Multnomah County Oregon

Board of Commissioners & Agenda

connecting citizens with information and services

BOARD OF COMMISSIONERS

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Nov. 23, 2010 BOARD MEETINGS HIGHLIGHTS

10:00 am – B-1 - Informational Board Briefing on DCHS Mental Health Accomplishments and Innovations.

10:45 am – B-2 - Board Briefing on the Findings of the 2009 Corrections Grand Jury Workgroup

NO MEETING THURSDAY IN HONOR OF

Meetings of the Multnomah County Board of Commissioners are held at 501 SE Hawthorne Blvd. most usually in the Commissioners Chamber off of the main lobby, on the first floor.

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(Portland & East County)
Thursday, 9:30 AM, (LIVE) Channel 30
Sunday, 11:00 AM Channel 30
(East County Only)
Saturday, 10:00 AM, Channel 29
Tuesday, 8:15 PM, Channel 29

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Tuesday, Nov. 23, 2010 - 10:00 am
Board of Commissioners Meeting
Multnomah County, Oregon
Multnomah Building, Commissioners Board Room 100
501 SE Hawthorne Boulevard, Portland

BOARD BRIEFINGS

B-1 Informational Board Briefing on DCHS Mental Health Accomplishments and Innovations. Presenters: Joanne Fuller, DCHS Director and Karl Brimner, Mental Health Director & Other Invited Guests (45 min)

B-2 Board Briefing on the Findings of the 2009 Corrections Grand Jury Workgroup. Sponsor: Commissioner Judy Shiprack, D-3. Presenter: Captain Drew Brosh (60 min)

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

(revised 08/02/10)

Board Clerk Use Only	
Meeting Date:	11/23/2010
Agenda Item #:	B-1
Est. Start Time:	10:00 am
Date Submitted:	11/17/2010

Agenda Title:	**Informational Board Briefing on DCHS Mental Health Accomplishments & Innovations**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title sufficient to describe the action requested.

Requested Meeting Date:	November 23, 2010	**Amount of Time Needed:**	45 Minutes
Department:	County Human Services	**Division:**	Mental Health & Addiction Services Division
Contact(s):	Erin McCarley		
Phone:	503.988.3691 **Ext.** 25390	**I/O Address:**	167/2nd Fl
Presenter Name(s) & Title(s):	Joanne Fuller, DCHS Director & Karl Brimner, Mental Health Director		

General Information

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

2. **Please provide sufficient background information for the Board and the public to understand this issue. Please note which Program Offer this action affects and how it impacts the results.**
   During the last few years our Mental Health and Addiction Services Division has experienced a great deal of change and improvement. We will be taking this time to brief the Board on current innovations and accomplishments in our system. These include positive outcomes from our EASA program (Early Assessment and Support Alliance), and our Coordinated Diversion (jail and hospital diversion) programs. We will also discuss the impact of innovations in Verity (our OHP funded mental health organization), including our Pay for Performance program, our web-based outcomes management system (ACORN), and the Verity Outreach & Engagement project.

3. **Explain the fiscal impact (current year and ongoing).**
   There is no fiscal impact to the County budget.

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

   none

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

   Our consumer advisory committees were involved in several of these initiatives to ensure that consumer voice was included in all our decisions impacting clients. These committees include the Adult Mental Health and Substance Abuse Advisory Council (AMHSAAC) and the Children's Mental Health Services Advisory Council (CMHSAC).

Required Signature

Elected Official or Department/ Agency Director: Kathy Sinkle for Joanne Fuller **Date:** 11/4/10

EARLY ASSESSMENT AND SUPPORT ALLIANCE

503-988-3272 PHONE
503-988-5870 FAX

What is EASA?
EASA stands for Early Assessment and Support Alliance. EASA is an early intervention program designed to provide rapid access to psychiatric, counseling, occupational therapy, and vocational services for individuals whom are experiencing psychosis for the first time. Independent living skill development is the primary goal. Individuals and their families are supported in increasing their knowledge about the cause, treatment, and management of psychosis. The EASA team promotes recovery and is dedicated to providing intervention as quickly and flexibly as possible with a minimum number of barriers.

How do I, or someone I know get into the EASA Program?
To refer a friend, yourself, or a family member to the EASA Program call 503-988-EASA (3272). A Call Center staff will take your information and submit it to the EASA team. An EASA team member will call you back within 1 business day.

Who is eligible?
If you (or someone you know) reside in Multnomah County, are age 15-25, has had their first episode of psychosis within the last 12 months, has an IQ of 70 or above, has symptoms that are not due to the temporary affects of substance intoxication, a mood issue, or known medical condition, you qualify for an EASA referral.

What is EASA's process for determining acceptance into the program?
The screening process that follows a referral is designed to gain additional information, so be prepared for additional questions about your experience. The team wants to create the best fit and set of services for you. A team member may want to meet with you or the person you are referring to determine appropriateness of fit.

What is the next step?
If you are accepted into the EASA program, an EASA team member will assist you through intake. Services start immediately. There is no waiting period before services will be available. Expect an EASA team member to call you and schedule a meeting.

If you are not deemed eligible, an EASA team member will help you find alternative services in the community.

Do I have to have insurance?
No. But, if you do have a primary insurance carrier, EASA will need that information and will bill the carrier. If you are unsure and you or someone you know is experiencing psychosis, call EASA at 503-988-3272. An EASA team member will address it with you directly.

EARLY ASSESSMENT AND SUPPORT ALLIANCE

503-988-3272 PHONE
503-988-5870 FAX

What services does EASA provide?
EASA is committed to providing individuals who are experiencing psychosis for the first time with assistance in removing barriers to independent, sustainable living. We will do our best to assist the individual in obtaining his or her employment and educational goals. We will work closely with the family and other supports.

EASA provides the following services:

Rapid access to psychiatric and therapy services
Multi-family problem solving groups
Symptom management support
Goal setting and planning
Education about psychosis
Vocational support
Occupational therapy
Crisis and relapse planning
Events which are fun & educational

Do I have to live in Multnomah County?
Yes. In order to participate in the EASA Program you or the person you are referring must reside within Multnomah County. If you have a special circumstance and have questions please call EASA at 503-988-3272. An EASA team member will address it with you directly.

MULTNOMAH COUNTY
DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTIONS SERVICES DIVISION
421 SW OAK ST. PORTLAND, OR 97204

503-988-5464
503-988-5870 Fax

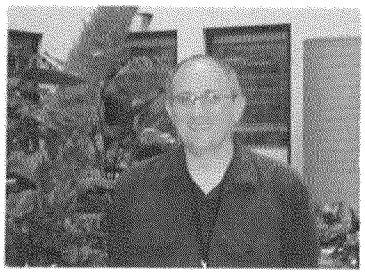
EARLY ASSESSMENT AND SUPPORT ALLIANCE

503-988-3272 REFERRAL LINE
503-988-5870 FAX

EASA UPDATE – June 2010

The Multnomah County EASA Team celebrates its two year anniversary this month. Many thanks for all your referrals! You have helped us to serve many of our community's young adults and families from diverse cultural and socioeconomic backgrounds. Here are some recent highlights from our program:

- We continue to accept referrals of young people between the ages of 15 and 25 years of age who have experienced their first episode of psychosis within the past year.
- We have made two recent additions to our team:
  Leslie Conlee, QMHA, Supported Employment/Education Specialist
  Robert Janz, LPC CADC1, EASA Team Supervisor
- We completed a Pacific University Occupational Therapy student internship Innovative Practice Project conducted by Lacey Bradford, MOTS and Chelsea Chamizo, MOTS. This project offered a brief group program focusing on identity and social skills. Since critical development in these areas can be a challenge for young people with psychosis we are excited about plans to continue this innovative model.
- Dr Neil Falk, who became the team's psychiatrist one year ago, furthers our mission by prescribing medications in concert with the EASA philosophy. This often includes a slow, low-key introduction of medications, prescribing in low doses, and discontinuing them after 3-6 months of stability.



"Medications are only helpful if people are willing to take them. This means valuing their beliefs about medications, and including them as primary decision makers in their treatment. Medication use is most successful when the client and prescriber agree on a plan, and work together as a team." *Dr. Neil Falk*

"What I like about EASA is that the Team comes to me and that services are personalized for each person". *EASA client.*

PSYCHOSIS RESEARCH IN THE NEWS

Read the recent research pointing to the importance of social skills development in the recovery from psychosis.

- http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/32/suppl_1/S12

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EASA

EARLY INTERVENTION AROUND THE STATE AND GLOBE

- http://www.eppic.org.au/
- http://www.tsweekly.com/news/features/

EASA CRITERIA/SERVICES

We are currently accepting new clients and look forward to your referrals.

EASA serves Multnomah County residents between the ages of 15 and 25 who have had a first episode of psychosis in the past year that is not caused by a medical condition or substance use and who have an IQ of 70 and above. EASA accepts clients regardless of their mental health insurance, including indigent clients. Our team offers:

- Case management
- Multi-family groups
- Vocational training
- 24/7 crisis support
- Rapid access
- Education about psychosis
- Individual, group and family counseling
- Occupational therapy
- Life skills coaching
- Low-dose medication management
- Community-based services
- Social activities

Please feel free to contact us for consultation if you have a potential client for our program who may not match the above criteria. Our referral number is **503-988-3272**. Community Education presentations are available by contacting EASA Supervisor Robert Janz at **503-988-5464 x 29334** or **503-793-0760. We look forward to hearing from you.**

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MENTAL HEALTH AND ADDICTIONS SERVICES DIVISION
421 SW OAK ST. PORTLAND, OR 97204

503-988-5464
503-988-5870 Fax

Verity Outreach and Engagement (VOE)

Program Description:
VOE was created to reach out to hospitalized Verity Members who are not connected to outpatient mental health services to get them into the most appropriate level of care they need to remain stable and in the community. The VOE team works with these members while they are in the hospital and upon their discharge. Together with the member they work through any barriers to getting necessary care.

GOALS:
- Reduce acute care admissions
- Track members' engagement in treatment post-hospitalization
- Assist members who are not currently engaged in treatment to do so

ACTIVITIES AND FUNCTIONS:

- We will meet with members on the psychiatric unit during acute hospitalizations
- We will meet with members and their mental health provider at their outpatient mental health services appointment
- When it adds value we will be part of treatment meetings
- Conversations with members will assist them to identify their mental health needs and any obstacles in getting care
- We will help members and providers understand the Verity benefit package
- We will help connect members and mental health providers to physical care providers and other resources to remain well
- We will encourage the development of natural support systems such as families and friends to help members maintain wellness

CLIENTS:
Hospitalized Verity members and individuals whose primary insurance is Medicare and secondary insurance is Verity who are not engaged with a treatment provider.

REFERRALS:
Hospital staff, Verity utilization review staff, agency providers, and Verity members

CONTACTS:
Lorea Alba – 503-988-5464 x26228
Valerie Stevens – 503-988-5464 x 24668

Measurement of Mental Health Treatment Outcomes with ACORN

The Need

Verity needed a consistent measure of mental health treatment outcomes across all systems of care. In the fall of 2008, we reviewed many tools, and selected A Collaborative Outcomes Resource Network (ACORN) to pilot. Before putting out a Request for Proposal (RFP), we piloted the ACORN to determine its utility and applicability within an Oregon Health Plan (OHP) population.

The Pilot

Five community mental health agencies volunteered to be in the pilot, which began in July 2009. Twelve months later, we needed more data to confidently determine the utility of ACORN in the OHP/Verity population. The pilot has been extended through June 2011, and nine additional agencies serving both children and adults have since joined.

The Cost & Benefits

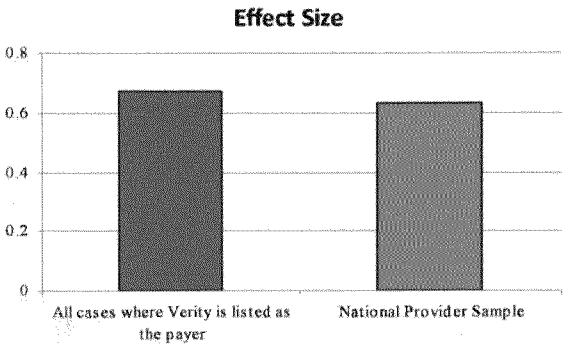
With over 300 clinicians and 1,000 forms processed monthly, Verity pays roughly $5,000 each month. Unit costs decreases as volume increases. The main benefits of ACORN can be identified as either clinical or system-wide. Clinically, ACORN provides the clinician with information they may not otherwise obtain. System-wide, each clinician, program, agency, and Verity as a whole have access to aggregate, objective measures of mental health treatment outcomes.

The ACORN Tool

ACORN is a frequently administered client self-report outcomes tool. There are 14-18 questions answered with a 5-point Likert scale. The client completes the form in the waiting room prior to every appointment, and then reviews their answers with their clinician in the therapy session. The data is entered by faxing completed forms to a toll free 1-800 number.

The Data

All data are available through a secure web-based "clinician toolkit." Mental health treatment outcomes are measured with a statistical measure of pre-post symptom decrease after controlling for diagnosis, severity of symptoms, and other personal characteristics (severity adjusted effect size, SAES). An SAES above 0.5 is considered "effective." Currently, Verity's effect size is 0.66 (n=759), higher than a national provider sample. Client charts tracking client distress at each appointment are also available online.



Moving Forward

Verity will release an RFP to contract for outcomes measurement services beginning July 2011. As each contract is renewed, language will be added requiring all Verity contractors to measure outcomes of mental health treatment.

Verity Integrated Behavioral Health Systems
Pay-For-Performance (P4P)

Verity Pay-for-Performance Principles

Verity Integrated Behavioral Health Services Pay for Performance Program focuses on the "Principles for the Construct of Pay-for-Performance Programs," as formulated by JCAHO (1).

1. The goal of pay-for-performance programs will be to align reimbursement with the practice of high quality, safe health care for all consumers.
   A. Payment systems will recognize the cost of providing care in accordance with accepted standards of practice and will guard against any incentives that could undermine the provision of safe, high quality care.
   B. Reward programs will encourage qualified clinical staff to accept patients where complexity, risk, or severity of illness may be considerations.
   C. Performance incentives will be aligned with professional responsibility and control.

2. Programs will include a mix of financial and non-financial incentives (such as differential intensity of oversight; reduction of administrative and regulatory burdens; public acknowledgment of performance) that are designed to achieve program goals.
   A. The type and magnitude of incentives will be tailored to the desired behavior changes. Rewards will be great enough to drive desired behaviors and support consistently high quality care.
   B. A sliding scale of rewards will be established to allow for recognition of gradations in quality of care, including service delivery.
   C. The reward structure will take into account the unique characteristics of a provider organization's mission.

3. When selecting the areas of clinical focus, programs will strongly consider consistency with national and regional efforts in order to leverage change and reduce conflicting or competing measurement. It is also important to attend to clinical areas that show significant promise for achieving improvements because they represent areas where unwarranted differences in performance have been documented.

4. Programs will be designed to ensure that metrics upon which incentive payments are based are credible, valid and reliable.
   A. Quality-related program goals will be transparent, explicit and measurable.
   B. Metrics will be evidence-based or, in the absence of strong science, be based on expert consensus.
   C. Metrics will also be standardized, be risk-adjusted where appropriate, and have broad acceptance in the provider and professional communities.
   D. Credible and affordable mechanisms to audit data and verify performance must be developed and implemented.
   E. The measurement set will be constructed to fulfill program objectives with the minimum amount of measurement burden needed.

5. Programs must be designed to acknowledge the united approach necessary to effect significant change, and the reality that the provision of safe, high quality care is a shared responsibility between provider organizations and health care professionals.
   A. Incentive payments will recognize systemic drivers of quality in units broader than individual provider organizations and practitioner groups and encourage improvement at these aggregate levels.
   B. Incentive programs will support team approaches to the provision of health care, as well as integration of services, overall management of disease, and continuity of care.
   C. Incentive programs will encourage strong alignment between practitioner and provider organization goals, while also recognizing and rewarding the respective contributions of each to overall performance.

6. The measurement and reward framework will be strategically designed to permit and facilitate broad-scale behavior change and achievement of performance goals within targeted time periods. To accomplish this, providers and practitioners will receive timely feedback about their performance and be provided the opportunity for dialogue when appropriate. Rewards will follow closely upon the achievement of performance.

7. Programs will incorporate periodic, objective assessment into their structure. The evaluations will include the system of payment and incentives built into the program design, in order to evaluate its effects on achieving improvements in quality, including any unintended consequences. The program and, where appropriate, its performance thresholds will be re-adjusted as necessary.

8. Provisions will be made to invest in sub-threshold performers who are committed to improvement and are willing to work themselves or with assistance to develop and carry out improvement plans. Such investments will be made after considering both the potential for realistic gains in improvement relative to the amount of resources necessary to achieve that promise, and what is a reasonable timeframe for achieving program performance goals.

Pay-for-Performance Program

The Institute of Medicine (IOM) report Crossing the Quality Chasm: A New Health System for the 21st Century made the case for changes in the health care system, including restructuring of payment methods, to close the quality gap. The report identified six aims for health care that will guide quality improvement efforts—safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. (2) When funds are available, new Pay-for-Performance programs adopted by Verity supporting the organization, delivery of services, as well as sustainability of future capitation payments will also support the realization of these aims.

The Verity Pay For Performance Program offers financial incentives that reward providers for the achievement of Verity objectives, including delivery efficiencies, submission of increased encounter data, improved access to care for members with higher level of need determination, and improved quality.

Pay-for-Performance Program Design

The Verity Pay-For-Performance Program (P4P) is designed to ensure that payments are based on credible, valid, and reliable metrics. Verity will use current eligibility, authorization and claims data to minimize the burden of measurement, while fulfilling program objectives.

1. Target Outpatient Provider Agencies That Self-Authorize Services

The new Verity P4P incentives are introduced where the greatest system gains can be achieved addressing underutilization of outpatient care, and where Verity has fully developed claims data for each provider. Verity has no plans to target individual practitioners for incentives.

2. Participation

Performance incentive payments will be applied to all contracted network outpatient providers that have the ability to self-authorize service and providers delivering intensive community based outpatient services, as many measures are already required in contracts. Verity hopes that each network agency will use this opportunity to focus their improvement efforts on these measures. The P4P performance rewards system is subject to funding availability.

Providers will not be eligible to receive any performance payment available during any time period providers are out of compliance with any required reporting as specified in their contracts.

3. Funding Source

Verity has notified providers that performance payment availability is subject to change each fiscal year.

4. P4P Goals

Verity's goals for the P4P program include addressing over/underutilization in outpatient care, Increasing access to services, and moving towards outcomes (state-level performance measures). Goals and payment are subject to change based on performance results.

a. P4P for Children FY09/10 and FY10/11

Improve initial access to services for members receiving care from general outpatient programs
$400,000 performance incentive pool
Second visit within 14 days <60% provider receives $75 dollars for each client seen twice in 14 days, =>60% provider receives $100 dollars for each client seen twice in 14 days

Four visits within 45 days <50% provider receives $200 for each client seen 4 times in 45 days, =>50% provider receives $300 for each client seen 4 times in 45 days

Decrease overutilization in lower CASII levels and increase utilization for children with CASII levels 3 and 4. Total services are measured for each child at the end date of the 6 month authorization.
$400,000 performance incentive pool

Target Service Levels
$700-CASII Level 1
$900-$1300- CASII Level 2
$1800-$2700- CASII Level 3
$3000 and over- CASII Level 4
$300 additional for each appropriately managed outpatient CASII authorization

Increase percent of community-based care provided to children receiving Intensive Community-based Outpatient Treatment
$100,000 performance incentive pool

Increase community-based care in INTOP services
$20 for each community based service day 45-59%
$40 for each community based service day 60% or greater

b. P4P for Adults FY09/10 and FY10/11

Improve initial access to members receiving care from general outpatient programs and programs serving individuals severely and persistently mentally ill
$250,000 performance incentive pool

Second visit within 14 days <60% provider receives $75 dollars for each client seen twice in 14 days, =>60% provider receives $100 dollars for each client seen twice in 14 days

Four visits within 45 days <50% provider receives $200 for each client seen 4 times in 45 days, =>50% provider receives $300 for each client seen 4 times in 45 days

Increase utilization of services by adults with SMI LOCUS 4 authorization
$300,000 performance incentive pool

Providers receive $20 dollars = >30% and < 50% on open authorizations when clients are seen weekly

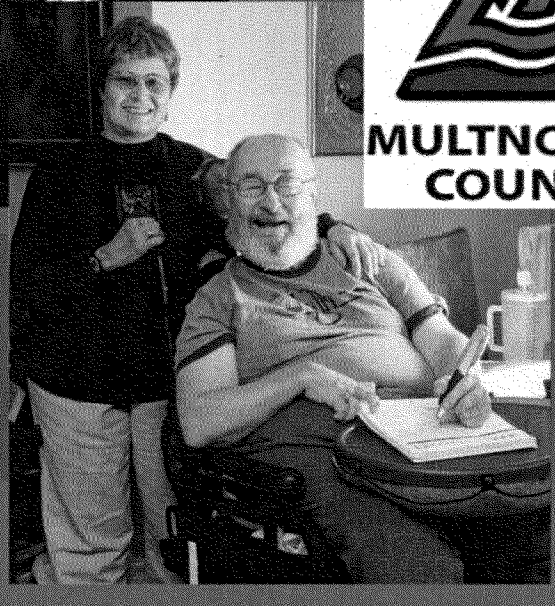
Providers receive $40 dollars =>50% and <70% on open authorizations when clients are seen weekly

Providers receive $60 dollars =>70% on open authorizations when clients are seen weekly

Increase access for Medicare/Medicaid Dual Eligible
$500,000 performance incentive pool

$98 per service day provided to dual eligible Medicare/Verity members
Due to EOB requirement data will be refreshed and future payments will contain unpaid balance from prior quarter.

5. Payout Time Period
October payout for April- June services
December payout for July-September services
March payout for October-December services
June payout for January-March services



MULTNOMAH COUNTY

DCHS Board Briefing Nov, 23, 2010

Mental Health & Addiction Services Accomplishments & Innovations

Innovations & Accomplishments

- Early Assessment & Support Alliance (EASA)
- Verity Outreach & Engagement (VOE)
- Measurement of Mental Health Treatment Outcomes with ACORN (A Collaborative Outcomes Resource Network)
- Pay for Performance (P4P)

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Early Assessment & Support Alliance (EASA)

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EASA Goals

- Assist young people with first signs of psychosis to continue/ return to normal life and goals.

- Support and educate families about evidence based practices and what we know works to best help their family member.

- Educate community about how to identify early warning signs and how to get help before becoming acute.

EASA Clients

- EASA serves:
  - Transition Age Youth ages 14 to 25
  - 1st episode of psychosis within past year
  - Psychosis not result of medical or drug induced causes
  - IQ of 70 or higher

- In the first 2.5 years of the program, 44% of clients served are people of color.

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EASA Model

- Trans disciplinary team providing rapid, intensive community-based mental health services.
- Team of:
  - 4-5 Mental Health Consultants
  - 1 Supported Employment/Education Specialist
  - 1 Occupational Therapist
  - 1 Part-time Registered Nurse
  - 1 Part-time Psychiatrist

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- Utilizing evidence-based practices based on Patrick McGorry's Early Intervention for Psychosis (EIP) model and William McFarlane's Multi-Family Group model.

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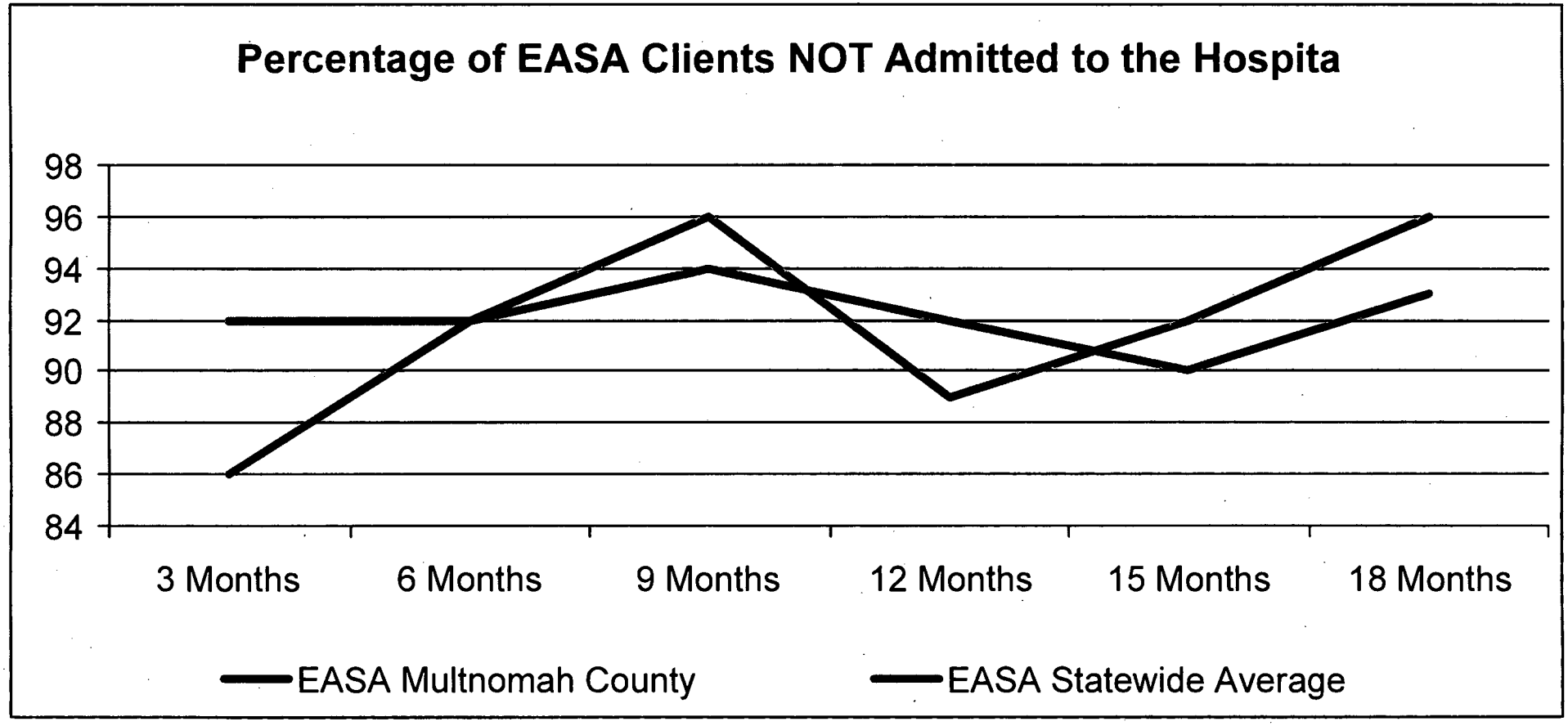
Reduced Recidivism



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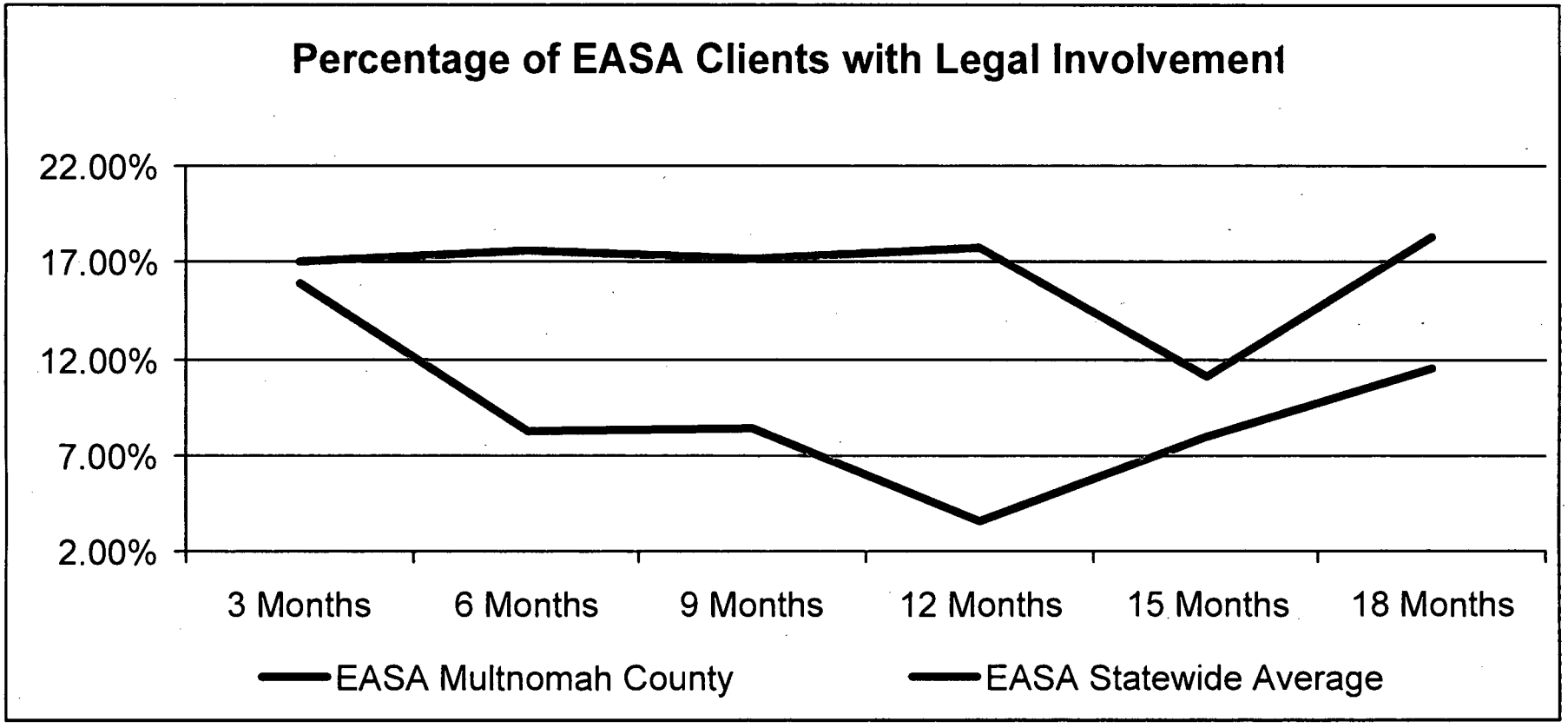
Reduced Legal Involvement



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Verity Outreach & Engagement (VOE)

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Verity Outreach & Engagement

- Designed to help Verity members being discharged from higher levels of care to connect and maintain connection to outpatient services.
- VOE staff are Qualified Mental Health Professionals that work with members and hospital staff with the following goals:
  - Assist members in understanding their Verity mental health benefits.
  - Collaborate with members, facility staff and outpatient providers to create optimum discharge plans that will provide continued support.
  - Assist with resources for complex treatment planning.

Verity Outreach & Engagement

- Goals cont'd:
  - Assist in complex care coordination by attending member staffings with the member and service providers.
  - Provide ongoing support and monitoring for treatment engagement by doing routine check-ins with the member and/or provider on a 30, 60, 90 day schedule, or as often as needed.
- Support the member with their recovery plan.

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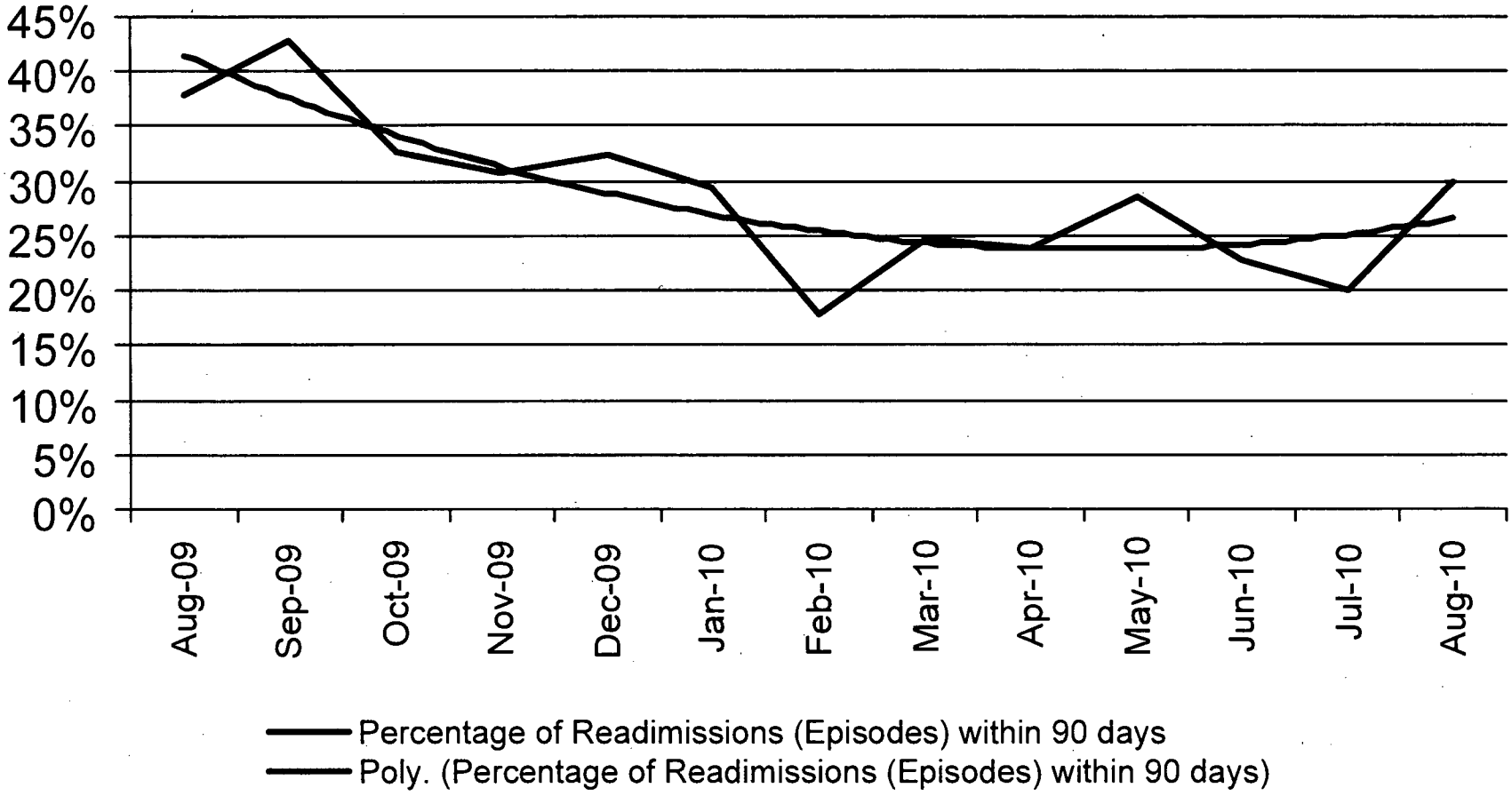
Hospital Recidivism



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Measurement of Mental Health Treatment Outcomes (ACORN)

MULTNOMAH COUNTY

Introduction & Timeline

- Identified need for consistent measurement of outcomes across Verity system of care
- Reviewed many existing outcomes tools (Fall 2008)
- Selected ACORN as potentially best tool (Spring 2009)
  - A Collaborative Outcomes Resource Network (ACORN)
  - ACORN not affiliated with the now-defunct controversial political group
  - ACORN is a frequently administered client self-report outcomes tool

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- The Pilot:
  - Began Spring 2009
  - Initially 5 agencies, currently 14 providers participating
- Multnomah is the first county in the US to measure self reported outcomes for individuals with severe mental illness
- Multnomah County results are being studied by researchers at Northwestern and Vanderbilt Universities.

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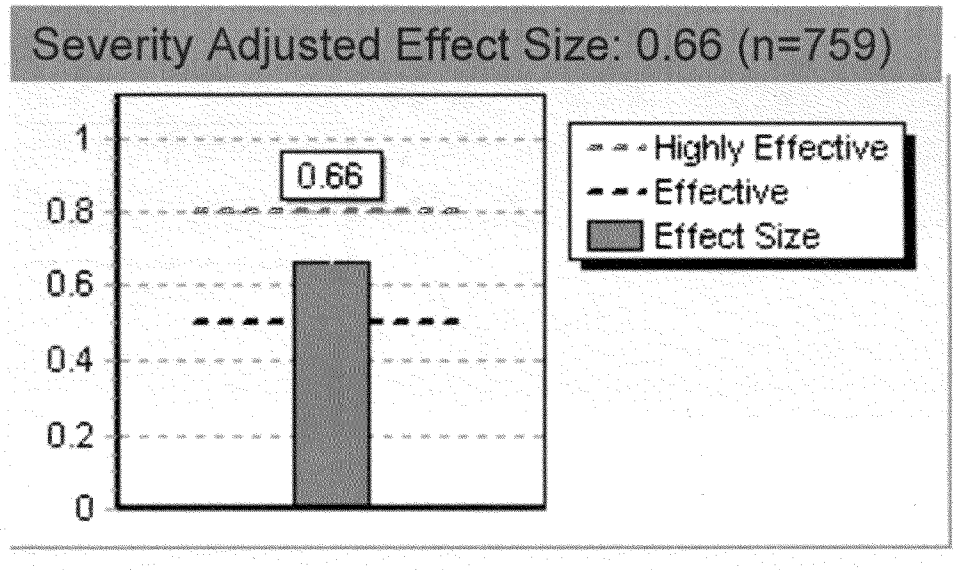
Main Benefits

- Clinical Benefit
  - Additional information for clinician about client symptoms, stressors, relationship
  - Track client distress over time, identify areas of progress
  - Solicit information clients are more likely to share in writing (e.g. thoughts of self harm)
- System Benefit
  - Aggregate, objective measure of outcomes of mental health treatment
  - Can stratify by clinician, program, and agency

Verity Outcomes (7/1/2009 – 11/6/2010)

Summary Statistics:

Case Count:	1,569
# w/Repeat Assessments:	971
% w/Repeat Assessments:	62%
Average Change Score:	0.3
Predicted Change:	0.3
Average Benchmark Score:	0.0

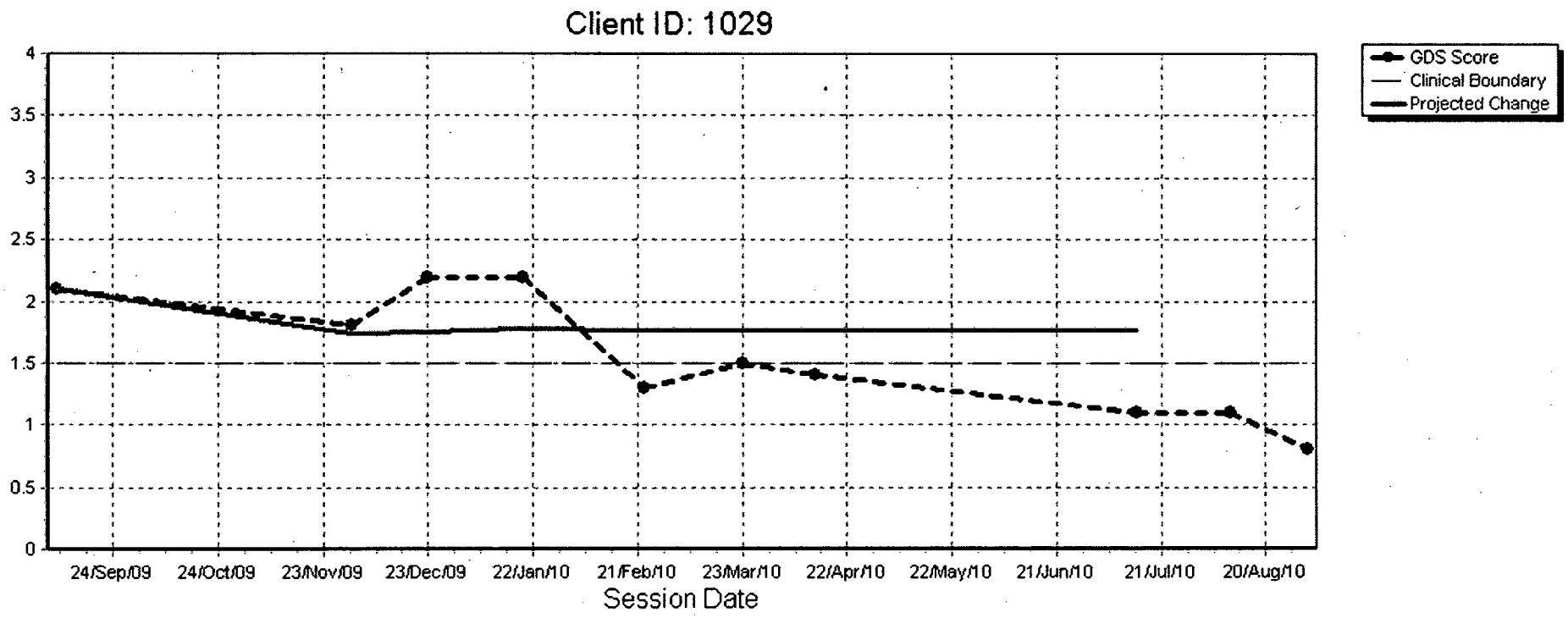


Client Outcomes

MULTNOMAH COUNTY

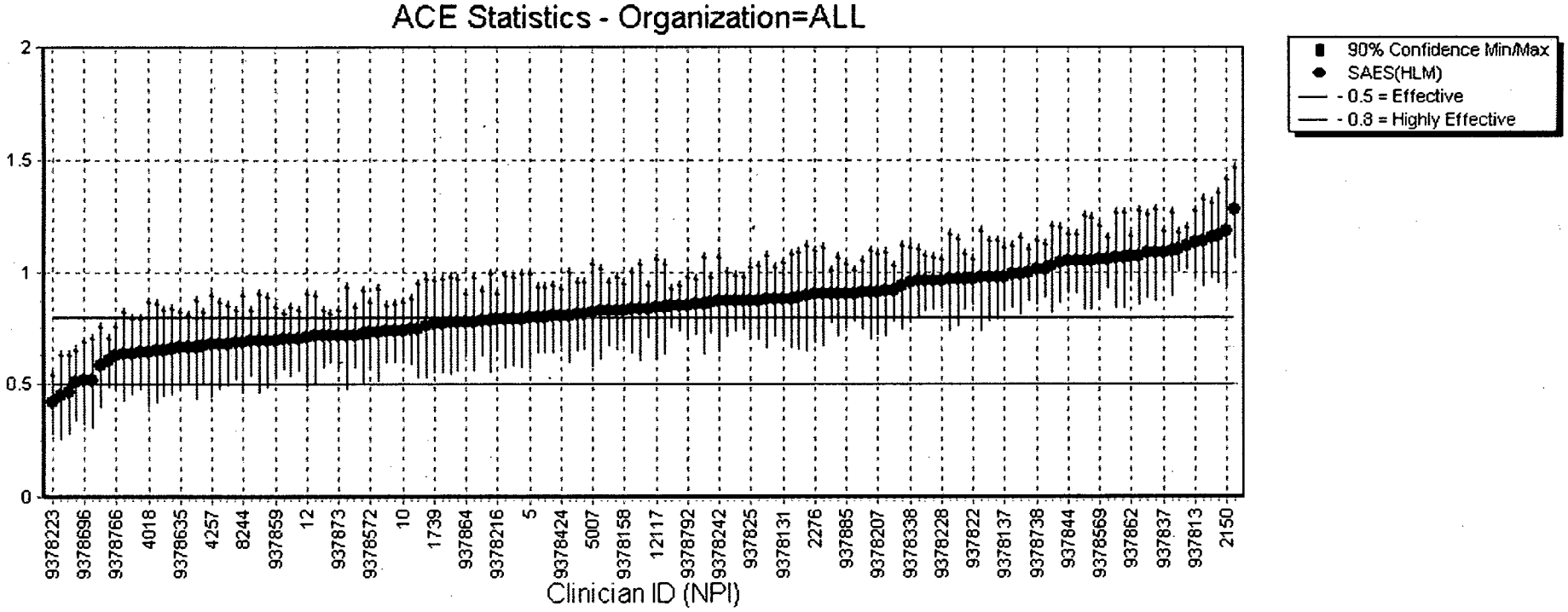
First Date:	9/8/2009
First GDS Score:	2.1
Most Recent Date:	9/1/2010
Most Recent GDS Score:	0.8
Total Assessments:	10

Outpatient client with monthly assessments/appointments and decreasing symptoms



Clinician Outcomes

- SAES for each clinician
- ACORN Criteria for Effectiveness (ACE) automatically calculated for each clinician
- Clinician 'certified' when meet minimum criteria



MULTNOMAH COUNTY

Moving Forward

- Verity will put out Request for Proposals (RFP) this winter
- Begin contract with outcomes system provider July 2011
- With each contract renewal, will add language requiring providers to use outcomes tool
- Continue work on Medicaid outcome norms, long-term SMI clients, and other special populations

MULTNOMAH COUNTY

Pay for Performance (P4P)

Pay for Performance (P4P)

- MHASD established the Verity Pay-For-Performance program to align reimbursement with the practice of high quality, safe health care for individuals receiving mental health services from Multnomah County mental health providers.

P4P Program Design

- P4P Goals
  - Address over/underutilization in outpatient care
  - Increase access to services
  - Move toward outcomes informed care
- Payment for outpatient provider agencies
- Providers gain financially by bringing more consumers into compliance with performance targets

P4P for Children

- Improve initial access to services for members receiving care from general outpatient programs
  - $400,000 performance incentive pool
- Decrease overutilization for children with lower levels of need and increase utilization for children with higher levels of need
  - $400,000 performance incentive pool
- Increase percent of community-based care provided to children in intensive outpatient programs
  - $100,000 performance incentive pool

P4P for Adults

- Improve initial access to members receiving care from general outpatient programs and programs serving individuals severely and persistently mentally ill
  - $250,000 performance incentive pool
- Increase utilization of services by adults with severe mental illness and highest level of need
  - $250,000 performance incentive pool
- Increase access for Medicare/Medicaid Dual Eligible
  - $500,000 performance incentive pool

MULTNOMAH COUNTY

Future Plans

- MHASD intends to move toward paying for outcomes versus other measures in fiscal year 2011
- Initially payments will be made each time an adult receiving services has their outcomes recorded for measurement of change in a web-based system
- Later payments will be adjusted based on the amount of improvement with higher levels of improvement receiving higher payment

MULTNOMAH COUNTY

Next Steps

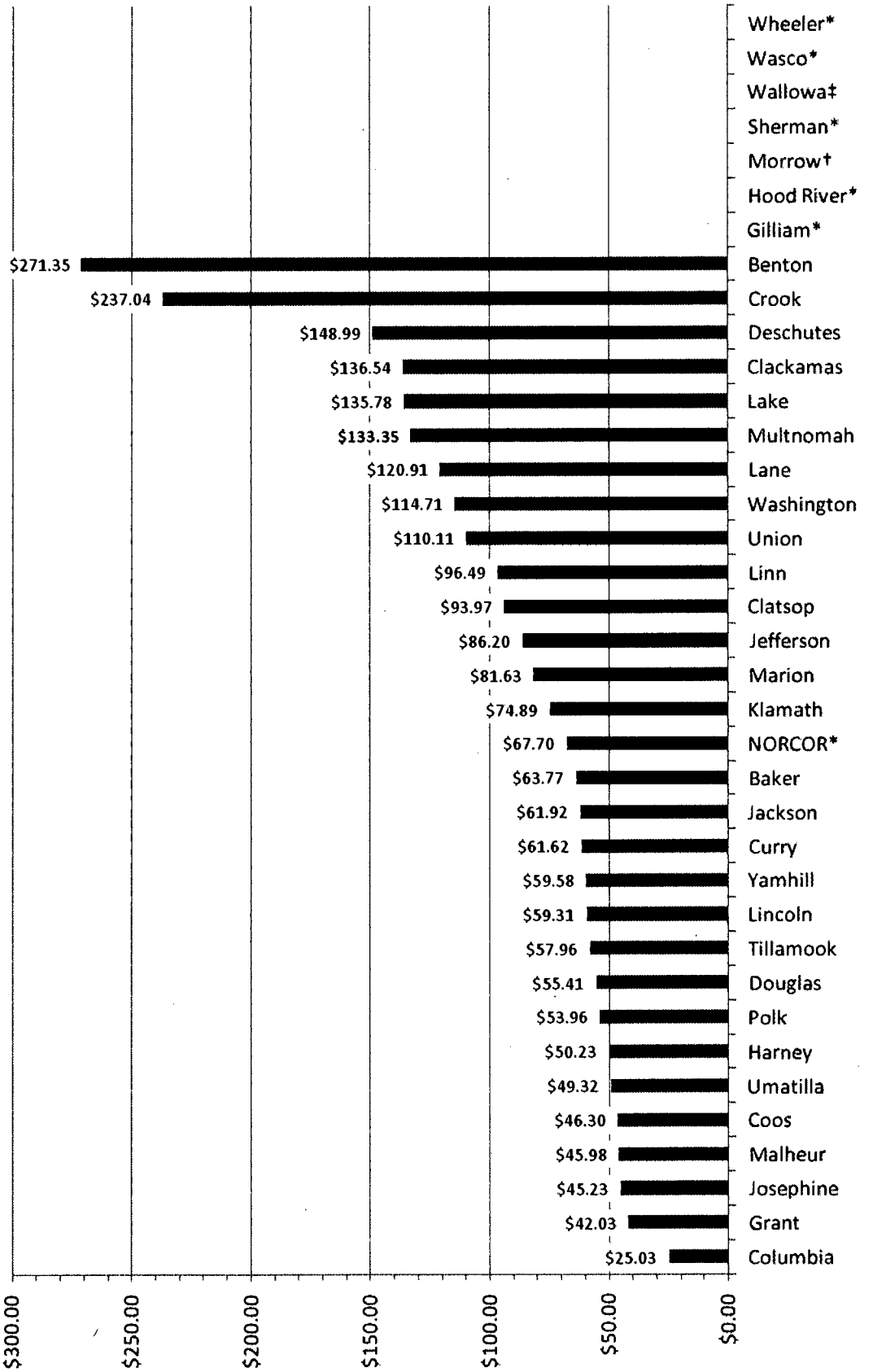
Multnomah County Sheriff's Office

Corrections Grand Jury Workgroup

November 23, 2010

Cost per Bed Day For Oregon Counties

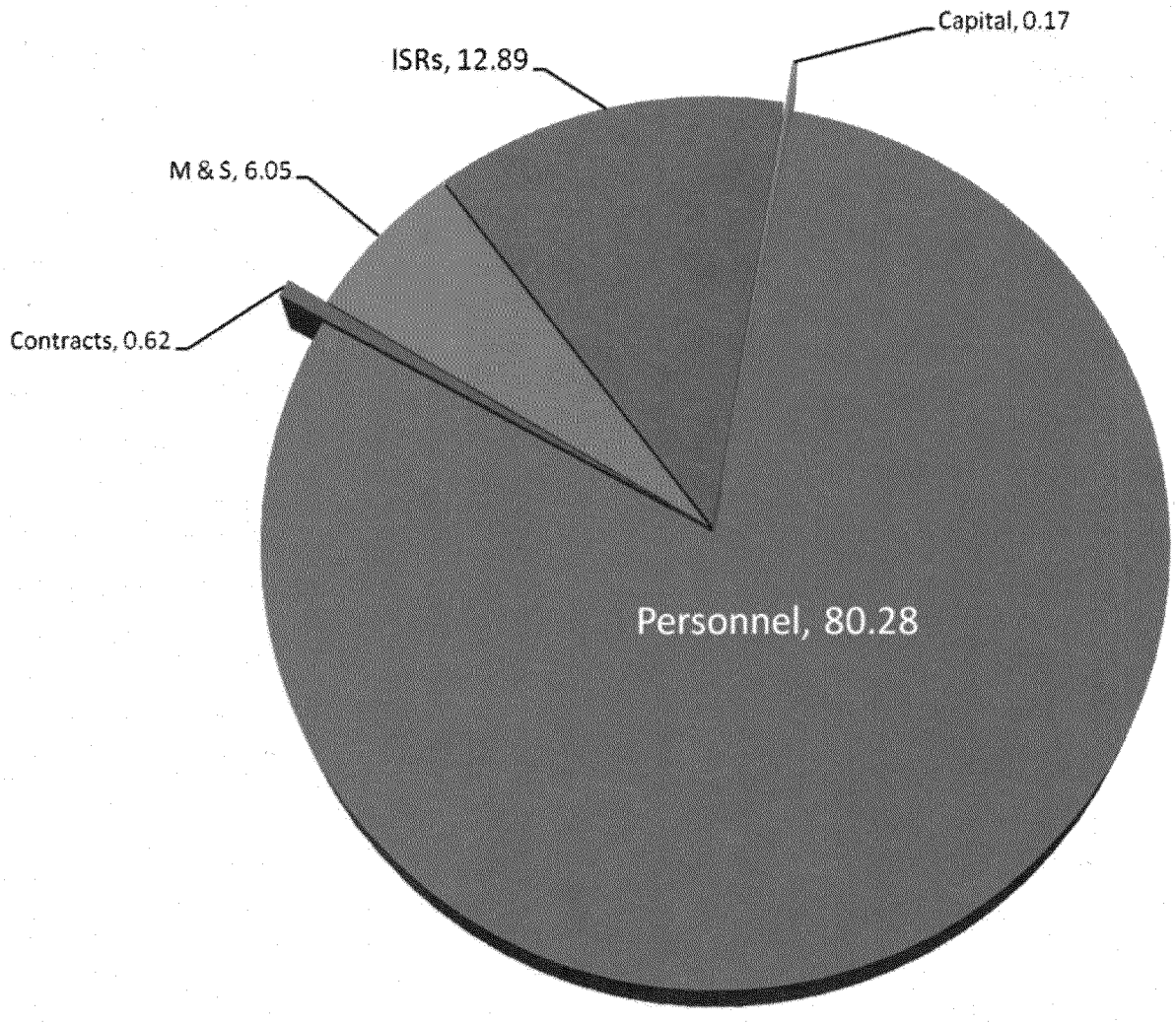
Data Source: Oregon Sheriff's Jail Command Council 2009 Report; July 6, 2010



A number of factors affect the costs of jail beds in any local system

- Number of facilities in the jail system (single, multiple and location of court facilities relative to jail facilities);
- Number of system beds (reducing beds may lower overall costs to county but raise the individual bed day cost);
- CPI issues (e.g. urban vs. rural);
- Circuit court requirements prevailing in system;
- Direct supervision vs. indirect supervision practices;
- Single bunking vs. double bunking practices;
- Classification of inmates in a particular facility;
- Building cost considerations (contracted, county owned, internal service reimbursements etc…).

Chart One - Percent of jail bed costs



Cost per day

From Draft 2 Report November 18, 2010

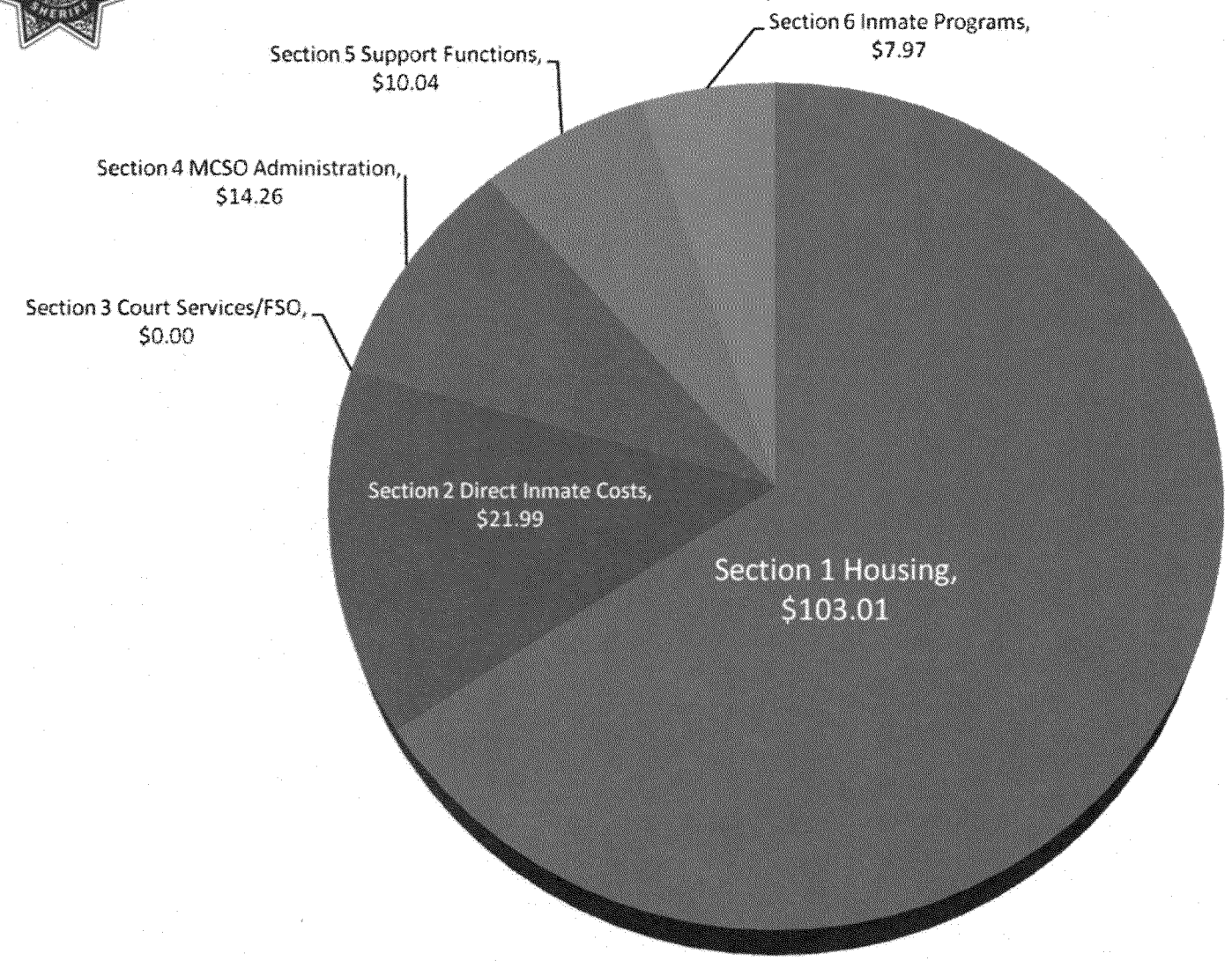


Table demonstrating the cost difference of adding additional jail beds to capacity					
	Cost per day per Bed				
	Current Budgeted Beds	Full Capacity no additional costs	Difference	Full Capacity adding the costs of three dorms	Difference
Beds	**1,310**	1,485	175	**1,485**	175
Section 1 Housing	$103.01	$90.87	-$12.14	$94.67	-$8.34
Section 2 Direct Inmate	$21.99	$18.60	-$3.39	$18.60	-$3.39
Section 3 Court Services	$0.00	$0.00	$0.00	$0.00	$0.00
Section 4 MCSO Central Administrative Costs for Housing	$14.26	$12.58	-$1.68	$12.58	-$1.68
Section 5 Support Functions	$10.04	$8.66	-$1.38	$8.66	-$1.38
Section 6 Inmate Programs	$7.97	$7.03	-$0.94	$7.03	-$0.94
Total all Sections	$157.27	$137.73	-$19.53	$141.54	-$15.73
Medical costs	$21.99	$19.39	-$2.60	$19.39	-$2.60
Total all costs	$179.26	$157.12	-$22.14	$160.93	-$18.33

Recommendations

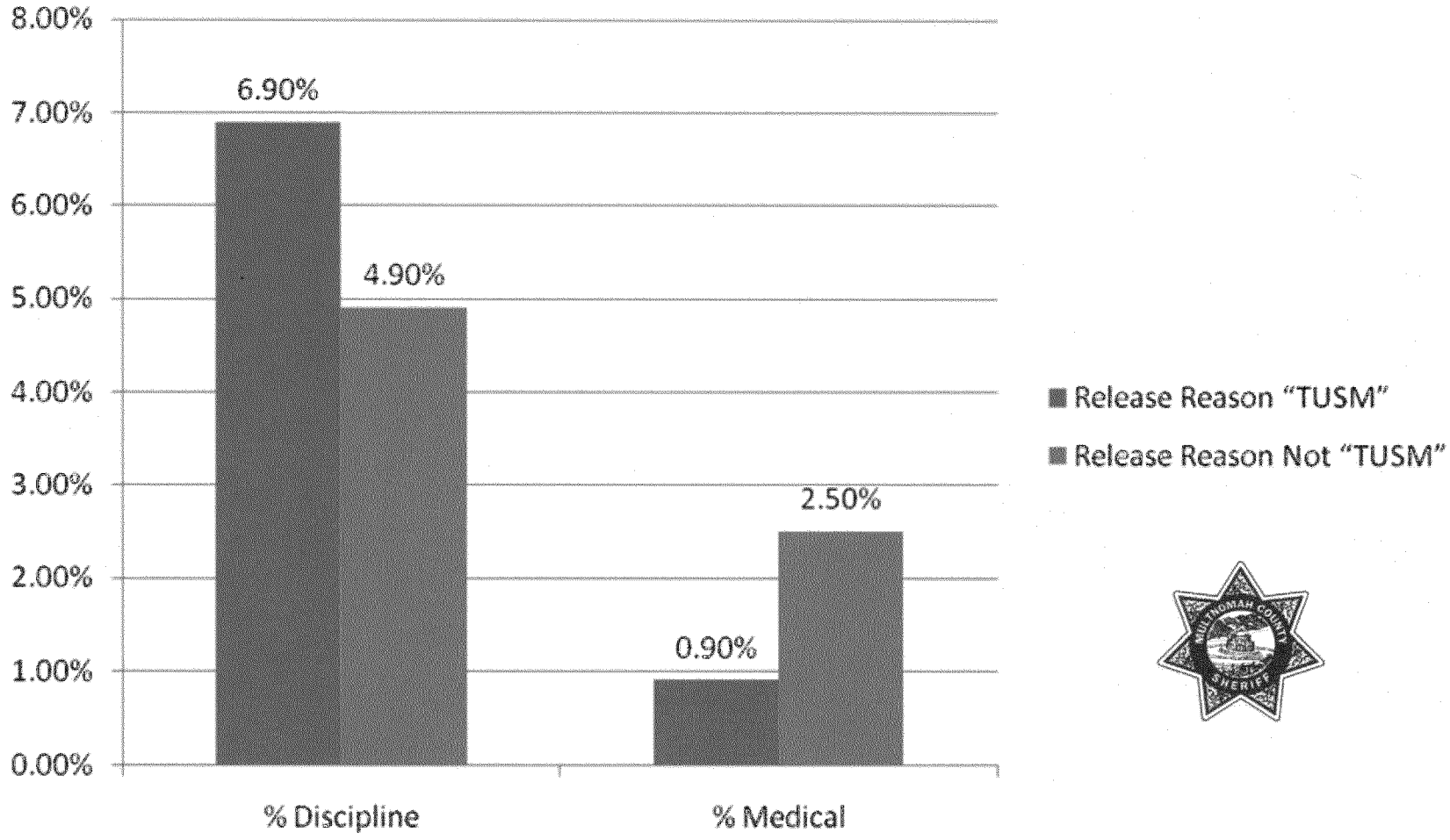
- Costing data may be useful to SB 1145 "opt out" discussion
- Explore the potential savings of utilizing civilian staff in non-inmate supervision functions
- The sick leave monitoring program is successful and recommend it continue

Recommendations

- Loss of US Marshal funds would force closure of local jail beds beyond what is utilized by the USM. Sheriff should continue to contract with US Marshal and continue to analyze the data that supports the conclusions
- Recommend continuation of costing analysis with multi-departmental group
- Proceed with a comparison with jails outside of Multnomah County

Chart indicates the percentage of inmates as compared to the total for that category.

Example: 6.90 Percent of US Marshal inmates in September of 2009 used a discipline bed



Estimated loss of $6.489 million of US Marshal Revenues—354 beds

Section 1 Housing		Cost in Budget						
Program Offer	Jail/Housing	Personnel	Contracts	M & S	ISRs	Capital	Total cost in budget	Beds
60041E	MCIJ Dorms 6 & 7	$2,086,650	$5,283	$126,578	$49,482	$0	$2,267,993	118
60041F	MCIJ Dorms 8 & 9	$1,168,344	$2,255	$54,026	$21,121	$0	$1,245,746	118
60041G	MCIJ Dorm 3	$1,830,016	$3,608	$86,442	$21,121	$0	$1,941,187	59
60041H	MCIJ Dorm 4	$653,514	$1,353	$32,414	$0	$0	$687,281	59
	TOTALS	**$5,738,524**	**$12,499**	**$299,460**	**$91,724**	**$0**	**$6,142,207**	**354**

Comparison of jail bed costs with all funds compared to General Fund only

Average Cost per Day per Bed			
	All funds	General Fund only	Difference
Section 1 Housing	$103.01	$84.87	$18.14
Section 2 Direct Inmate	$22.10	$22.10	$0.00
Section 3 Court Services	$0.00	$0.00	$0.00
Section 4 MCSO Central Administrative Costs for Housing	$14.26	$14.26	$0.00
Section 5 Support Functions	$10.04	$9.96	$0.08
Section 6 Inmate Programs	$7.97	$5.08	$2.89
Total all Sections	$157.37	$136.27	$21.11
Total Sections 7 & 8 Medical Support	$21.99	$21.99	$0.00
Total Plus Medical	$179.37	$158.26	$21.11

Summary

- The Technical Work Team comprised of representatives from MCSO, the County Budget Office and LPSCC will continue to refine the jail bed costing formulas and figures
- MCSO will continue to work with our partners in developing a jail bed costing methodology that works for everyone.

What is EASA?

EASA stands for Early Assessment and Support Alliance. It is a program that was created to help young people who are experiencing symptoms of psychosis. Research shows that getting help as early as possible makes treatment easier and recovery quicker.

What is Psychosis?

Psychosis describes a medical condition that affects the brain. It can make it difficult for you to think clearly. You may hear or see things that other people don't.

Medical researchers believe psychosis may be caused by vulnerabilities people are born with. When that vulnerability is combined with a physical illness, a lot of stress, or drug use, it can trigger psychosis.

Psychosis can happen to anyone. It affects 3 out of every 100 young persons. <u>But with treatment, recovery is possible!</u>

You can call us seven days a week, 24 hours a day.
503-988-EASA (3272)

Is EASA right for you?

If you have experienced several of the symptoms below, EASA is probably right for you:

Feeling like something's "not right"

- Not able to do schoolwork or your usual job
- Very sensitive to sights, sounds, smells or touch
- Feeling cut off from life and the world

Jumbled thoughts and confusion

- Trouble focusing and paying attention
- Difficulty reading or understanding sentences
- Not understanding what others say
- Have a hard time making decisions

Not interested in friends, family, and activities

- Not motivated/No energy
- Big changes in sleeping or eating patterns
- Little or no interest in your appearance, or things you used to enjoy doing

Hearing sounds/voices that others don't hear

- Seeing or hearing things others don't see or hear
- Feeling like someone is putting thoughts into your brain

Becoming fearful of others

- Worrying that others are thinking bad thoughts or wish to harm you

What happens when I call?

When you call us the first thing we do is make sure you are safe. Then we ask some basic questions to find out more about you. After that first phone call, an EASA team member will call to tell you more about the program. Together you will decide if the program is a good fit for you.

What happens once I'm in treatment?

EASA services are based on the most current research available. Working together, you and the team members will figure out the best treatment plan for you.
Here are some of the EASA services available to you:

- Low-dose medication to manage your symptoms and avoid side-effects as much as possible
- Regular appointments with a counselor who can help you understand the illness
- Support so that you can be successful in your education
- Assistance with building job skills
- Help identifying your life's goals and how to work towards them
- Group activities to get involved in the community and discover new interests
- Education and support for your family so they can help you be successful in your recovery

"When I was in middle school I started hearing voices and thinking people were

putting thoughts in my head. I got into drugs. My senior year people finally recognized my symptoms. I went from dropping out to graduating from high school. I just wonder how life might have been different if someone had seen the symptoms earlier."

"I thought people had tapped the phone and computer and were watching me. It made working really hard. I had been athletic but now I had no energy. I couldn't keep food in for nine months. Finally, I found EASA and they really helped."

Sponsored by Multnomah County Mental Health and Addiction Services Division

Multnomah County EASA is part of a network of Oregon providers

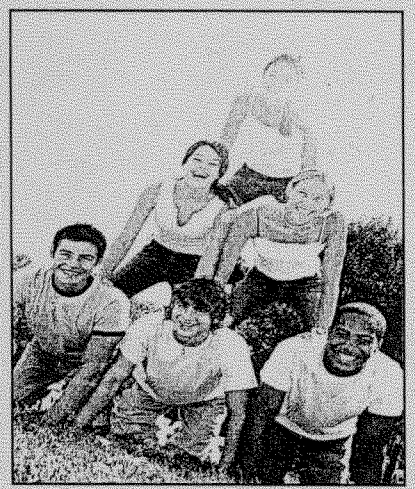
503-988-EASA (3272)

EASA serves ages 16 - 25 in Multnomah County

EARLY ASSESSMENT AND SUPPORT ALLIANCE
503-988-3272 REFERRAL LINE
503-988-5870 FAX

EASA

Welcome to EASA!



Early Assessment and Support Alliance

503-988-EASA (3272)

DEPARTMENT OF COUNTY HUMAN SERVICES
MENTAL HEALTH AND ADDICTIONS SERVICES DIVISION
421 SW OAK ST. PORTLAND, OR 97204
503-988-5464
503-988-5870 Fax

Psychosis Symptoms

Psychosis is a term used to describe a condition affecting the mind when there has been some loss of contact with reality. It affects the brain's ability to process information.

Symptoms can emerge gradually and include:

- Confused thinking
- False beliefs about reality
- Hallucinations: hearing or seeing things that aren't there
- Changes in behavior: extremely active or extremely lethargic.
- Mood swings or less emotion than normal
- Sleep disturbances
- Difficulty concentrating or remembering things
- Believing other people or things can influence thoughts
- Thinking they are being persecuted or watched

Psychosis Causes

Many things can cause an episode of psychosis, including going days without sleep, taking drugs and certain medical conditions. That is why it is so important to contact a medical professional or call the Early Assessment and Support Alliance (EASA) team as soon as possible.

About EASA

Multnomah County's Early Assessment and Support Alliance (EASA) is an intervention program designed to educate people about the initial signs of psychosis and provide treatment to young people who are experiencing a first episode of psychosis. With early access to treatment young people can stay in school or at work and live the life they planned before the illness.

The EASA team is made up of a multi-disciplinary team:

- Psychiatrist
- Nurse
- Occupational Therapist
- Vocational Therapist
- Mental Health Consultants

Treatment

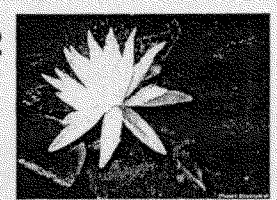
The EASA team offers a full array of treatment designed to stabilize the young person and begin their recovery.

- Psychiatric medication management
- Individual and group counseling
- Family education and support
- Multi-family groups
- Occupational therapy
- Vocational/educational support
- Case Management

People we can serve

- Young person must be a Multnomah County resident
- Between the ages of 15—25
- Symptoms not due to substance abuse or a known medical condition.
- First episode of psychosis occurred within the last year.

Call **503-988-3272** to find out how to access services.



How families and friends can help

DON"T

Do not feel guilty. You are not responsible for the illness.

Don't forget to take care of yourself. Especially if you are the young person's caretaker.

DO

Remember that the young person with the illness is still the person you know and love. If he/she is experiencing symptoms it is difficult for him/her to be the person you are used to.

Get support by attending the family support sessions and multi-family groups.

Talk to the EASA team about how you can be a partner in the recovery process.

Please call EASA to find out more about our program

503-988-3272

24-hours/7 days a week

With treatment recovery is possible!

MULTNOMAH COUNTY

Multnomah County
Department of County Human Services
Mental Health and Addiction Services Division
Phone: 503-988-5464
Fax: 503-988-5860

EARLY ASSESSMENT AND SUPPORT ALLIANCE
503-988-3272 PHONE
503-988-5870 FAX
EASA

What Families and Friends should know about Psychosis

Early Assessment and Support Alliance

503-988-3272

MULTNOMAH COUNTY
AGENDA PLACEMENT REQUEST

(revised 12/31/09)

Board Clerk Use Only	
Meeting Date:	11/23/2010
Agenda Item #:	B-2
Est. Start Time:	10:45 am
Date Submitted:	11/18/2010

Agenda Title: **Board Briefing on the Findings of the 2009 Corrections Grand Jury Report Workgroup**

Note: If Ordinance, Resolution, Order or Proclamation, provide exact title. For all other submissions, provide a clearly written title sufficient to describe the action requested.

Requested Meeting Date:	November 23, 2010	**Amount of Time Needed:**	60 Minutes
Department:	**NonDepartmental**	**Division:**	District 4
Contact(s):	Corie Wiren		
Phone:	503-988-5213 **Ext.** 26234	**I/O Address:**	**503/6**
Presenter(s):	Captain Drew Brosh		

General Information

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

   No action is necessary. This is a requested briefing on the findings of the 2009 Corrections Grand Jury Report Workgroup. This briefing will focus on the analysis of jail system cost factors and recommendations presented in the final report.

2. **Please provide sufficient background information for the Board and the public to understand this issue. Please note which Program Offer this action affects and how it impacts the results.**

   After the release of the 2009 Corrections Grand Jury Report, Multnomah County Sheriff Dan Staton convened a work group to analyze and respond to the findings.

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

   None

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

   ORS 132.440 requires that each year a grand jury inquire into the conditions and management of the corrections facilities in each county of the state.

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

   The 2009 Corrections Grand Jury Report Workgroup involved representatives from the Board of

County Commissioners, LPSCC, Department of Community Justice, County Attorney's Office, County Budget Office, a local public safety educator, District Attorney's Office, the 2009 Corrections Grand Jury Foreman and the County Auditor's Office.

Required Signature

Elected Official or Department/ Agency Director: Diane McKeel **Date:** 11.18.2010

2009 CORRECTIONS

GRAND JURY REPORT

WORKGROUP REPORT

As submitted to Sheriff Dan Staton and Chair Jeff Cogen, July 15 2010

In February of 2010, Sheriff Staton directed the formation of a workgroup with regard to a collaborative consideration and response to the 2009 Corrections Grand Jury Report. The following report is a summary of the group's discussions, research, findings and recommendations to the Sheriff and Chair regarding the recommendations cited in the 2009 Corrections Grand Jury Report:

Workgroup Attendees:

Co-chairs Multnomah County Commissioner Diane McKeel, District 4 Commissioner, Peter Ozanne, LPSCC Executive Director and Captain Drew Brosh, MCSO Corrections Division;

Captain Raimond Adgers, MCSO Court Services Section Commander;

Truls Neal, Manager, Department of Community Justice;

Chuck French, Senior Deputy District Attorney, District Attorney's Office;

Jacquie Weber, Assistant County Attorney, Office of County Attorney;

Mark Ulanowicz, Principal Auditor, Auditor's Office;

Christian Elkin, Principal Analyst, Budget Office;

Rob Milesnick, Adjunct Professor, Portland State University;

Chet Lee, 2009 Grand Jury Foreman;

Markley Drake, MCSO Senior Research Analyst;

Elizabeth Davies, LPSCC Staff Analyst

Background:

On March 2, 2010, Sheriff Staton testified before the Board of County Commissioners and Chair Ted Wheeler regarding the 2009 Corrections Grand Jury Report. At that time he identified areas of overall jail operations he felt had improved over previous years and areas meriting further evaluation. He also noted several areas identified for cost savings by the report that in his view were areas ultimately administrated by the Board and Chair rather than the Sheriff's Office. The Sheriff also shared these views in response to the Grand Jury Report during the February 2 Local Public Safety Coordinating Council meeting. In both of these presentations, Sheriff Staton committed to the formation of a workgroup to review the Grand Jury Report findings, identify those opportunities for savings under the exclusive authority of the Sheriff, and to develop a jail bed costing model that both identifies the true cost of local jail bed days for cost-saving analysis and contract pricing, and for equitable comparative analysis with other jurisdictions using the same comparative cost factors.

Discussion:

The workgroup had its first meeting on March 16, with two subsequent meetings April 15 and June 22 (May was skipped due to analyst involvement in FY2011 budget preparations). Research and information sharing was also conducted between meetings. Initial discussion focused on those areas for cost saving identified in the 2009 Corrections Grand Jury Report with regard to contract beds, medical services, labor costs and identifying those areas where the Sheriff could and could not act on recommendations. Further discussion was largely dominated by two topics: the complexity of determining true beds costs (for internal and contracting purposes) and how those costs, once determined, might be equitably compared with other jail systems, understanding a perfect match may be difficult with regard to system size, multiple facilities, CPI factors, state requirements, presence of collective bargaining etc... not likely being the same for other systems, and also understanding these differences may factor into beds day costs, making the efficiencies possible in some jurisdictions impossible in others.

The most common method of determining jail costing is to simply establish the jail "budget" for one year, divide that number by 365 days to establish a daily jail operations cost, then to divide that number by the number of operational beds to determine a "jail bed day" cost. However, each agency arrives at a jail budget number differently, therefore costs some jails consider part of the jail budget others may not. A good local example of this issue is a snapshot of the 2009 OSSA Jail Statistics by County, where each of Oregon's 36 counties reports their jail budget and operational capacity to the Jail Command Council for statistical purposes. When applying the common formula to those counties reporting both total jail budget and operations beds (not all did), Multnomah County cost per day ranked 6th highest in the state. However, as described above, this simplistic model does not reflect an equitable comparison of what costs

each county considered as part of their jail budget (administration, facility expense, medical, booking, court security etc...) and what other factors may be involved in daily operations affecting daily costs for some and not for others (transportation, facility type, maximum security/special needs inmates, local economics etc...).

After a comparison of multiple jail costing methods including local, state and federal models, the group decided upon a full cost model to include all jail funded activities and supporting activities to arrive at a true cost for our system. Once done, the results could be used both as a comparator to other agencies both local and regional, utilizing the same criteria used to develop our local model, and as a factor in determining jail bed pricing for contract beds to ensure Multnomah County recovers full costs from its contract bed partners, or when subsidizing contract partners, policy makers can make an informed decision to do so. With the costing methodology established, the task of developing the actual cost figures was assigned to Analyst Christian Elkin (Budget Office), Analyst Markley Drake (MCSO) and Analyst Elizabeth Davies (LPSCC).

Findings:

A number of factors affect the costs of jail beds in any local system, and these must be part of any comparison of costs across systems, as well as factors in consideration for what may allow or prohibit cost saving opportunities locally. These factors include:

- Number of facilities in the jail system (single, multiple and location of court facilities relative to jail facilities);
- Number of system beds (reducing beds may lower overall costs to county but raise the individual bed day cost);
- CPI issues (e.g. urban vs. rural);
- Circuit court requirements prevailing in system;
- Direct supervision vs. indirect supervision practices;
- Single bunking vs. double bunking practices;
- Classification of inmates in a particular facility;

It was also determined that an alternate method of costing may be more effective when considering contract beds (apart from comparisons) based on the following factors:

- Marginal costing and the potential to rent less expensive beds at the "end of the system;"
- Actual costs involved with individual inmate needs/classification;
- Consideration of housing costs post-booking;
- Consideration of a sliding scale contract with variables in price based on inmate need.

After much discussion, it was determined that while it is desirable to come to a average bed day cost across the system, the actual costs of each inmate varies as they travel through the system, and it may be useful to commit further study to various classifications of inmates as to what resources are used by varying inmates and at what

cost. However, for our present purposes our current program offers were applied to our chosen costing model to establish jail bed day costs in our system. Costs were broken out by both housing areas and categories, including core housing, direct inmate, admin, support, programs and medical. This was done to better identify which costs are identified with differing jail housing areas and services required. Factors were then used to apply to certain cost categories, some at 100% (dorm costs for example) others at a lesser percentage (the percentage of a whole program offer like IT or Fiscal for example that applies to jail functions).

Summary of Jail Bed Costing Worksheets (complete worksheets are attached)

Table One
Worksheet 1 Budgeted Housing Costs and Direct Inmate Costs
Section 1 - Housing
Section 2 - Direct Inmate Costs
Section 3 - Court Services/FSOs (Facility Security Officers)
Worksheet 2 Budgeted Administration and Support Costs
Section 4 - MCSO Administration
Section 5 - Support Functions
Section 6 - Inmate Programs
Worksheet 3 Budgeted Health Care Costs
Section 7 - Medical Housing
Section 8 - Medical Booking

Three worksheets have been prepared that outline the costs associated with housing inmates and processing offenders in the system. The three worksheets are outlined in Table One. All figures used in the worksheets are taken from the Adopted Budget for Fiscal Year 2010/2011 (FY 2011) program offers. The data was then entered into Excel spreadsheets. The divisor used for all worksheets is 1,310 budgeted jail beds. Each worksheet is further divided into three parts displayed left to right; the *Cost in Budget* for each program offer in the left portion, the middle portion is the *Cost Factored for Corrections Housing & Inmates*, and the part on the right, is the *Cost per Jail Bed per day*.

Costs in Budget figures are from each program offer and no changes are indicated. The middle part of the worksheets is the *Cost Factored for Housing and Inmates* shows a column indicating the factor to each budgeted costs applied, which ranges from 1.00 (100%) to 0.00 (0%) for each program offer. The notes below each worksheet explain basically how the factor is determined. These factors will change as the committee continues to deliberate the costs.

The third part on the right shows the cost per jail bed. The chart below shows that personnel make up 80.28 percent of the cost with Internal Service Reimbursements (ISRs) making up 12.89 percent of the total.

Table Two	
Total Costs Per Bed Per Day	
Section 1 Housing	**$103.01**
Section 2 Direct Inmate	**$21.99**
Section 3 Court Services	**$0.00**
Section 4 MCSO Central Administrative Costs for Housing	**$14.26**
Section 5 Support Functions	**$10.04**
Section 6 Inmate Programs	**$7.97**
Total all Sections	**$157.27**
Total Sections 7 & 8 Medical Support	**$21.99**
Total all sections Plus Medical	**$179.26**

Table two below shows the total cost per bed day for each section. The total for all sections is $157.27, with housing costs at $103.01. Medical Cost from the Health Department adds $21.99 per day per bed on average. Medical or Infirmary beds can cost in excess of $400 per day. Some inmates use no health care costs as compared to some inmates with severe medical conditions requiring infirmary costs, hospitalization and other costs.

Chart two illustrates the information in Table Two without the medical cost.

Currently the method to determine jail bed cost is the following formula:

> ([Budgeted Cost] ÷ [Number of Budgeted Beds]) ÷ 365 days = Average cost per day per bed (Cost per bed)

The number of *Budgeted* jail beds can change the cost per jail bed considerably. A change of 59 beds (one dorm) results in a change of 21,535 to the divisor. Jail beds are added and subtracted using whole dorms thereby changing the divisor artificially changes the jail bed cost. This creates fluctuating jail bed costs based on changes to the number of beds when in fact the cost may not have changed plus or minus to the amount indicated by the jail bed cost figure. A more stable number to use may be

the *operating capacity* of 1,485 beds. This allows for trending of cost data, cost projections and other useful analysis and reporting. This total operating capacity excludes Wapato and double bunking. Current Policy and budgetary limitations will exclude double bunking and the opening of Wapato for the foreseeable future thereby stabilizing the divisor.

Table Three below demonstrates this factor. As jail beds are added or deleted the cost per jail bed changes. Column one shows the current costs using budgeted jail beds. Column two shows the costs as they would appear if the total operating capacity were used. Column Three shows the difference between columns one and two. Column four demonstrates the cost using an additional cost for the three additional dorms or 175 beds added. Column five is the difference between columns one and four.

Table Three

	Cost per day per Bed				
	Current Budgeted Beds	Full Capacity no additional costs	Difference	Full Capacity adding the costs of three dorms	Difference
Beds	**1,310**	1,485	175	**1,485**	175
Section 1 Housing	$103.01	$90.87	-$12.14	$94.67	-$8.34
Section 2 Direct Inmate	$21.99	$18.60	-$3.39	$18.60	-$3.39
Section 3 Court Services	$0.00	$0.00	$0.00	$0.00	$0.00
Section 4 MCSO Central Administrative Costs for Housing	$14.26	$12.58	-$1.68	$12.58	-$1.68
Section 5 Support Functions	$10.04	$8.66	-$1.38	$8.66	-$1.38
Section 6 Inmate Programs	$7.97	$7.03	-$0.94	$7.03	-$0.94
Total all Sections	$157.27	$137.73	-$19.53	$141.54	-$15.73
Medical costs	$21.99	$19.39	-$2.60	$19.39	-$2.60
Total all costs	$179.26	$157.12	-$22.14	$160.93	-$18.33

These costs are subject to change and dependant in part on changing budgetary policies. The additional factor of using budgeted jail beds also creates difficulties in comparing bed cost from year to year and its use as a comparison of cost recovery. A costing method using activity based costing along with a consistent divisor of operating bed capacity may provide better results for comparative purposes.

Recommendations:

The workgroup determined that while some recommendations are fairly straightforward, recommendations based on jail bed costing data analysis come from a complexity of factors and require continued and ongoing analysis and validation. That said, the workgroup reached the following conclusions based on our continuing discussion and research.

It is agreed that "opting out" of contracting jail beds to Oregon DOC under SB1145 is not under the auspices of the Sheriff to act upon, nor is the option currently available under state budget rules. In the event that the current state budget reduction created an opportunity to opt out of the SB1145 funding program, that decision will ultimately come from the Board of County Commissioners with a consideration of overall public safety system impact, as the Sheriff's Office is only affected by reimbursement for jail bed occupancy under the program, while the Department of Community Justice receives a larger portion (65%) for SB1145 funding for community supervision of offenders. Outsourcing Corrections Health to a private contractor is also outside the Sheriff's sole authority to act upon, provided medical care provided in the jail is delivered at a constitutionally required standard. However, costing information developed by the group may be useful to the Sheriff in larger public safety discussions concerning SB1145 funding in Multnomah County, and we recommend the Sheriff consider this information as part of those discussions.

As personnel costs make up roughly 80% of overall jail operational expenditures, we recommend the Sheriff explore the potential for savings with regard to utilizing of civilian staff in non-inmate supervision functions, and the potential of utilizing retired sworn staff for the backfill of vacant posts in the jail in the place of current sworn staff on overtime. However, any utilization of current or retired staff requiring collective bargaining must be weighed against overall bargaining strategies, as current contract language may prohibit implementation of such strategies or may be less effective in cost savings than other bargaining efforts.

The Sheriff has been successful in curbing sick leave issues, and we recommend the Sheriff continue close monitoring of time and attendance data and enforcement of agency and county policy regarding leave generally.

As data produced by our analysts indicates the relatively low impact of US Marshal prisoners to the more expensive systems beds, and understanding the removal of US Marshal revenues to our system would force the closure of more local beds than US Marshal prisoners currently occupy, we recommend the Sheriff continue to contract with the US Marshal provided *continuing analysis* of data supports these conclusions.

Representatives from the Health Department and Corrections Health recently joined our discussion and have attached notes to the worksheets with regard to medical costing in the jail, and are currently preparing an independent response to the Grand Jury Report. Data analysis continues at the writing of this report, and respecting the requests of the Sheriff and Board members we make the above recommendations now in the interests of time, with the understanding that a follow up report with an "apples to apples" comparison of our jail system with other local and regional systems will be made as that information becomes available.

Attachments: Jail Bed Costing Worksheets
US Marshal Revenues and Impacts
OSJCC 2009 Jail Stats by County

MEMO

TO: Captain Drew Brosh

CC: Larry Aab, Business Services Director

Lt. Jeffery Wheeler

From: Markley Drake & Wendy Lin-Kelly, Senior Research Analysts

DATE: July 1, 2010

RE: US Marshal Costing

INTRODUCTION

As part of the overall jail bed costing research, the impact of US Marshal Inmates on the system was discussed. The hypothesis proposed was that US Marshal Inmates cost the system more than the revenue being paid and therefore there is a subsidy of US Marshal Inmates by the County General Fund.

The US Marshal contracts with various county jails throughout the United States and the reimbursement calculations are based on a Federal format that is not negotiable. There are some negotiations on the final reimbursement rate, but not the methodology. The agreed upon rate by the Federal government is approved by the Board of County Commissioners. The text box to the right offers a brief explanation of the process to calculate the US Marshal rate.

A comparison of US Marshal Inmates to non-US Marshal Inmates and the use of disciplinary and medical beds were completed. These two types of beds were chosen for this study as these beds are the most expensive beds in the system. Expensive in terms of the number of personnel required to operate the respective housing units.

METHODOLOGY

Following is a description of the methodology used:

- Using the eSWIS data base, all inmates with a release reason of "to the US Marshal (TUSM)" and all other release reasons (Not-TUSM) were complied.
- This study examined inmate movement reason.
- Total time in a special use bed was not calculated.
- The time frame for the comparison look was September 2009. Since the number of TUSM inmates was small (n=116), all TUSM releases were examined for

Calendar Year 2009. This was done to validate the percentage of medical and discipline movement reason cases.

- For September, TUSM n = 116; Not TUSM n= 1,804 for a total of 1,917.
- Calendar Year 2009 for TUSM, n= 884
- All inmates with a total time from booking to release of less than 0.4 day (9.6 hours) were eliminated from the data set. Those with less than 0.4 day admission time were not likely housed and thereby not likely to receive admission to a bed including a specialized bed.

The remaining inmate data was sorted as appropriate and some descriptive statics were calculated along with a number of visual charts were developed to display the data sets.

FINDINGS

In calendar year 2009, TUSM used ten percent of the total bed days . In September 2009, the average number of days in jail was 48.3 for TUSM and 19.8 for not-TUSM respectively. TUSM comprised about 6.05 percent of the total releases. For September, using the total TUSM *inmates*, 6.90 percent of TUSM inmates used discipline beds compared to 4.90 percent of not-TUSM inmates. The same comparison was done for Medical beds showing 0.90 percent of TUSM inmates compared to 2.50 percent of not-TUSM inmates. This demonstrates that a small percentage of US Marshal Inmates use medical beds. The comparisons are illustrated in the chart above. The reasons for the increase in the use of discipline beds were not explored in this study. Subsequently the smaller percentage for use of medical beds was also not explored. However, the US Marshal contract and practice is to move inmates to the hospital to receive medical care. The hospital charges the US Marshal directly and does not charge Corrections Health (Multnomah County). *Not TUSM* inmates if they require hospitalization or hospital service, the hospital charges the County. Therefore the medical cost for TUSM inmates is lower.

Next the two bed types were compared to the inmate population as a whole for that month. Looking at all inmates released within that month 0.05 percent of all inmates were US Marshal *and* used a medical bed. For Discipline 0.42 percent of all inmates were US Marshal *and* used a discipline bed. This is compared to 2.40 percent of non-US Marshal using medical beds and 4.64 percent using discipline beds. The US Marshal inmates represent a very small percentage of the total inmate population for those bed types.

Summary

The most expensive beds in the system are medical beds with the additional cost of medical staff. Disciplinary beds at the Multnomah County Detention Center (MCDC) are the next most expensive beds due to the amount of staff used to supervise a low

number of inmates. Data shows that US Marshal Inmates use a low percentage of both medical beds and disciplinary beds. If the US Marshal inmates were not included in the inmate population, there would be no decrease in both medical and disciplinary services and thereby no significant decrease in costs for those services. Materials and Services represent 6.87 percent of the Corrections' Health care cost for housing. The US Marshal revenue helps to support both the medical care, which includes medical beds, and disciplinary beds.

Addendum - An explanation of Marshal Revenues and Potential bed closure if revenue was forfeited

The Table One lists the actual and budgeted US Marshal Revenues for five fiscal years. For Fiscal Year (FY) 2011 the estimated revenue is 6.489 million for an average of 140 inmates per day. The rates are adjusted for inflation in March of each year for the three year contract.

Table One

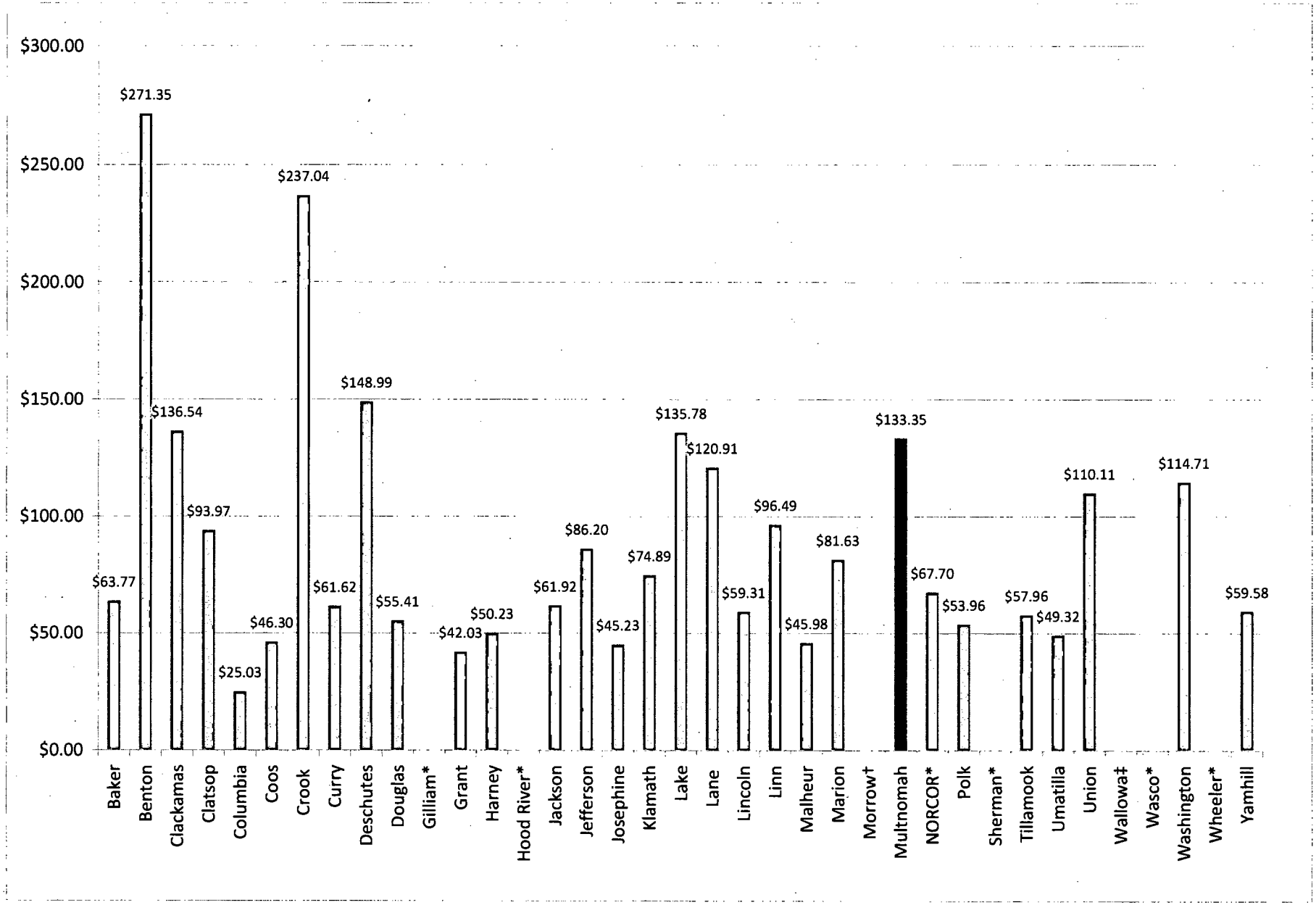
	Fiscal Year	US Marshal Rate per bed per day	Average number of inmates per day	Average income per day	Annual Income	Average per bed day costs	Notes
Budgeted	2011	$127.00	140.00	$17,780.00	$6,489,700.00	$127.00	1
Actual	2010	$127.00	154.00	$19,558.00	$7,138,670.00	$127.00	2,3
Actual	2009	$125.00	159.42	$19,927.50	$7,273,537.50	$125.00	
Actual	2008	$115.90	135.92	$16,161.92	$5,899,100.80	$118.91	4
Actual	2007	$115.90	158.08	$18,321.47	$6,687,337.28	$115.90	

Notes for Table One

1. Budget for Fiscal year 2011
2. For the year ending June 30, 2010, final accounting has not been completed for June 2010
3. Rate changed from $125.00 to $127.00 in March of 2010
4. Rate changed from $115.90 to $125.00 in March of 2008

If the County were to decide to cancel the US Marshal Contract the County would reduce the general fund allocation to the Sheriff's Office by 6.489 million. If that revenue was eliminated, the following housing units may be eliminated at the Inverness jail. Most of the other inmate related services, such as booking, classification, FSOs, are all capacity related programs and therefore the costs would not be reduced. Some programs such as *Inmate Programs* would see some adjustments and loss of personnel. Table Two shows that with the loss of 6.489 million an estimated 354 beds would be cut. If the assumption is the Marshal Inmates are 140 of the 354 beds, than the net loss of local beds is 214. The actual impacts to the system and number of beds cut would have to be determined by a team of corrections command staff.

Table Two								
Section 1 Housing		**Cost in Budget**						
Program Offer	Jail/Housing	**Personnel**	**Contracts**	**M & S**	**ISRs**	**Capital**	**Total cost in budget**	**Beds**
60041E	MCIJ Dorms 6 & 7	$2,086,650	$5,283	$126,578	$49,482	$0	$2,267,993	118
60041F	MCIJ Dorms 8 & 9	$1,168,344	$2,255	$54,026	$21,121	$0	$1,245,746	118
60041G	MCIJ Dorm 3	$1,830,016	$3,608	$86,442	$21,121	$0	$1,941,187	59
60041H	MCIJ Dorm 4	$653,514	$1,353	$32,414	$0	$0	$687,281	59
	TOTALS	**$5,738,524**	**$12,499**	**$299,460**	**$91,724**	**$0**	**$6,142,207**	**354**


$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
$63.77
$271.35
$136.54
$93.97
$25.03
$46.30
$237.04
$61.62
$148.99
$55.41
$42.03
$50.23
$61.92
$86.20
$45.23
$74.89
$135.78
$120.91
$59.31
$96.49
$45.98
$81.63
$133.35
$67.70
$53.96
$57.96
$49.32
$110.11
$114.71
$59.58
Baker
Benton
Clackamas
Clatsop
Columbia
Coos
Crook
Curry
Deschutes
Douglas
Gilliam*
Grant
Harney
Hood River*
Jackson
Jefferson
Josephine
Klamath
Lake
Lane
Lincoln
Linn
Malheur
Marion
Morrow†
Multnomah
NORCOR*
Polk
Sherman*
Tillamook
Umatilla
Union
Wallowa‡
Wasco*
Washington
Wheeler*
Yamhill

Worksheet 2

Budgeted Administration and Support Costs FY 2011

Section 4 MCSO Administration		Cost in budget						Cost Factored for Corrections Housing & Inmates								Cost per Jail bed per day [11]						
Program Offer	Description	Personnel	Contracts	M & S	ISRs	Capital [2]	Total cost in budget	Factor applied	Personnel	Contracts	M & S	ISRs	Capital	Total applied cost	FTE	Jail Beds	Personnel	Contracts	M & S	ISRs	Capital	Cost per bed
60000	Sheriff Office Admin [1]	$689,651	$32,462	$121,168	$154,860	$0	$998,141	0.2300	$158,620	$7,466	$27,869	$35,618	$0	$229,572	5.00	1,310	$0.33	$0.02	$0.06	$0.07	$0.00	$0.48
60005A	Professional standards (IAU) [3]	$981,468	$67,161	$22,376	$104,255	$0	$1,175,260	0.6700	$657,584	$44,998	$14,992	$69,851	$0	$787,424	7.00	1,310	$1.38	$0.09	$0.03	$0.15	$0.00	$1.65
60006	Training Unit [4]	$791,259	$0	$158,079	$27,779	$0	$977,117	0.6562	$519,224	$0	$103,731	$18,229	$0	$641,184	6.00	1,310	$1.09	$0.00	$0.22	$0.04	$0.00	$1.34
60010	Business Services Admin [5]	$366,056	$11,728	$976,107	$22,864	$0	$1,376,755	0.6487	$237,461	$7,608	$633,201	$14,832	$0	$893,101	1.00	1,310	$0.50	$0.02	$1.32	$0.03	$0.00	$1.87
60011A	Human Resources [4]	$780,326	$10,743	$20,594	$146,324	$0	$957,987	0.6562	$512,050	$7,050	$13,514	$96,018	$0	$628,631	7.20	1,310	$1.07	$0.01	$0.03	$0.20	$0.00	$1.31
60012	IT [5]	$1,035,378	$25,000	$317,691	$2,648,341	$0	$4,026,410	0.6487	$671,650	$16,218	$206,086	$1,717,979	$0	$2,611,932	8.00	1,310	$1.40	$0.03	$0.43	$3.59	$0.00	$5.46
60013A	Fiscal Unit [5]	$642,005	$853	$11,362	$75,727	$0	$729,947	0.6487	$416,469	$553	$7,371	$49,124	$0	$473,517	6.00	1,310	$0.87	$0.00	$0.02	$0.10	$0.00	$0.99
60014	Payroll Unit [5]	$402,794	$0	$12,638	$47,230	$0	$462,662	0.6487	$261,292	$0	$8,198	$30,638	$0	$300,129	5.00	1,310	$0.55	$0.00	$0.02	$0.06	$0.00	$0.63
60015A	Research & Analysis Unit [5]	$358,254	$3,732	$662	$26,317	$0	$388,965	0.6487	$232,399	$2,421	$429	$17,072	$0	$252,322	3.00	1,310	$0.49	$0.01	$0.00	$0.04	$0.00	$0.53
	TOTALS	**$6,047,191**	**$151,679**	**$1,640,677**	**$3,253,697**	**$0**	**$11,093,244**		**$3,666,748**	**$86,313**	**$1,015,391**	**$2,049,360**	**$0**	**$6,817,812**	48.20	**1,310**	**$7.67**	**$0.18**	**$2.12**	**$4.29**	**$0.00**	**$14.26**
																Percent	53.78	1.27	14.89	30.06	0.00	
Section 5 Support Functions																						
60016	Logistics Unit [7]	$356,451	$1,066	$8,800	$605,298	$0	$971,615	0.5000	$267,338	$533	$4,400	$302,649	$0	$574,920	4.00	1,310	$0.56	$0.00	$0.01	$0.63	$0.00	$1.20
60017	Procurement & Warehouse [5]	$636,450	$533	$15,256	$165,298	$0	$817,537	0.6487	$412,865	$346	$9,897	$107,229	$0	$530,336	6.16	1,310	$0.86	$0.00	$0.02	$0.22	$0.00	$1.11
60018A	Property and Laundry [5]	$1,978,869	$0	$95,694	$251,997	$172,900	$2,499,460	0.6487	$1,283,692	$0	$62,077	$163,470	$112,160	$1,621,400	21.00	1,310	$2.68	$0.00	$0.13	$0.34	$0.23	$3.39
60030A	Corr Div Administration [4]	$754,999	$323,409	$72,461	$86,603	$0	$1,237,472	0.6532	$493,165	$211,251	$47,332	$56,569	$0	$808,317	3.00	1,310	$1.03	$0.44	$0.10	$0.12	$0.00	$1.69
60031A	Corr Support-Records [8]	$3,406,132	$3,931	$70,456	$34,241	$0	$3,514,760	0.3600	$1,226,208	$1,415	$25,364	$12,327	$0	$1,265,314	39.00	1,310	$2.56	$0.00	$0.05	$0.03	$0.00	$2.65
	TOTALS	**$7,132,901**	**$328,939**	**$262,667**	**$1,143,437**	**$172,900**	**$9,040,844**		**$3,683,269**	**$213,545**	**$149,069**	**$642,244**	**$112,160**	**$4,800,287**	**73.16**	**1,310**	**$7.70**	**$0.45**	**$0.31**	**$1.34**	**$0.23**	**$10.04**
																Percent	76.73	4.45	3.11	13.38	2.34	
Section 6 Inmate Programs																						
60019	Inmate Welfare & Commissary	$777,786	$78,488	$342,753	$182,988	$0	$1,382,015	1.0000	$777,786	$78,488	$342,753	$182,988	$0	$1,382,015	8.34	1,310	$1.63	$0.16	$0.72	$0.38	$0.00	$2.89
60037A	Inmate Programs	$2,269,401	$43,781	$88,906	$25,655	$0	$2,427,743	1.0000	$2,269,401	$43,781	$88,906	$25,655	$0	$2,427,743	22.00	1,310	$4.75	$0.09	$0.19	$0.05	$0.00	$5.08
60039	Corr Work Crews	$373,989	$9,580	$78,552	$82,697	$0	$544,818	0.0000	$0	$0	$0	$0	$0	$0	2.00	1,310	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
60043A	Close Street	$1,106,516	$56,000	$20,240	$39,486	$0	$1,222,242	0.0000	$0	$0	$0	$0	$0	$0	9.00	1,310	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	TOTALS	**$4,527,692**	**$187,849**	**$530,451**	**$330,826**	**$0**	**$5,576,818**		**$3,047,187**	**$122,269**	**$431,659**	**$208,643**	**$0**	**$3,809,758**	41.34	**1,310**	**$6.37**	**$0.26**	**$0.90**	**$0.44**	**$0.00**	**$7.97**
	Costs Per Bed day	$7.34	$0.30	$0.86	$0.54	$0.00	$9.04		$4.94	$0.20	$0.70	$0.34	$0.00			Percent	79.98	3.21	11.33	5.48	0.00	

Average Cost per Day per Bed	
Section 1 Housing	**$103.01**
Section 2 Direct Inmate	**$21.99**
Section 3 Court Services	**$0.00**
Section 4 MCSO Central Administrative Costs for Housing	**$14.26**
Section 5 Support Functions	**$10.04**
Section 6 Inmate Programs	**$7.97**
Total all Sections	**$157.27**

Total Sections 7 & 8 Medical Support	**$21.99**
Total Plus Medical	**$179.26**

Notes

1 Factor of 0.23 is percent of Sheriff administration time associated directly with Corrections
2 Some Programs have zero dollars appropriated to Capital
3 A factor of 0.67 was applied as 67% of work is applicable to Corrections.
4 Factor of 0.6532 is calculation for percent of Corrections Personnel that are applied to Housing and inmates; based on the Total MCSO Personnel for FY2011
5 Factor of 0.6487 is calculation is based on Percent of Corrections applied to total MCSO budget for FY 2011
6 Factor of 0.6670 is applied to the number of offenders booked that how are housed FY 2011
7 An overall factor of 50% was applied but a 75% was applied to personnel, as 12 of the 16 staff work on corrections(inmate property and other corrections activities)
8 There are 33 Correction Record Techs, 21 (64%) are assigned to the booking process and 12 (36%) for housing purposes. This information provided by the Corrections Record Manager
9 Factor of 0.6400 is applied to the number of offenders transported for Jail or housing purposes only; information from transport logs for 9 week period.
11 Jail bed cost per day is calculated using the Total applied cost ÷ number of beds ÷ 365 days