jim Gaynor as the Director of Mental Health System Redesign. Jim comes to the County after serving as the CEO of Unity Inc., a local not-for-profit outpatient mental health agency.

- Mary Anne Hannibal was just hired as the program manager for the Department's Managed Care Division. Mary Anne most recently directed the mental health managed care system for Providence Health Care Systems.

- We have reduced administrative overload by eliminating duplication in managed care organizations. With the exception of a small number of consumers, all Oregon Health Plan clients in Multnomah County are now covered for their mental health managed care services through the County's mental health organization, formerly known as CaapCare.

The Department of Community and Family Services will be presenting its budget for mental health services to the Board of County Commissioners on May 15. Over the next several months we anticipate additional changes in the way the public mental health system is structured and operates. A lot of work remains to be done. However I am happy to report that we are off to a good start.

I'll keep you posted on other important Multnomah County developments in coming weeks.

Mental Health System Redesign

An Action Plan for Multnomah County

Phase I:
Resolving the Acute Care Crisis

Initial Draft
Presented to the Mental Health Coordinating Council
May 16, 2001
Jim Gaynor, Director of Redesign

TABLE OF CONTENTS

Introduction

This draft action plan should be as a working document, that is, an ongoing work in progress. It outlines a strategic planned change initiative deemed to be the most viable solution to resolve the acute care crisis being experienced in Multnomah County. It is not yet a strategic business plan per se; however it does provide the substantive groundwork upon which a value-added budget can be built. Two critical factors exist which need rapid negotiation prior to projecting accurate costing models. The first factor involves the inpatient providers' decision to forgo previous risk based contracting models in favor of a return to fee-for-service vendor status. Accordingly, we are currently involved in active negotiations to arrive at a competitive daily (per diem) bed rate. The second factor involves the successful negotiation of a shared risk contract with an integrated outpatient delivery system.

This action plan is also meant to serve as a stimulus for a proactive public dialogue. It is envisioned that an ongoing inclusive process of stakeholder involvement will yield better ideas which can then be incorporated into the plan. Better ideas are hereby defined as alternatives that provide better service value to the consumer while mitigating financial risk exposure. The proper forums for this exchange currently exist in the MHCC, CAMHSA, AMHSA, and the Verity Management Council.

This plan is consistent with all the values and goals identified in Resolution 00-161, which is included in this document as an appendix. The plan's integrity rests in its ability to operationalize the charge put forth by the Multnomah Board of County Commissioners in the resolution. We also acknowledge and thank the many people who took part in the design process that led to the crafting of Resolution 00-161. We now look forward to making it come alive together.

Finally, this plan revisits the problems associated with the current system. Let it be hereby noted that the problem statement is by no means an indictment of the many dedicated, talented, and hard working professionals that comprise our mental health system. In fact, a strong case can be made that the system should have self destructed already had it not been for this "impassioned people factor." The problem statement is intended to serve as a departure point from which the change process most effectively can be launched. A proactive sense of urgency can be the fuel for new solutions to emerge.

VERITY

Integrated Behavioral Healthcare Systems

Core Values

1. Customer Service

- Consumers are always the primary (i.e. most important) customers.
- We exist solely to serve consumers with the right care, delivered at the right time, for the right cost.
- The most important employees in the system are those providing direct services that result in good client outcomes; everything else is overhead.
- Necessary overhead is defined as those activities that add value to the delivery of effective direct services to the consumer.
- We recognize that there exist multiple internal and external customers involved in constant service transactions geared to best serve consumers.
- A customer is anybody receiving goods or services in exchange for reward.
- Anybody who can better serve our customers deserves the business of doing so. The converse is also true.

2. Accountability

- We employ fact-based decision making utilizing evidence based standards of care to ensure best practices.
- Outcome/results driven measurement systems and methods will be adopted to generate publicly posted status reports along with performance profiling.
- Performance based contracting will be actively managed.
- Sharing risk will increase the likelihood of mutually beneficial partnerships.
- Robust information technology infrastructure will be employed in recognition of the degree to which: "Excellent care management is dependent upon excellent information management"
- We seek to increase leadership and decrease micro-management processes.

3. Quality

- Quality is that which meets or exceeds the customer's needs and reasonable expectations at a cost that represents value to them.
- "Good enough"....isn't. Excellence is the enemy of the mediocre and vice versa. Quality service is not an average service. Who would prefer to be operated on by an average surgeon?
- The customer defines quality.
- Quality is not an abstraction; it is a measurable and manageable business practice. Continuous quality improvement is our core management philosophy and business strategy.
- Quality is about passion and pride. Scarcity of resources demand innovation.
- Higher quality costs less, not more.

4. Integrity

- We will recognize and embrace the moral high ground.
- Say what we mean and mean what we say, then do what we say we are going to do. We must "walk the talk."
- Utilizing dignity and respect, conflicts will be resolved in a collegial and professional manner.
- Acknowledge honest mistakes and recognize problems as opportunities for improvement. A problem is the gap between the existing situation and a better situation.
- Honest straightforwardness is recognized as a key element of any successful transaction.
- Accepting responsibility while building our response-ability is the desired way to replacing blame, cynicism, and excuses with results that work. Find remedy, not fault.
- We will foster productive labor-management partnerships that are consumer focused.
- Trust is built through proactive versus reactive activity.
- To not see a problem is in itself a problem. However, the worst thing a person can do is to ignore or cover up a problem.

Executive Summary

Resolution of the accelerating acute care crisis is the most critical system redesign initiative facing the mental health system in Multnomah County. The effective management of quality, access, utilization, and cost elements must be brought about swiftly. At the same time, the solution which is deployed to resolve our acute care crisis must establish long term foundations upon which recovery and child/family based systems of care will more naturally emerge and flourish.

The current system is fragmented and perpetuates costly redundancies. This is neither cost effective nor clinically efficient. It also provides unnecessary impediments for consumers attempting to access the right care at the right time. Accordingly, system accountability suffers.

The solution outlined in this plan is dependent upon the integrated consolidation of system providers, infrastructure, and the blending of funding streams wherever possible. The solution is offered based on the belief that in eliminating unnecessary administrative overhead, dollars can be freed up for reinvestment in service expansions and capacities that will result in easy access to the right care, delivered at the right time, for the right price. As old silos are replaced with a new seamless array of easily accessible services, true public-private partnerships based on risk as well as gain sharing will emerge. A new era of system accountability will be born that is much more self-regulating, consumer centered, and responsive.

Consumer choice will be enhanced by providing expanded service options that produce good consumer outcomes. Synergies will be achieved through ongoing horizontal and vertical integration initiatives resulting in systems of activities that are complementary, consistent, interconnected, and mutually reinforcing. The finite pool of system dollars will be managed for maximum effectiveness for the maximum amount of consumer gain. This will be achieved by blending funding streams into a single risk pool managed by the MHO. Performance based contracts will be executed and actively managed by continuous quality improvement specialists serving in responsive outcomes management roles.

Providers will be increasingly self-regulated through shared risk financing models which reward the generation of good consumer outcomes while also assuming the risk and responsibility associated with negative outcomes. Any remaining fee-for-service provider contracting will be aggressively managed. Consumers will no longer be "exiled" from treatment options for any reason. The MHO will be a proactive partner in the development and deployment of productive and innovative systems of care that minimize risk and promote success. Reinvestment plans will be negotiated that result in increased risk reserves, employee compensation, and capacity building.

Background and Problem Statement

The problems in the mental health system are well known and have been well documented over the course of the past 2 years of redesign initiatives. These problems are interconnected and require an integrated approach to solutions. This section will identify the prioritized target issues most in need of immediate turnaround solutions.

ACUTE CARE CRISIS

Escalating Utilization

Multnomah County has an inpatient utilization rate that is more than twice that of the statewide average when adjusted per capita (bed days/1000 members). When Multnomah County's utilization data is removed from the statewide aggregate data, we exceed inpatient rates by a factor of 4. Multnomah County is almost 10 times (1000%) higher than the other state MHOs (22/1000 vs. 2.5/1000). State hospital beds serve as overflow capacity (at a cost to the taxpayer of $800/day) when bed capacity is filled. The major reason for this predicament is the lack of less costly and more clinically appropriate sub-acute and crisis response alternatives. It should be noted that risk often motivates the deployment of these types of service alternatives, yet this idea was never pursued by the partner hospitals under the risk partnership contractual arrangements over the past 2 years. The hospitals' most recent request was for the premium share to be increased from 22% to 28% (from $8,359,916 to $ 10,639,892). Inpatient care should be targeted to stabilize individuals so that they can be more actively engaged in community based recovery oriented treatment. Instead, it is capable of consuming over a third of the total available system treatment resources if left uncontrolled.

Movement to Per Diem Inpatient Vendors

The inpatient providers have indicated their intent to sever their current risk contract with the County and return to individually negotiated per diem bed rates. This return to a fee-for-service relationship will result in a significant net increase in the cost of a bed day of 30%-40% over current rates. When factored in to present utilization rates, this could result in an annual inpatient cost of $13,000,000. Suffice it to say that this development mandates a rapid utilization management solution to reverse this scenario.

Absence of Vital Crisis Response Service Continuums

The Crisis Triage Center (CTC) performs a vital system function but is nonetheless providing significantly fewer crisis response services than it agreed to perform in its winning proposal to the original RFP. Because of this, the CTC is a very expensive system component. The CTC's efficacy is severely compromised due to the lack of a strongly coordinated system of adjunct crisis services geared toward mitigating the inpatient risk with more appropriate and less costly alternatives. This most critical service element is also the most glaring service gap in the current system.

OUTPATIENT DELIVERY SYSTEM

Fragmentation and Market Rivalry

Multiple providers delivering basically the same types of services while looking to protect and expand their historical market share does not drive good collaboration or true partnership. It does drive a lot of expensive window dressing and meeting time which only resembles true collaborative partnership. Competition for scarce clinical resources across professional disciplines results in added ongoing recruitment costs that could be better spent by providing a more stable integrated workforce at higher wages. The providers could look to create seamlessly integrated niche specialties and clinical centers of excellence that would better benefit consumers and the system as a whole. Historically, there was little financial incentive to explore these concepts of co-opetition and consolidated service delivery models.

Fee-for-Service Program Structure

The current outpatient reimbursement formula pays for services based 50% on encounter and 50% on case rates. This enables the outpatient system to perform in much the same way as in the fee-for-service encounter days of Medicaid screens. The case rate portion results in a net loss from those historical Medicaid fee-for-service revenues. Therefore, the outpatient system is experiencing much downside associated with risk while still operating the same way as before. This dual mismanagement rewards the system for focusing on those who are easiest to care for while neglecting the difficult client most likely to need more costly and intensive services. Currently, the outpatient system is financially encouraged to shift the care for difficult clients to hospitals rather then expend the overburdened clinical resources to provide alternatives to hospitalization.

Administrative Redundancy

The current multiple providers all carry with them multiple administrative structures that are mirror operational components of one another. These redundancies come at a high cost to the system, whereas, if providers were consolidated, the savings would be reinvested in vital service and capacity expansion. The two major contracting networks (ABH and HSA) show some economies of scale, but it can also be argued that they provide yet another layer of administrative overhead. Member organizations must reduce their individual administrative structures to offset the costs the networks charge back to the members.

Low Productivity

Despite feeling genuinely overburdened with huge caseloads and dramatically reduced fiscal reserves, the average time clinical staff spend in direct clinical encounters with consumers averages less than 50% across the system. Paperwork, meetings, lack of automated processes, and antiquated infrastructures are offered up as excuses as to why more direct service time isn't being spent with consumers. Productivity should be in the 70% range at a minimum. In some cases this would represent a twofold increase over existing service capacity. Nationwide, successful provider organizations have found ways to work smarter, resulting in more effective and efficient clinical service models. Providers must find ways to reduce their clinical staff overhead costs to the 30% or less

range rather than the existing 50%-60% overhead costs in place. This, coupled with unnecessary administrative overhead, is a huge drain on system cost and performance. How many airlines could stay in business with less than half of their seats filled?

Access

Waiting times to access outpatient services are too long. Forty percent of all consumers accessing the inpatient system are not assigned to any outpatient provider. This results in a very expensive access system whose doorbell is, by proxy, a bad outcome (i.e. deterioration to the point of requiring an inpatient stay).

The providers, with a combination of poor productivity, greatly increased caseloads, and little incentive to successfully move clients from out the back door (i.e. successful recovery oriented treatment utilizing natural community systems of support), are in fact unwittingly contributing to their own burnout and failure. The bottleneck at the front door is experienced by the providers as being a direct result of a real lack of service capacity to meet the demand needs of clients wishing to access outpatient services. The reality is that as access to less expensive and most appropriate care is impeded at the outpatient level, more and more consumers are deteriorating to the point of having to access the inpatient system. This in turn bleeds more money out of the outpatient pools, which then results in more diminished outpatient capacity. This downward spiral must be reversed. The best way to achieve this is to provide adequate incentives to provide access on demand and to lower hospitalization

PROPOSED MHO BUSINESS MODEL

Risk Alignment

If one were forced to choose the single variable most responsible for the deterioration of the mental health system with the advent of capitated Medicaid funding, it would be the adverse alignment of risk and reward across the system. Shared risk contracting, when properly aligned and aggressively managed, generates true partnerships and, most importantly, effective, expanded, and seamless clinical care continuums. This is the difference between managed care nightmares and good managed care being synonymous with good and timely clinical intervention. Risk contracting can and must result in the right care being delivered at the right time and for the right price. When done effectively, the consumer benefits enormously. Secondarily, so does everyone else.

Contract Compliance Management

The County's contracting process needs some improvement. Its contract management process needs a major invigoration. Multiple contracts with multiple terms and expiration dates that get changed, sometimes only verbally, are often signed several months after the services are being delivered. The ongoing management of performance metrics and other contract terms is all to often renegotiated in the direction of less value than the original terms. MHO staff will be focused on performance that generates good consumer outcomes. Contingencies must be considered and acted upon when, despite all efforts otherwise, contract agencies fail to meet necessary conditions specified in the contract.

This includes the option of pulling service segments in house when it is deemed they can be more effectively delivered in accordance with contract terms.

Role Diffusion

The relationship between the MHO and the Behavioral Health Division (BHD) has been unclear in the past. Clear boundaries and relationships must be defined and operationalized to maximize accountability while maintaining the flexibility to continuously improve in mutually effective ways. As always, assuring that the right care is taking place at the right time and for the right price will be the ultimate yardstick against which any change is made and measured. Fiscal accountability between the two divisions must be reconciled accordingly.

Data Analysis and Infrastructure

Standardized reporting across specified outcomes management targets must be made available through sound database/data warehouse development and ongoing analytical processes that can optimize continuous quality improvement activities.

CONSUMER INVOLVEMENT

Advocacy versus Empowered Ownership

The consumer advocacy landscape in Multnomah County is very impressive. This is due to the inclusive process involvement by consumers throughout the redesign process. This is also due to the level of talent and commitment embodied in the advocacy community. It is time to take advantage of this underutilized resource. We need to provide a conducive platform that shifts the advocacy community away from a reactive mode towards more proactive involvement and ownership in making new solutions work. In this regard, consumers are most likely to become the true partners in crafting the solutions they so desperately deserve. Development of Ombudsman functions, expansion of the office for consumer affairs, and deployment of expanded peer support services will serve to enhance the continued proactive involvement in existing stakeholder forums. Additionally, inclusion as valued contributing members on contract provider Boards of Directors will serve to secure necessary governance representation as well.

THE PLAN FOR SYSTEM REDESIGN: PHASE I

The charge has been made. The problems have been identified. The obstacles have been targeted for solutions to take their place. The sense of urgency is real and must now be harnessed to promote an immediate transformational redesign initiative. The time to act is now. Together we can make it happen. Apart, we are doomed to fail. The opportunity to create a national model of success is before us. Let us create that future together. What follows are recommended solutions toward the realization of that vision.

ACUTE CARE CRISIS RESOLUTION

The resolution of the spiraling acute care dilemma will necessitate a new shared-risk partnership between the County and a reconstituted integrated outpatient delivery system. This re-orientation is contingent upon a number of assumptions that must rapidly become real for this to be successful. Furthermore, these contingencies establish a secure foundation upon which future success can be best ensured. This shared-risk partnership also allows for continuous quality improvement management processes to reach true fruition. The contingencies are as follows:

Integration/Consolidation

A single contract with a truly integrated outpatient delivery system is preferred. "Truly integrated" is defined as achieving economies of scale via reducing existing overhead costs, blending the pool of covered members to spread Beta risk, assuming life risk for all covered members, expanding consumer choice by providing an expanded array of specialty services, and removing all barriers to accessing treatment services. This will also help resolve the "shadow treatment systems" that have developed over time (e.g. jailed consumers)

Integration of governance functions should also include a commitment to assure that one-third of governing Boards' membership will be composed of secondary and primary consumers.

Ability to Rapidly and Successfully Deploy Crisis Service Continuum

A plan must be negotiated that will assure the rapid deployment of a full range of crisis stabilization service lines within the next 60 days. These services must include but are not limited to:

1. Mobile Crisis Teams that can respond rapidly to mental health crises in the community and provide expanded backup and consultation to law enforcement and corrections.
2. Intensive Community Support Services utilizing a multidisciplinary intensive case management approach that is outreach focused taking place in the community versus facility-based.
3. Sub-Acute stabilization beds serving as an alternative to, and step down from, inpatient stays. 23-hour observation bed capacity is also desired.
4. Expanded respite services and supported transitional housing.

5. Safe shelters with "warm lines" and 24/7/365 drop in availability for consumers wishing that level of service.

Ideally, many of these services could be centrally based out of the CTC facility and create staffing economies of scale that would serve to reduce the current costs associated with CTC.

Overhead Reduction

We expect a 5%-10% efficiency margin as a direct result of system consolidation. This will result in real capital savings gained through elimination of redundant administrative functions and increased productivity at the direct service level. This activity alone would generate up to an additional $750,000 for reinvestment.

Reinvestment in Capacity Building

A reinvestment plan must be developed and approved to specifically address how savings will be reinvested in both the short term and the long term. Priorities include but are not limited to:

1. Living Wage and employee compensation enhancement plans to promote a stable workforce and reduce turnover costs;
2. establishment of a risk reserve pool;
3. deployment of necessary risk-bearing infrastructure, particularly in information system functionality; and
4. establishment of revenue generating capacities not currently available that could further subsidize care for the public consumer. Examples could include development and fundraising/foundation initiatives, commercial product lines, and corporate service product lines.

Adoption of a Recovery-Based Clinical Model greater than the sum of its pre-existing parts (and for children, a family and child centered system of care)

The integrated provider system must demonstrate how an expanded continuum of care will be deployed that also provides the retention of specialty services and/or niche providers in the community. This will be an ongoing organic process as prioritized identified community service needs change, expand, or decrease.

Responsibility and a Committed Focus on Treating the "Most Difficult to Serve"

Historically, the outpatient system was not sufficiently incentivized to do whatever it takes to work effectively with difficult to treat or traditionally non-compliant consumers. This has led to clients falling through the cracks and/or being "ping-ponged" around the fragmented delivery system. In some cases, clients were, in effect, exiled from treatment that works. This negative phenomenon disappears under risk based contracting as the costs associated with untreated multi-problem cases are directly absorbed by the new integrated outpatient solution.

The outpatient providers are hereby requested to submit a written plan proposal by June 15, 2001 that details their ability to comply with the above-stated contingencies for a to be negotiated shared-risk contracting amount.

COUNTY RESPONSIBILITIES

Provide Adequate Capitalization and Flexible Risk-Sharing Funding

Effectively managing an integrated system of care model will necessitate the integration of funding streams into the MHO risk pool. Initially, this integration should be composed of State General fund dollars and the OHP premium share. County General funds targeted for specialized programming will always remain under the exclusive prerogative of the Board of County Commissioners.

This represents a departure from historical categorical budget practices targeting specific programming with annualized funding levels towards a more consumer demand driven global mental health budget model. This is more consistent with fiduciary structures associated with pre-paid health plans. This would allow for more system accountability as well as assuring that dollars can be rapidly and flexibly deployed based on changes in consumer demand needs and trends that are dynamic in nature and fluctuate over time. This will allow for services to be dynamically tailored to be responsive in meeting emergent consumer demand needs as they occur in real time. The reality that systems of care are adaptive in nature is an important construct. Consumer demand needs shift over time, not necessarily in convenient annual cycles that just so happen to coincide with annual budgetary processes. The ability to provide flexible funding that can best assure dollars will flow to consumer/community determined service priorities as they are identified is the best way to assure that the right care at the right time occurs.

Risk sharing then will be a formulation whereby this blended risk pool, minus necessary administrative overhead, would essentially be allocated in 12 monthly installments to the integrated outpatient system. If necessary, the first and twelfth month's installment could be distributed up front to capitalize the rapid deployment of acute care alternatives, with the associated anticipated savings being realized over the first 11 months of operations. Risk sharing corridors will be negotiated based on demonstrated capacity to manage same in the provider proposal due June 15.

MHO as Sole Operational Authority of System Accountability

The ultimate responsibility for all mental health authority functions including risk is held with the Multnomah Board of County Commissioners. The MHO should serve as the engine by which these authority functions are best operationalized and delivered. It establishes a focal point for all system accountability issues to be remedied in a "The buck stops here" responsibility that answers to the County and its entire community constituency simultaneously and reliably.

In this scenario, the Behavioral Health Division's role becomes focused on the provision of prevention and safety net services. This will allow for all service provision, be it internally provided by BHD and/or externally provided by the integrated private service providers, to be held accountable by the same consistently applied standards and measurements. This also provides for organizational alternatives to be utilized quickly if a particular service segment is determined to be more effectively delivered in house (public sector) or externally (private sector). Ideally, it would drive public-private partnerships that yield the most optimal consumer outcomes as well as overall system accountability measured by the same value-driven yardstick.

CQI Driven Contract Management Capacity

An expanded contract management capacity will be the major process which will be employed by the MHO to ensure overall system accountability toward the delivery of more effective and efficient service delivery options. The contract management team will be comprised of clinically experienced contract managers who possess a strong orientation to the principals and practice of continuous quality improvement (CQI). They will be responsible for assuring that all performance metrics identified in the contracts are being attained. They will be responsible in working with providers in developing 90 day correction plans when contractors are out of compliance. Team members will also be actively available in consultative capacities for the successful resolution of corrections plans. Contingencies for failure to resolve non-compliant performance issues will result in corrective action steps up to and including contract termination dependent upon the nature and degree of infraction.

Consumer Representation

In addition to Verity's office of consumer affairs, a new official Ombudsman position will be created with the intent of serving the entire consumer community. Role and scope of responsibilities will be determined in conjunction with consultation and recommendations from the consumer community.

Political Support and Will

Whatever variation of this plan is officially adopted for rapid implementation and transition management, it is not going to be without a small percentage of detractors. Nonetheless, drastic times require bold solutions. The success of a planned change initiative of this magnitude will require the political commitment and conviction of the Multnomah Board of County Commissioners to see to it that the consumers needs are being most effectively addressed. It will take courage to persevere toward the attainment of nothing less than a nationally recognized model of excellence.

PHASE I OUTCOME INDICATORS

All outcome initiatives will be conducted and coordinated through the MHO's research and evaluation team. It is their intent to create an evidence-based best practices model of system accountability and value.

Customer Satisfaction

This will be formally measured and posted throughout the implementation phase with the expectation that consumer satisfaction will increase over historical benchmarks. Additionally, secondary customers (e.g. the BCC, State MHD, community stakeholders, and referral sources) also will be surveyed in this regard.

Successful Recovery Utilizing Natural Community Based Supports

This will be formally measured by employing the Functional Assessment Inventory incorporating specific items geared for both child and adult populations.

Significant Decreases in Inpatient Utilization

This will be measured in the industry standard days/per 1000 covered lives. A significant reduction from the current 22/1000 will be expected. Additionally, this only will be seen as an optimal outcome if the first 2 indicators above are in the positive range.

Reinvestment of Overhead Savings into Service Capacities

A minimum target expectation of one million dollars worth of net expanded service capacity to be successfully deployed within the first year of plan implementation is the Phase I goal.

Resolution 00-161	
Type:	Resolution, Order or Proclamation
Date:	09/28/2000
Number:	00-161
Title:	ADOPTING A VISION STATEMENT FOR A CONSUMER AND FAMILY CENTERED MENTAL HEALTH SYSTEM
Text:	BEFORE THE BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON RESOLUTION NO. 00-161 Adopting a Vision Statement for a Consumer and Family Centered Mental Health System The Multnomah County Board of Commissioners Finds: A. On May 4, 2000 the Board of County Commissioners adopted Resolution No. 00-063 creating a Mental Health Design Team " to work with county, state, and community personnel to develop short and long term action plans to improve County mental health services." B. The Design Team has determined that an underlying vision and a unifying philosophy is needed to guide system design efforts. This vision and philosophy should apply to services for adults, children and adolescents at all levels of care. C. The Design Team has recommended that the Board of County Commissioners adopt the vision statement expressed in a " Consumer and Family Centered Mental Health System" . The Multnomah County Board of Commissioners Resolves: 1. The values and principles described in the attached document " Consumer and Family Centered Mental Health System" will provide the underlying vision and unifying philosophy for the mental health system in Multnomah County.

2. County Departments that provide mental health services will distribute this document to all employees and to appropriate contractors, advisory board members and other partners.

3. County Departments that directly provide mental health services will incorporate these values and principles into those services to the fullest extent possible.

4. County Departments that contract for mental health services will include these values and principles in all relevant contracts and will insure that these values and principles are incorporated into the services delivered through those contracts.

5. The Department of Community and Family services will provide leadership in the collaborative development of a training program to increase system-wide understanding of these values and principles. Planning and implementation of this training program will include consumers, members of their support teams, families and providers.

6. The County will work with community advocates and organizations to encourage State and Federal policy makers to develop and fund programs which are consistent with this vision statement.

ADOPTED this 28th day of September 2000.

BOARD OF COUNTY COMMISSIONERS FOR MULTNOMAH COUNTY, OREGON

Beverly Stein, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY FOR MULTNOMAH COUNTY, OREGON

By Thomas Sponsler, County Attorney

A Consumer and Family Centered Mental Health System For Multnomah County

This document expresses the underlying vision and unifying philosophy that will guide the design and operation of public mental health services in Multnomah County. Consumers receiving mental health services (including adults, adolescents, children and families as appropriate) are at the center of the mental health system. The system is organized and operated to meet their needs. While there may be resource constraints the ultimate goal of the system is to improve the lives of those receiving mental health services.

The services for children, adolescents and their families will focus on a developmental model of intervention and on age and developmentally appropriate outcomes for children within the contexts of their individual family situations. The services for adults will be recovery-oriented with a focus on developing natural systems of support and self-determination. Within the adult and children service systems there may be different providers, programs and types of services but common values and principles will anchor and unify all mental health services.

Our vision for mental health services has three sections: attitudes and values; the service system; and accountability and management.

A. The attitudes and values of the mental health system support and encourage consumers to achieve their full potential.

1. Everyone receiving services in the Multnomah County Mental Health System is supported and encouraged to reach his or her full potential. Consumers are supported by attitudes and services that communicate hope, focus on strengths, nurture recovery, promote optimal development and support achievement of goals. Respect and dignity will be embraced throughout the County' s caring and flexible system.

	2. The services provided by the mental health system in Multnomah County are individualized, and in the case of children, child-centered and family-focused. The needs, goals and preferences of consumers dictate the types and mix of services provided. 3. The mental health system is community based, with the location of services and decision-making resting at the community (i.e. local) level. 4. Agencies, programs, services and staff are culturally competent; that is, sensitive and responsive to all the elements of consumers' identities, including but not limited to age, ethnicity, race, religion, gender, sexual orientation, disability and culture. 5. Adult consumers may choose to identify friends, family members or others to participate in planning for their care and service delivery. The families and/or surrogate families of children receiving mental health services are full participants in all aspects of the planning and delivery of services. 6. Mental health services for children and adolescents will be guided by the best interests of the child or adolescent. Services will support, assist and strengthen the family system. This may include identifying and addressing changes needed to better support the child' s optimal development. B. It is the goal of the mental health system to work toward the provision of a wide range of services that support recovery and optimal human development. 1. Services for adults maximize the opportunity for self-sufficiency, autonomy and a self-directed practice of recovery. Services for children reflect the " System of Care " principles. Services and models for adults and children will evolve in response to consumer needs and evidence-based changes in best practices. 2. Services are provided in the least restrictive setting that is clinically appropriate and meets consumers' needs. Services to achieve stabilization and recovery at lower levels of care are prioritized so that they are available when needed,

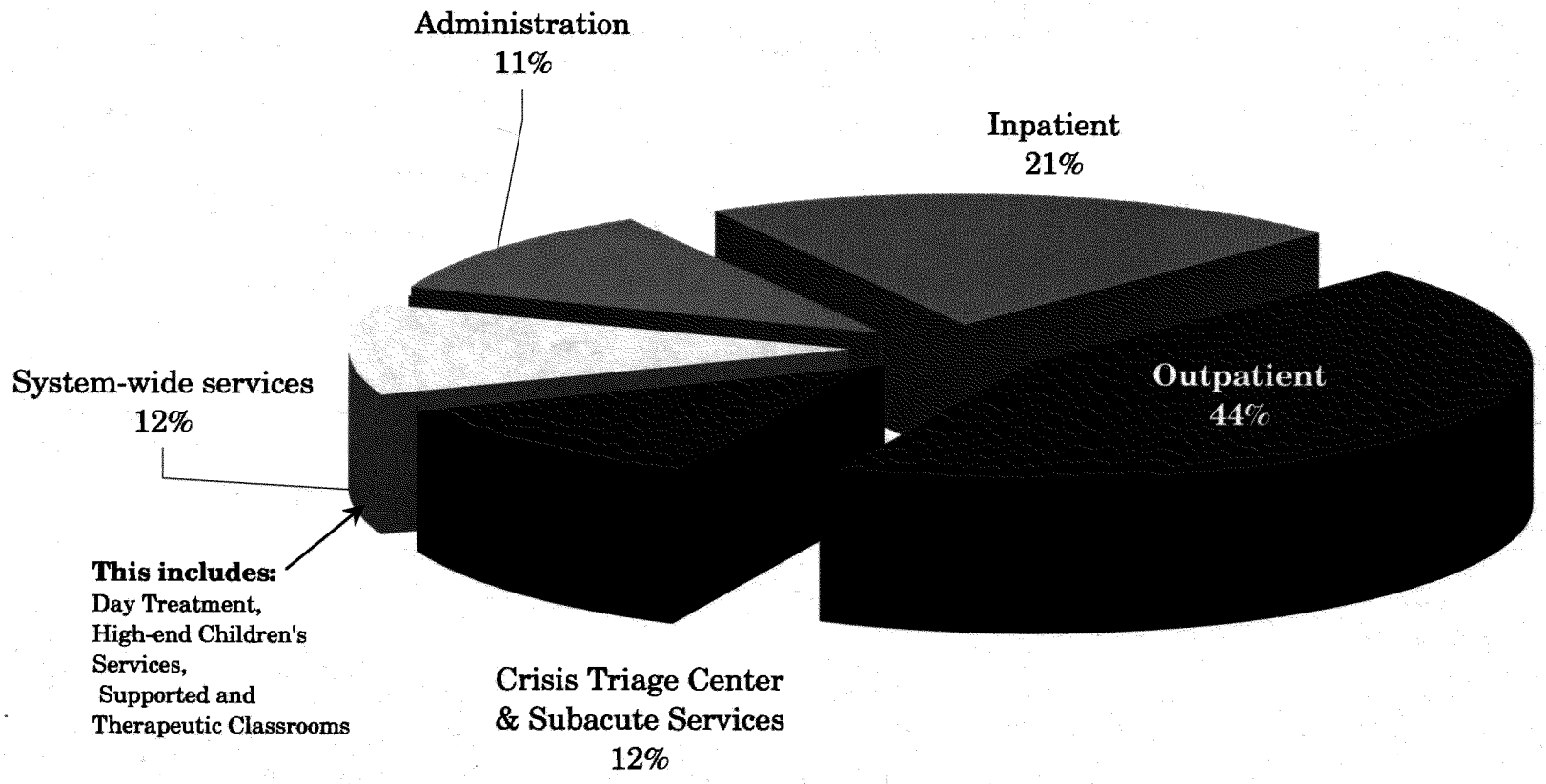
	thereby reducing utilization of higher levels of care such as crisis services and hospitalization. Services are organized to avoid inappropriate use of the criminal and juvenile justice systems as a substitute for mental health care. 3. Every person receiving mental health services has access to competent diagnosis and an appropriate and affordable menu of treatment. Access to and coordination with competent, comprehensive physical health care is arranged. 4. Every consumer is assured of having a prompt and clinically appropriate response to his or her crisis and acute care needs. 5. Adult consumers have access to a range of safe, affordable housing options and the support services needed to successfully retain their housing over time. 6. Every person receiving mental health services has access to suitable employment, training and/or education services in order to reach his or her full potential for independence and contribution to society. 7. Every person receiving mental health services has access to a network of natural supports including transportation and affordable social, cultural, physical and recreational and/or faith-based activities that promote integration into the community, optimal development and recovery. 8. Competent care management services are provided based on need. Case managers insure that multiple services are delivered in a coordinated and therapeutic manner and that consumers can navigate smoothly through the system. 9. Services from multiple agencies including the education, criminal justice, juvenile justice, child-welfare, health and chemical dependency systems are coordinated and/or integrated to better serve consumers. 10. In order to support prevention and effective treatment, the mental health system provides consultation to other health and social service providers.

	11. Mental health services include outreach and education in order to increase early identification and intervention and to increase appropriate continuation in care, leading to earlier recovery. 12. Consumers and families are able to access services easily. They are offered at convenient and accessible locations and times. 13. Services include consumers as providers and include opportunities for peer support and self-help. Services for children include opportunities for family peer support. C. The mental health system is publicly accountable and well managed. 1. In order to be truly accountable the mental health system is organized with clear lines of responsibility and authority. The policy, planning, resource allocation and evaluation functions are centralized and consolidated and/or coordinated. 2. Consumers, providers, families and a wide range of stakeholders are involved in policy development, program planning, service delivery and evaluation for the mental health system. 3. The mental health system is publicly accountable for the resources that have been entrusted to it. Service delivery systems are integrated administratively to eliminate expensive fragmentation and duplication. Financial risk and incentives are utilized as tools to achieve system goals. 4. At all levels, the system is accountable for service delivery and outcomes. Clear, quantifiable measures are established to show efficiency and effectiveness. These measures include consumer satisfaction and improving the quality of life for people receiving services. The system uses data to monitor costs and outcomes and to improve quality and access. 5. A centralized data system is structured to increase coordination across service

	systems and provide the demographic, financial, service and outcome data necessary for system reporting, management and accountability. 6. The mental health system supports a positive working environment for its providers and staff. Competitive salaries and benefits, training and education and reasonable workloads reduce turnover and support the provision of high quality services and positive interactions with consumers 7. The system vigorously pursues new resources and partnerships that will help to meet the mental health needs of County residents. The system is expert at blending funds from a variety of sources to meet consumer needs. 8. Advocacy for the needs and rights of those with mental health disabilities is an important component of system management. Stigma and discrimination make recovery more difficult. Education and advocacy is carried out in order to increase understanding and support for consumers and families and their needs. 9. Critical incidents are investigated and, where appropriate, result in corrective action. A fair and consistent process exists to respond to grievances and complaints.

Verity's Mental Health Services Mix
Current Allocation of Funding
Capitation and Crisis Revenue Only*

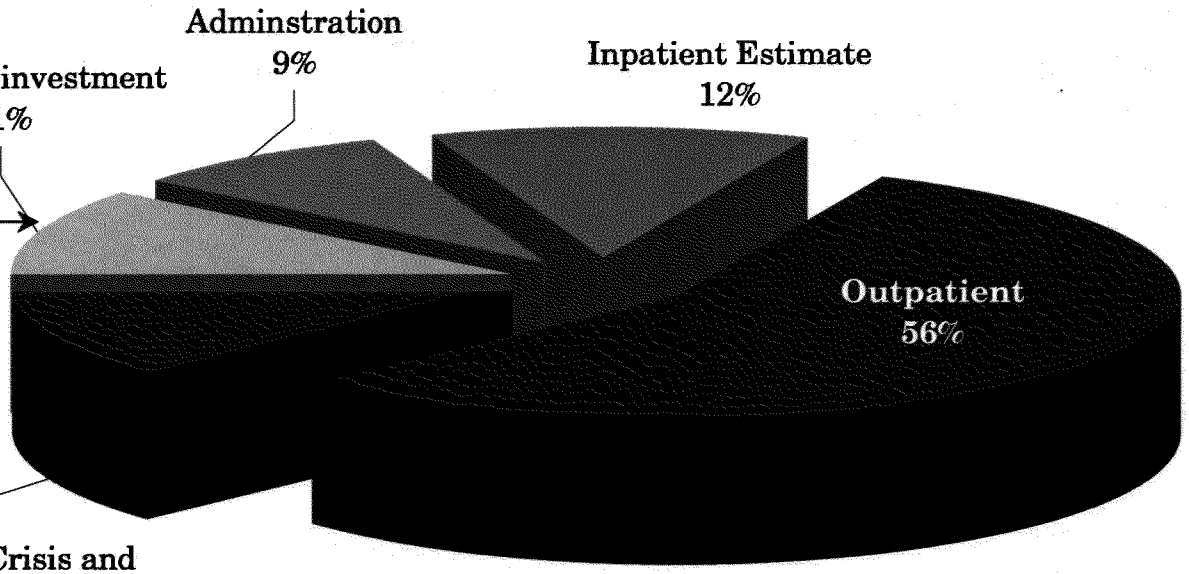
Based on Budget for FY02



Note: The percentages shown include the use of capitation and crisis revenue. The percentages will not correspond to the allocation of capitation revenue alone.

Verity's Mental Health Services Mix
Proposed Reallocation of Funding
Capitation and Crisis Revenue Only

Based on Budget FY02



For investing in services and service delivery
includes,
expanded supported housing,
mobile crisis,
intensive case management

All Outpatient Services
including those previously paid out of the system-wide pool, such as high-end Children's care, Therapeutic Schools, Day Treatment

Wall Street Journal
5/2/01

Housing Homeless Who Are Mentally Ill Cuts Their Emergency Costs, Study Says

By BARBARA MARTINEZ
Staff Reporter of THE WALL STREET JOURNAL

Getting mentally ill homeless people off the streets and into supportive housing costs taxpayers only slightly more than leaving them to fend for themselves, according to a study to be released today.

Researchers at the University of Pennsylvania Health System in Philadelphia studied nearly 10,000 mentally ill homeless people in New York, half of whom were placed in government-funded housing with mental-health assistance. The individuals who were not housed ended up costing taxpayers, on average, $40,500 a year for their time in emergency rooms, psychiatric hospitals, shelters and prisons.

But those provided with housing and mental-health assistance used far fewer emergency-type services, the study found. Including that huge savings, researchers found setting up the mentally ill homeless in housing with support services costs only about $994 more than the $40,500 these individuals run up when they don't have homes.

While the five-year study focuses only on New York, homeless advocates say the results could have a powerful effect across the country, where an estimated 110,000 chronically homeless people have mental illnesses. The research could help convince government leaders about the cost-effectiveness of doing more to solve the problem of mentally ill homeless people in major cities.

"A considerable amount of public dollars are spent essentially maintaining people in a state of homelessness," said the study's lead author, Dennis P. Culhane, associate professor of social welfare policy at the University of Pennsylvania. Mr. Culhane added that the cost-reduction estimates of housing the mentally ill in his study are conservative, considering he didn't include the savings that come from fewer burdens on the police and court systems, nor the economic impact of homelessness on local businesses and tourism.

"This study shows that providing supportive housing to homeless people with psychiatric disabilities is not only the right thing to do, but the smart thing to do," said Carla Javits, president of the Corporation for Supportive Housing, a national nonprofit group on homelessness and a funder of the study. The study also was backed by the Fannie Mae Foundation in Washington, the United Hospital Fund of New York, the Conrad N. Hilton Foundation in Los Angeles and the Rhodebeck Charitable Trust in New York.

The study is among the most comprehensive estimates of the costs society incurs because of the mentally ill homeless. The researchers obtained the costs of specific individuals, matching their names and Social Security numbers as they wended their way through various shelters, hospitals and prison systems during several years. It took Mr. Culhane four years to get seven New York city and state agencies that oversee shelters, jails and hospital reimbursements just to agree to share their data with him for this study.

Among the findings, the researchers determined that the average homeless person with severe mental illness works up a huge bill in one year by spending 4.5 months in a shelter, two months in state psychiatric hospitals, seven weeks in various hospitals, and nearly three weeks in jail or prison.

WSJ.com **Journal Link:** University of Pennsylvania researchers studied the impact of supportive housing on mentally ill homeless in New York City. See the full report in the online Journal

AT&T Broadband Unit Plans to Increase Rates For Fast Internet Access

Dow Jones Newswires

NEW YORK—AT&T Corp.'s broadband unit, which sells cable services, will increase monthly rates for most high-speed Internet service by $6 starting June 1.

The rate increases will affect customers of AT&T@Home and AT&T Roadrunner, with some exceptions, spokesman Steve Lang said. He declined to say how much revenue the new rates will bring or whether the higher rates will affect the company's projections for the year.

The large majority of AT&T Broadband Internet customers lease modems from the company and pay $39.95 a month, Mr. Lang said. Their rates will rise to $45.95 a month, he said.

Customers who have their own modems will pay $35.95 a month, compared with $29.95 a month now, he said. The $49.95 monthly fee for customers who chose not to have AT&T Broadband's cable-television services bundled with their Internet services won't change, he said.

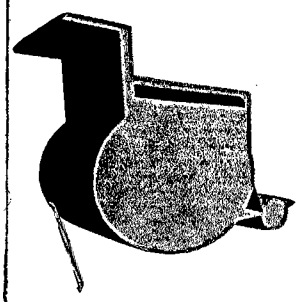
A statement by Laddie Read:

I have been following this process since day one. I have to say that I have become disillusioned. Since the beginning I have held out hope that we could see some **real** results. Instead there were committees and councils and work groups with little change in the system. I would like to know what I can do to help the process move along. If you want me to do **anything**, I am willing. I want to advocate for people with all kinds of disabilities. I get frustrated when I hear bureaucratic mumbo-jumbo. Please note that when I yell out it is not to offend people. I just have to express my passion. I am available through email. I have developed my own web-site. I would like to help redesign the system so it meets the needs of those it is supposed to serve. I don't want to offend people. If I have offended anyone, I apologize. If my passion has offended the group, I am sorry.

Thank you,

LaddieRead@msn.com

LADDIE'S SELF-ADVOCATE SITE



Laddie Read

President and Founder

http://communities.msn.com/
LaddiesSelfAdvocateWebSite

Master Tracking Sheet
Budget Worksession Follow-Up Questions

No.	Date	Commissioner	Respondent/ Dept	Completed	Question
1	5/1/01	Naito, Farver	Budget Office	Noted	Flag decision points when potential for urban renewal district property to come back on the tax rolls.
2	5/1/01	Cruz	MCSO	5/18/01	Issue paper on Pay to Stay; provide rough draft at MCSO budget session
3	5/1/01	Roberts	DCJ	5/22/01	Describe the issues that keep kids from going to school.
4	5/1/01	Naito	CFS		Historically, how have we funded our other community centers (i.e. Clara Vista, Brentwood Darlington). Who are our other partners? Provide details on the service components, funding capital contribution, other source (city) contributions?
5	5/1/01	Cruz	Chair/Budget		Provide FFP funding and develop language to create placeholder for Clara Vista and Rockwood concurrently if there is additional FFP funding.
6	5/1/01	Andersen	Budget Office	5/04/01	Create MH Council Follow Up session
7	5/1/01	Naito	DA/DCJ		What type of funding can we expect from LLEBG as compared to a national perspective? Additionally, what has the city spent LLEBG funding for in the past (police overtime, equipment, etc...)?
7	5/1/01		DCJ/MCSO/ Evaluation	5/18/01	Pretrial Release issue paper as a result from Chicago visits
9	5/1/01	Andersen	Finance		Describe funding proposal for Mainframe migration
10	5/1/01	Andersen	Finance		Status of bond projects and remaining funding available. Risk ranking
11	5/1/01	Naito	DSCD/Finance	5/29/01	Facilities Finance Committee report (Naito resolution)
12	5/1/01	Cruz	Budget Office	5/16/01	List of items in budget funded by FFP
13	5/1/01	Cruz	MCSO	5/11/01	Report on MCSO implementation of Fleet Audit; in compliance why or why not
1	5/8/01	Naito	Budget	Noted	Lay out budgets by funding source (see state for example)
2	5/8/01	Naito/Farver	Budget	Noted	Levy Planning for Library, Public Safety. Hard data for potential operating levies this fall. Budget Office to prepare information this summer.
3	5/8/01	Cruz	DSCD/ MCSO	5/18/01	Work Crew Proposal Concerns: Is it legal to use MCRC residents for custodial work? Will we have enough time to address significant policy questions during budget process? What will it look like (implementation and operationally).
4	5/8/01	Naito	Depts/ F&PM	Noted	Policy threshold re: bringing leases to bcc under $50,000. Forward policy matter to BCC even though small amounts as an FYI.
5	5/8/01	Roberts	Library	5/14/01	How does the Library interact with SUN Schools? Library to provide brochure
6	5/8/01	Anderson	Library	5/14/01	Delineate OTO payments in FY 2002.
7	5/8/01	Naito	Library	Noted	Summer project to review county services in schools (prior to Library Levy review)
8	5/8/01	Cruz	DSCD	5/16/01	Follow-up on number of properties available to Tax Title and strategies to fund

					in future. Shortfall?
9	5/8/01	Cruz	DSCD	5/16/01	Additional discussion on our role as developed for mixed used buildings.
10	5/8/01	Anderson	DSCD	Noted	Provide information in advance of capital budget presentation.
11	5/9/01	Naito	DSCD	5/16/01	**Amendment**: Rail line between Portland and Lake Oswego - $30,000/year have we been contributing that amount? IGA. What amount have we given? History and status. Possible amendment item.
12	5/9/01	Anderson	CCFC		**Amendment**: Native American Youth
13	5/9/01	Naito	CBAC	5/15/01	**Amendment**: CIC restoration $8,447
14	5/9/01	Cruz	ONI/PAO	5/14/01	Provide a sense of the siting calls, in terms of operations of office.
15	5/9/01	Cruz	Cooperative Extension		**Budget Note:** Review funding for non-d regarding (extension)agencies and county funding
16	5/15/01	Cruz	ADS/Health/ Budget Office		**Amendment**: How to fund the MDT Nurses? Total funding; Medicaid match and non-Medicaid match? And split between ADS and Health? Present options.
17	5/15/01	Cruz	ADS/PAO		**Budget Note:** Keep OPI at the top of our legislative agenda. Help state approach federal government (federal to advocate for a change in Medicaid to recognize OPI for eligibility)
18	5/15/01	Farver	DRM		**Budget Note**: DRM's to develop county-wide policy paper for bcc consideration over the summer re: state funding for formula issues. (reference ADS equity issue). Consider DHR reorganization as part of the partnership context.
19	5/15/01	Farver	CFS/Mental Health		Clarify differences/costs between today's presentation and prior resolution (Lane County model). Commissioner concerns: Naito: Case management piece; more detail re: contracting out. Variation on theme how gatekeeping is done and how we would contract out. Why is this the best model with cost comparison of a couple of models. Want to see here is the best and why. Cruz- concerns center around where plan doesn't follow resolution case management; cost analysis consistent with resolution (case management function); wants collaborative process utilizing our expertise and the provider networks. Anderson-walk through the plan. Set up meeting at later time to review. Farver-looking for budget specifics and tradeoffs to make it real. Timelines.
20	5/15/01	Farver	MH Dept/ Jim Gaynor		**Budget Note-** come back with package of budget amendments; come back in a series of meetings over the course of the year. MH Redesign group to return with a group of amendments about the specifics of the system re-design.
21	5/16/01	Cruz	Health		**Budget Note**—Time frame for reviewing revenues coming into Health Department/Primary care clinics. Include potential cuts, if revenues do not meet projections. Quarterly Status Report. Have a broader issue to capture FFP, fees, etc

22	5/16/01	Anderson	Health		How do you measure the success/effectiveness of the STARS program? Forward evaluation.
23	5/16/01	Cruz	Health		**Amendment**: Restore MDT Nurses (4, ½ time in ADS/Health) $75,000-$100,000.
24	5/16/01	Naito	Health		**Amendment**: Restore $250,000 for second OLDs team in North Portland.
25	5/16/01	Naito	CFS		**Amendment**: Restore PEIP $147,000 (early intervention). Explore DD settlement funding (even if not funded by Gov's Budget)
26	5/16/01	Naito	Health/CFS		**Amendment**: Restore $106,000 for Connections contract (funded in CFS).
27	5/16/01	Naito	Health		**Amendment**: Restore $35,000 for SKIP.
28	5/16/01	Farver	Health/ADS		Follow-up information to address "shared" staff at the new East County Building.
29	5/16/01	Naito/Farver	MCSO/Health/ DCJ	5/18/01	**Budget Note:** Pretrial release redesign briefing; mental health issue; impact/analysis of number of bookings on mental health system. Include the effect state mental health system (closing of hospitals) on mentally ill in local jails.
30	5/16/01	Naito	Health		Legal question about federal payments for mental health disabilities of jail inmates.
31	5/16/01	Cruz	Health		Provide information on HD Tobacco Cessation efforts.
32	5/16/01	Cruz	CFS		Additional information on CFS GF expenditures, direct and indirect; include information on how CFS made 7% target.
33	5/16/01	Cruz	CFS		**Budget Note**: Future expansion of Bienestar into Columbia Villa
34	5/16/01	Cruz	CFS/SUN		**Amendment**: Cut funding for SUN Schools at Robert Gray, Buckman; Clear Creek. Return with additional information.
35	5/16/01	Farver	CFS		**Budget Note:** Possible contingency request this fall for $$$'s for single access point into Homeless Shelter. First priorities Homeless Families Plan.