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THE STATE OF OREGON

DEPARTMENT OF HUMAN SERVICES
ADDICTIONS AND MENTAL HEALTH

Assessment and Evaluation of the Mental Health Care Delivery System in Oregon

FINAL REPORT

November 2008

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1 Executive Summary

Introduction

In early 2008 the Oregon Legislative Assembly directed the Oregon Department of Human Services (DHS) to conduct an assessment and evaluation of the adult community mental health care component of the state's mental health care delivery system. DHS issued a Request for Proposals (RFP) reflecting the legislative directive, evaluated proposals received in response to the RFP, and awarded the contract to Public Consulting Group, Inc (PCG). PCG began work on the study with a project kick-off meeting with DHS staff and members of the stakeholder coalition on July 25, 2008.

The following report is the result of the Assessment and Evaluation of the Mental Health Care Delivery System in Oregon conducted by Public Consulting Group, Inc.

Overview of Mental Health Programs, Services, and Regulations

The Oregon Department of Human Services (DHS) is responsible for the oversight and management of publicly funded health and human services in Oregon. DHS funds over 300 services and programs that reach more than 1 million Oregonians. With an operating budget of more than $11.5 billion, DHS provides an array of services and resources throughout the state through its five health related divisions.

The Division of Medical Assistance Programs (DMAP) administers the Oregon Health Plan (OHP) which includes the state's Medicaid and Children's Health Insurance programs. OHP covers both physical and mental health services and programs. DMAP oversees these activities with the exception of mental health services, which have been carved out and put under the authority of Addictions and Mental Health Division (AMH). AMH contracts directly with Mental Health Organizations (MHOs) to locally administer mental health services to OHP enrollees.

AMH is responsible for the oversight and management of all state funded community mental health services and programs across Oregon. In addition to contracting with MHOs for the delivery of Oregon Health Plan mental health services, AMH provides funding to Local Mental Health Authorities (LMHA) that have the statutory responsibility of providing mental health services to those in need to the extent that funding is available. LMHAs use a combination of AMH funding and county and municipal dollars to ensure that services are delivered locally through either Community Mental Health Programs (CMHPs) or mental health service providers. AMH is also responsible for the state-operated psychiatric hospitals, Oregon State Hospital and the Blue Mountain Recovery Center.

AMH has made concerted efforts in recent years to address the issue of a lack of safe and affordable housing for individuals suffering from mental illness. The lack of appropriate housing, however, is not necessarily related to low funding dollars. The stigma surrounding mental health disorders has created difficulties in securing locations to develop needed affordable housing across the state.

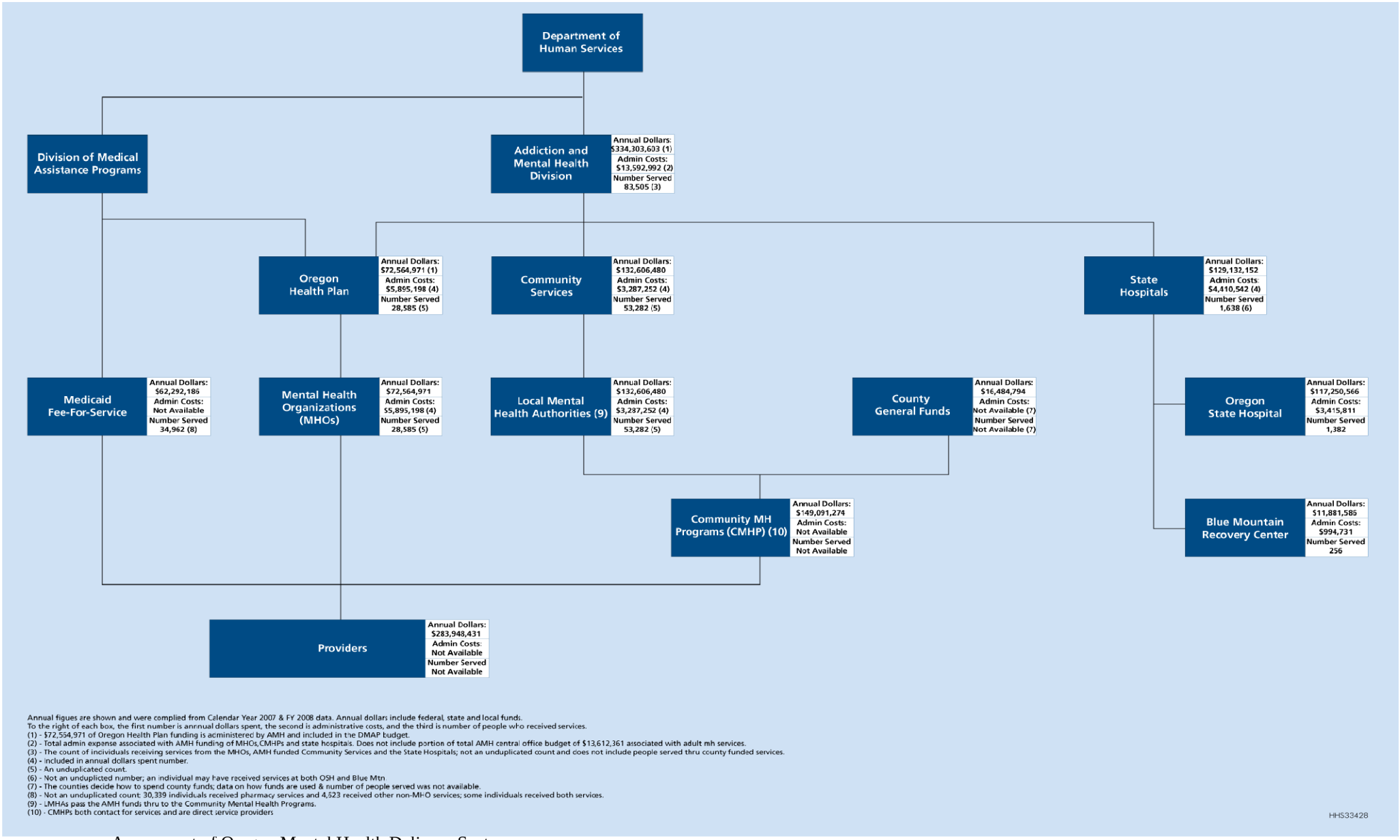
Separate from AMH, the Psychiatric Security Review Board (PSRB) was created by the Oregon Legislature in 1977 to monitor and provide jurisdiction over individuals found guilty except for insanity. ORS 161.336(10) states:

> In determining whether a person should be committed to a state hospital or to a secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society.

Currently, 745 individuals are under the PSRB jurisdiction, with 368 residing in the Oregon State Hospital (OSH). The remaining 377 individuals are held in numerous community-based facilities of varying degrees of security.

Figure 1.1 outlines the basic structure of the DHS as it relates to mental health services. Figure 1.1 also specifies the total funding, administrative costs, and number of individuals served, where applicable. Section 5 - Investment Analysis provides more detailed information about the funding streams.

Figure 1.1 DHS Mental Health System



Beyond the State's DHS system, other public agencies provide mental health services throughout Oregon. More than 7,500 members, or 25 percent, of the Oregon National Guard have been activated to serve in Operations Enduring Freedom and Iraqi Freedom.[1] National statistics suggest that the number of active duty military members suffering from mental health disorders has increased in the last decade. 1 in 5 meets the criteria for Post-Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), or Major Depressive Disorder (MDD).[2] This data suggests that a high percentage of active duty military members, as well as veterans, have and will be accessing some level of care through the publicly funded mental health care system.

The federal Department of Veterans Affairs has increased efforts to improve the availability and accessibility of mental health services to veterans in need. A recently launched suicide hotline together with increased development of community based outreach clinics has increased the availability of services across the state. Section 3 - Gap Analysis takes a more detailed look at the specific issues facing this population.

In recent years, the criminal justice system, consisting of both the Department of Corrections (DOC) and the county-run jails, has begun to play an increasing role as a mental health provider. DOC reports that 5,600, or 41 percent, of the 13,600 inmates currently incarcerated have an Axis I or II mental health diagnosis.[3] The county-run jails have reported in a recent survey that nearly 9 percent of individuals incarcerated has a serious mental illness diagnosis.[4]

The statutory and regulatory framework created through the mental health care specific Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs) gives the mental health system the structure within which it operates. The statutes and rules have been categorized into three groups, *Commitment Laws*, *Patients' Rights*, and *Administrative and Business Practices*, and more detailed information

[1] Oregon Military Department. (31 December 2003) "Annual Performance Report."
[2] Constans, Joseph, *What we "know" about OEF/OIF vets*, http://www1.va.gov/scmirecc/docs/Constans_MIRECC_Retreat_2008WHATWEKNOW.ppt#259,1,Slide 1.
[3] An Axis I diagnosis is defined as clinical disorders, including major mental disorders, as well as developmental and learning disorders. An Axis II diagnosis is defined as underlying pervasive or personality conditions, as well as mental retardation.
[4] "Oregon Jail Survey Highlights Needs of Inmates with Mental Illness," (31 July 2006) *Salem-News*.

regarding each of these is available in the full report.

Gap Analysis

Oregon ranks fifteenth in the nation for total per capita spending for mental health programs and services[5]. Use of community mental health program in Oregon is higher than the national average while its hospitalization and admission rates are markedly lower than national averages. Applying national standards, approximately 5.4 percent of Oregonians are estimated to have a serious mental illness. About 15,500 individuals have a serious mental illness and are neither covered by insurance nor receive mental health services through any state programs, including OHP.

The Community Services Workgroup Report for the Oregon State Hospital Master Plan (Fall, 2008) estimates that approximately $579 million biennially in additional funding is needed to provide services to all individuals who have a serious mental illness and are not otherwise cared for now. This is consistent with estimates of unmet needs that have been developed in the past. Prevention, case management, crisis, and acute care services, as well as more supportive services such as housing and employment, have long been identified as a need. The estimated need for additional funding also includes expanded jail diversion programs to keep people with mental illness out of the prison system.

Approximately 1,400 returning Oregon veterans from Iraq and Afghanistan received mental health services from the United States Veterans Health Administration (USVHA) during July 1, 2007 through June 30, 2008 at a cost of about $3.0 million. The geographical distribution of current and new (USVHA) hospitals and community outpatient clinics planned for the southern coast and eastern Oregon appears to cover almost all of Oregon. As the result, the availability of mental health services to veterans should improve. At the same time, transportation to services, especially in rural areas, may continue to be a challenge for some veterans.

[5] National Association State Mental Health Research Directors Research Institute 2008

There appears to be low utilization of mental health services by older adults including those served by the MHOs. As the result, there is a need to provide programs that encourage seniors to seek out mental health resources and to make sure those resources are available.

The DHS Division of Seniors and People with Disabilities (SPD) has a joint program with AMH for enhanced care community placements in which approximately 200 individuals with mental health needs are served.[6] AMH has a coordinator who supports programs for older individuals and those with disabilities; however, there is not a specific office or program with multiple staff with substantial funds to support mental health issues for older adults.

An examination of rate cells forming the MHO capitation rates and the MHO utilization reports indicates that there is a substantial amount of Medicaid mental health spending for individuals who have a disability. It is difficult, however, to determine how many individuals with disabilities who are not on Medicaid also have untreated mental health issues. Oregon does not have specific programs that are oriented toward individuals with disabilities.

Ethnic and minority groups make up roughly 14 percent of Oregon's population. In many cases these populations seek mental health service at a lesser rate than non-minority populations. A lack of health care coverage of minority and ethnic populations serves as a barrier to access to the mental health services that they need. A person who is not Medicaid eligible and in need of mental health services must reach the point of crisis before he or she will receive services, while those who are Medicaid eligible have greater access to needed services. Traditionally, funding, or a lack thereof, has created the largest gaps within the system. Other gaps in service for ethnic and minority populations are created by cultural barriers and beliefs.

Investment Analysis

[6] State of Oregon 2008-2009 Community Mental Health Services Block Grant Application Salem, OR. P. 61 see http://www.oregon.gov/DHS/mentalhealth/docs/block2007grant.pdf

Currently, Oregon annually invests approximately $447 million of federal, state, and local dollars in adult inpatient and community-based mental health services. These funds include dollars from the Department of Human Services, the Criminal Justice System, and local governments. Funding for adult mental health services is derived from a variety of revenue streams including Federal Financial Participation (FFP) in the state Medicaid program, federal grant dollars such as the Community Mental Health Block Grant, state appropriated funds, as well as county and municipal appropriated funds. The intermingling of these funding streams makes it difficult to discretely identify specific funding by service.

Annually, AMH allocates and administers the majority of the statewide funding for adult mental health services, roughly $334 million. Oregon State Hospital and Blue Mountain Recovery Center, which together provided adult psychiatric inpatient services to 1,638 unique clients in calendar year 2007, receive over $129 million annually. The remaining $205 million managed by AMH funds adult community mental health services. AMH distributes approximately $133 million annually to Local Mental Health Authorities (LMHAs) and community mental health providers for the provision of services that are not billable to Medicaid. Payments made to the Mental Health Organizations (MHOs) on the basis of a fixed fee per member per year (called capitation) for approximately 28,585 Medicaid eligible recipients account for the remaining $72 million administered through AMH.

DMAP processes an additional $62 million annually in Medicaid fee-for-service payments for mental health drugs and non-MHO covered Medicaid billable services for adult clients.

Within the Criminal Justice System, approximately $33.6 million was identified as attributable to mental health services for adult recipients. Although complete data was not available, the Department of Corrections estimates that annually 5,600 unique inmates receive mental health service.

Another revenue stream relates to county appropriated funds for adult mental health services. These funds are used to complement state and federal funding for services provided through the LMHA. Through a self-reported survey, the counties reported that $17 million in county funding was appropriated for adult

mental health services in state fiscal year 2008.

Of the total $447 million in annual investment for adult mental health services, 68 percent or $303 million can be attributed to six counties: Clackamas, Jackson, Lane, Marion, Multnomah, and Washington. These counties also account for 65 percent of the adult population over the age of 18 in Oregon. All of the funding identified in this analysis, however, does not go directly to the counties; instead, the dollars were attributed to counties where providers within the county received payment and where the county residents benefited from the services rendered.

Data was collected, where possible, to identify the types of mental health services and the quantity of services provided. Due to the insufficiency of the AMH data system, CPMS, it was not possible to identify the number of units that correspond to the $133 million in non-Medicaid billable services purchased by the State. Improving this data system should be a priority so that information is readily available to illustrate the types and the amounts of services being purchased through the community funding.

Catalogue of Information and Outcomes

DHS has established systems to monitor and evaluate the performance of Mental Health Organizations and the Community Mental Health Programs. Such systems are also used to monitor the outcomes achieved as the result of mental health services provided, though these efforts are evolving. At the same time, AMH's internal capacity to monitor the performance of the MHOs and the CMHPs is weaker than it should be. In addition, AMH does not have a data management system in place that is efficient, effective, and timely in supporting monitoring activities and facilitating data driven management decisions.

The contract between AMH and the Mental Health Organizations (MHOs) contains specific provisions to support an evaluation of their performance. The 204 page contract is very direct and prescriptive in what AMH requires and it provides ample opportunity for the performance review of all aspects of an MHO's operations.

The financial assistance agreements between AMH and the counties are not as prescriptive as the agreements with the MHOs and take a different approach.

Administrative rules are used as the basis for monitoring whether services are being provided as intended. These rules focus on the licensing of programs, the credentials of individuals who provide services, and the eligibility of those who receive services. There are a few performance related indicators specified in the agreements. AMH does conduct on-site quality reviews of the CMHPs every three years.

AMH also produces an annual quality improvement work plan. The Work Plan identifies system performance indicators used to determine whether overall objectives are attained. The Work Plan also creates benchmarks against which the results of the indicators can be compared.

AMH publishes quarterly an Oregon Health Plan Utilization and Enrollment Report which contains enrollment, service and hospitalization data. This report reflects only Medicaid members who were eligible, enrolled, and who received mental health services during the reporting period.

A private contractor performs an annual External Quality Review (EQR) for AMH of the delivery of mental health services to OHP enrollees. Federal law requires such a review in states such as Oregon that use a managed care approach to provide Medicaid services.

AMH reports on National Outcome Measures (NOMS) to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its Mental Health Block Grant reporting. NOMS are reported by all states to SAMHSA and this permits national comparisons across states. SAMSHA is still in the process of refining NOMS.

Oregon is a national leader in the implementation of evidence based practices in the provision of mental health care services. AMH oversees the program and provides progress reports to the legislature.

Each MHO produces an annual quality improvement work plan and/or a quality report that contain specific performance measures that are monitored internally. Some CMHPs have developed their own systems for internal monitoring of performance and outcomes.

Data on individuals with psychiatric and emotional disorders and the services they

receive is collected and stored in three primary databases:

- The Medicaid Management Information System (MMIS) provides information on those who receive health insurance benefits under the Oregon Health Plan.

- The Oregon Patient/Resident Care System (OP/RCS) includes records for all publicly funded psychiatric inpatient care delivered in the State Hospital and in regional acute care units.

- The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs.

The MMIS which has significant reporting capacities and provides detailed and timely data on services provided through the OHP. CPMS has limited reporting capacity due to the nature of the data in the system, the system architecture and the antiquated nature of the system. As the result, CPMS is the weak link in providing the Legislature, DHS, and AMH with timely and accurate reports that can be used in making policy and management decisions.

Strengths and Weaknesses Analysis

The Strengths and Weaknesses Analysis focuses on four major categories, each of which are expanded upon in greater detail in the full report:

- Access and Availability;
- Coordination;
- Cost Effectiveness; and
- Quality.

Access and Availability

Overall, the mental health system in Oregon does not have the funding to serve all individuals in need. While individuals covered by the Oregon Health Plan (OHP) are entitled to receive a fairly comprehensive package of mental health services, limitations in the availability of service providers and barriers created by

geography, cultural and ethnic differences inhibit access and availability of services. These barriers are further exacerbated for those not covered by OHP as the added financial barriers significantly increase the difficulty in obtaining needed services. The barriers to access and availability of services varies dramatically based on existing resources within counties and the statutory requirement that Local Mental Health Authorities (LMHAs) provide basic mental health care services and alternatives to hospitalization for individuals in need. This requirement is subject to funding availability, and recent budgetary reductions have limited the LMHAs ability to effectively provide these services.

Coordination

The regionalized model adopted by the Mental Health Organizations (MHOs) has proven both useful and effective for coordinating services and care for OHP recipients. However, the lack of a clear vision as to what the overall statewide mental health care delivery system should include and how it should operate limits the effectiveness of the existing state mental health system.

Cost Effectiveness

Based on available data and national statistics, Oregon provides a variety of services at relatively reasonable costs. However, as the result of people not having access to preventative and maintenance services, there is a trend that individuals are increasingly accessing care through higher cost services such as emergency rooms, hospital inpatient psychiatric services, and state psychiatric hospitals. This increases the costs associated both with services and programs and with administrative procedures.

Quality Assurance

There are currently reporting systems in place that track and monitor the quality of services provided through the community-based programs. Legislative initiatives focusing programs and services on evidence-based practices have been widely accepted and implemented across the State. Despite the positives, these efforts have redirected some of the focus of the program away from previous quality assurance measures as no additional funding was provided. There has been no

funding for the additional administrative costs associated with either quality monitoring systems or the evidence-based practice initiatives.

Recommendations

Listed below are brief descriptions of each of the study's recommendations, which are discussed in greater detail in the full report. These recommendations are based on the results of interviews with a broad audience of stakeholders, a review of reports from previous studies of Oregon's community mental health system, and the results of the Gap Analysis, Investment Analysis and Strengths and Weaknesses Analysis conducted as part of this study

1. **Oregon should establish a regional approach and contract with regional authorities for the delivery of mental health care services. The regional entity would be responsible for both Medicaid and non-Medicaid services**.

The benefits of a regional approach include:

- A simplified mental health care delivery system with greater cross county portability;
- Greater uniformity in the availability of mental health services across the state;
- Increased consistency and efficiency in the service delivery system;
- Enhanced transparency and accountability; and
- Reduced administrative costs at the state and local levels.

2. **The emphasis in mental health program and funding priorities must be on increasing access to and strengthening community supports, including prevention and early engagement.**

In the past ten years, programmatic and funding changes in Oregon have resulted in decreased access to community based mental health care services. This has resulted in increases in the census at state psychiatric hospitals, increases in the number of individuals involved with the criminal justice system who have mental health diagnoses, and increases in the use of emergency rooms for reasons associated with mental health issues. This situation is not clinically advisable, cost

effective, nor financially sustainable.

Eligibility for services through the Oregon Health Plan should be expanded and funding for community services should be increased. The Community Services Workgroup Report provides an excellent analysis of the investments that need to be made in the community mental health system.

3. **Oregon needs to define the System of Care model that it is committed to implementing.**

A clear vision of what the Oregon mental health care system should entail needs to be established. Having a clear vision is critical to ensuring that incremental policy and funding decisions made by the executive and legislative branches of Oregon government are constructive, effective and efficient. The System of Care must include the elimination of programmatic silos and the identification of institutional and legal barriers to attaining the vision.

4. **Coordination of efforts among the DHS, the Criminal Justice System, the Department of Corrections, and Public Safety needs to be strengthened at the state and local levels.**

In recent years Oregon's public safety system at the state and local levels has been increasingly challenged by individuals with mental health conditions. In fact, the Department of Corrections has become one of the largest providers of mental health services in the State. In the long run, the most appropriate and cost effective approach to meeting individuals' mental health needs is through an effective community mental health care delivery system that emphasizes prevention and treatment. In the short term, from a public safety and financial perspective, there is a need for greater communication, cooperation, and coordination among the State and local mental health, public safety, and criminal justice systems.

5. **The mental health needs of underserved populations should receive more attention.**

As noted in Section 4 of this report, the Gap Analysis, the mental health care needs of seniors, individuals with physical and intellectual disabilities, members of

cultural and ethnic groups, and Native Americans are not being met. This disparity in the availability of mental health services must be addressed

6. **DHS should interface with the reintegration efforts of the Oregon National Guard and the US Veterans' Administration in meeting the needs of returning veterans.**

The mental health care needs of veterans returning from duty in Iraq and Afghanistan are well documented. The United States Veterans Health Administration is an established source of mental health funding for those veterans who need mental health supports. Given the availability of services for individuals, it is important that DHS assist veterans in gaining access to services. A specific area of need is transportation to and from services.

7. **Funding for housing and supportive employment and education programs for individuals with mental illness needs to be increased.**

The importance of providing good housing options and supportive employment and education opportunities to individuals with mental health challenges cannot be overstated. The benefits of publicly funded mental health care services will not be fully realized until individuals have both a stable, comfortable, and healthy place to live and the supports necessary to be engaged in meaningful employment or other equivalent activity.

8. **The availability of community residential treatment programs needs to be increased.**

The limited availability of community residential treatment programs, whether sub-acute or step-down units, is causing more unnecessary admissions to the state hospital system and longer lengths of stay. In response, adequate funding needs to be maintained in support of further development of community residential treatment programs. State officials should work closely with community-level partners such as the local hospitals and the CMHPs to secure community approval of development of these programs. State legislation should be enacted that mirrors the federal Fair Housing Laws.

9. The integration of physical and behavioral health needs increased emphasis.

Numerous studies have found that individuals with serious mental illnesses are more likely to have poor physical health than those who do not have mental illnesses. AMH needs to take a leadership role in creating greater integration of physical and behavioral services for individuals with mental illness. Barriers to integration need to be eliminated, incentives and accountability for integration need to be established, and greater consistency in integration across all counties in Oregon needs to be achieved.

10. AMH needs additional funding in order to take the lead in creating greater accountability and transparency within the mental health care delivery system.

There is a perception that there is an insufficient degree of accountability and transparency within Oregon's mental health care delivery system. At the same time, there are systems in place to create accountability and transparency. Part of this issue is directly related to the limited resources available to AMH to monitor the system. AMH needs to establish standard business practices that promote accountability and transparency and build these practices into service contracts. There should be consistency across the State in the availability of services, how those services are provided, and in record keeping.

11. DHS needs to develop a data management system that provides accurate, timely, and insightful information in order to make informed management decisions.

Existing DHS data systems have significant limitations, especially the CPMS. At the same time, important and difficult policy and resource allocation decisions must be made by both the legislature and DHS. The decision making process would be well served by having accurate, timely and insightful information.

12. The program to promote evidence based practices in mental health services should be reviewed.

Oregon is a national leader in the area of evidence based practices and has made

substantial progress in the adoption of evidence based practices as a means of improving the quality, consistency, and cost effectiveness of mental health services. Now is an appropriate time to review, reassess, and refine the evidence based practices program.

2 Introduction

In early 2008, the Oregon Legislative Assembly directed the Oregon Department of Human Services (DHS) to conduct an assessment and evaluation of the community mental health care component of the mental health care delivery system in Oregon:

"(2) The assessment conducted under subsection (1) of this section shall include but is not limited to:

> (a) An assessment of the gap between the number of Oregonians in need of community mental health care and the number who receive community mental health care;
>
> (b) An assessment of the investment that the Department of Human Services, the Department of Corrections and local governments make in community mental health care, including an examination of the amount spent on community mental health care;
>
> (c) As assessment of the community mental health needs of particularly vulnerable populations in this state; and
>
> (d) A catalog of the information that agencies and local governments use to evaluate the performance of providers of community mental health care, including the data collected and the performance measures and outcomes that are tracked by each agency and local government.

(3) The assessment conducted under subsection (2)(a) of this section must include a separate analysis of the gap between the demand for community mental health care by veterans returning from tours in Iraq, Afghanistan and other hostile fire areas and the community mental health care that is provided at United States Department of Veterans Affairs facilities.

(4) The evaluation conducted under subsection (1) of this section must contain:

(a) An analysis of the strengths and weaknesses in the state community mental health care delivery system;

(b) An overview of future community mental health care delivery system needs; and

(c) Recommendations from the Department of Human Services for improving the quality, effectiveness and efficiency of the community mental health care delivery system.

(5) The department shall provide a written report of the results of the assessment and evaluation conducted under subsection (1) of this section to the Senate Interim Committee on Health and Human Services and the House Interim Committee on Health Care no later than October 1, 2008.

(6) The department may contract with a private entity or individual to conduct the assessment and evaluation and to produce the report required by this section.

DHS issued a Request for Proposals in accordance with the legislative directive, evaluated proposals received in response to the RFP, and awarded the contract to Public Consulting Group, Inc (PCG). PCG began work on the study with a project kick-off meeting with DHS staff and members of the stakeholder coalition on July 25, 2008.

At the beginning of the study, our work efforts included meeting with various stakeholders and reviewing past, relevant studies. Oregon's mental health system has been studied on numerous occasions since 2000 and there are consistent themes that emerge from those studies that remain issues today. There was a clear consensus among stakeholders that this study should build on, not duplicate, past efforts.

Two areas in particular were identified where this work could help move forward on-going efforts to improve the state's mental health system: provide a simple and understandable description of how the current system works (Section 3 - Overview of Mental Health Programs); and, describe the flow of public funding within the system (Section 5 - Investment Analysis). We have made a concerted effort to

address these two components of the study as simply and thoroughly as possible given the resources available to us. At the same time, given the scope of the study, our work necessarily addresses many of the issues facing the system that are familiar to stakeholders. We have attempted to acknowledge and expand upon the excellent work that has been completed in the past and to be as thorough as possible given the broad charge of this study.

The following report is the result of the Assessment and Evaluation of the Mental Health Care Delivery System in Oregon that was conducted by Public Consulting Group, Inc.

3 Overview of Mental Health Programs, Services, and Regulation

Summary of Key Findings

In order to conduct an assessment of Oregon's mental health care delivery system, it is important to begin with an understanding of how the system is structured. It is generally agreed upon that the system is complex and complicated with several moving parts working both in tandem and separately. However, breaking the system down and examining more closely the three areas listed below creates a more accurate representation of how the system works:

- The delivery of all publicly funded mental health programs and services;
- General funding sources utilized; and
- Regulatory framework.

Based on the above criteria, these key areas are outlined and expanded upon within this section:

- Statewide adult mental health system
    - Department of Human Services
        - Addiction and Mental Health Division
            - Community Mental Health Services
            - Oregon State Hospital System
        - Division of Medical Assistance Programs
            - Oregon Health Plan
    - Local Government
        - Local Mental Health Authorities
            - Community Mental Health Programs
    - Psychiatric Security Review Board
    - Criminal Justice System
        - County Jails
        - Department of Corrections
    - Military Services
        - Veterans Affairs

- AMH received $358.8 million in funding the current biennium for community mental health services and programs. This funding is directed primarily to the counties; however, AMH does a limited amount of direct

contracting for some services throughout the state.

- AMH allocated $261.2 million in the biennium to the state hospital system including both Oregon State Hospital and Blue Mountain Recovery Center.

- The statutes and rules can be categorized into three groups: *commitment laws*, *patients' rights*, and *administrative and business practices*.

Please note: This study examines all aspects of the publicly funded mental health system[7] as it relates to adults. As there has been considerable work focusing on mental health services for children, this report reviews only those programs that serve transitional age youth (ages 16 and older) and adults 18 and older.

Department of Human Services

The Governor and Legislature have designated the Department of Human Services (DHS) to oversee and manage publicly funded health and human services in Oregon. Each year DHS funds over 300 services and programs that reach more than 1 million of Oregon's most vulnerable residents.[8] With an operating budget of more than $11.5 billion, DHS provides an array of services and resources throughout the state through its five health related divisions. Each division's role is defined below:

Public Health Division (PHD)
PHD focuses on protecting and promoting the health of every resident in Oregon through more than 100 prevention-related programs.[9] Programs focus on three main areas: *Healthy Families*, *Safer Environments*, and *Community Health Protection*. PHD works closely with the 34 local health departments to effectively administer programs and services across the state. Behavioral health programs and services are not delivered directly through PHD.

Seniors and People with Disabilities (SPD)
SPD offers "person-centered services" to seniors, individuals with physical disabilities, and individuals with developmental disabilities "that focus on

[7] The study does not take into account individuals accessing mental health care with aid from private insurance, Medicare, or "private-pay," but rather only examines publicly funded programs.
[8] Oregon Department of Human Services. "DHS At A Glance," (November 2007).
[9] Ibid.

independence, dignity, and choice."[10] The necessary services are determined by financial needs as well as personal daily needs of the individual. SPD acknowledges that there are behavioral health needs within the population it serves; however, SPD does not currently offer mental health specific services or programs.

Children, Adults and Families (CAF)
CAF offers programs designed to stabilize and strengthen Oregon families by "helping [them] become self-sufficient, reducing barriers to employment, and improving the health and welfare of children."[11] Adult mental health and behavioral health programs are not directly administered through CAF programs and services. While transitional youth and adults are included within this report, CAF does not provide dedicated mental health and behavioral health program and/or service for this population.

Division of Medical Assistance Programs (DMAP)
DMAP administers the Oregon Health Plan (OHP) which includes the state's Medicaid and Children's Health Insurance programs. OHP covers both physical and mental health services and programs if they are above the cut-off line on the Prioritized List of Health Services.[12] DMAP oversees these activities with the exception of mental health services, which have been carved out and put under the authority of AMH. AMH contracts directly with Mental Health Organizations to locally administer mental health services to OHP enrollees.

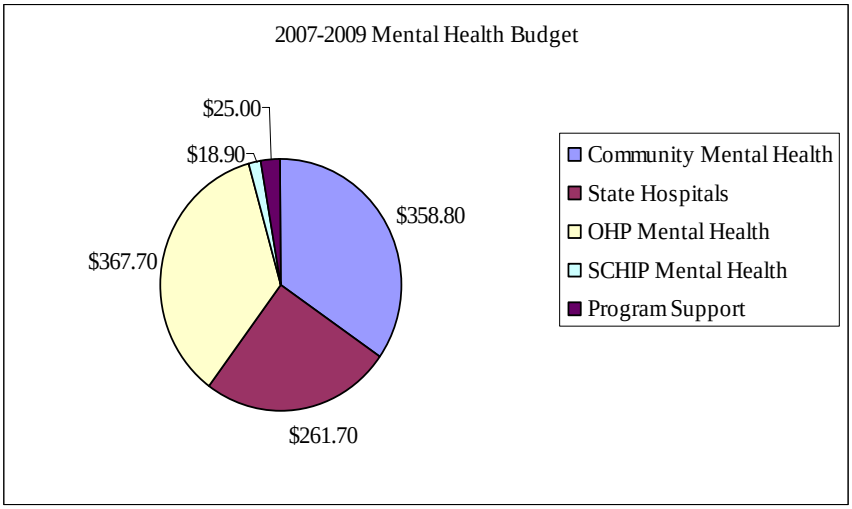
Implemented in 1994, OHP was designed to extend medical coverage to the hundreds of thousands of uninsured or underinsured Oregonians who were unable to qualify for traditional Medicaid benefits. Within its first year, OHP enrolled 120,000 new members, and Oregon was hailed a national leader in healthcare reform. But with soaring costs of the program and an economic slowdown, OHP was no longer sustainable in its originally conceived form. In 2003, the Legislature split OHP into OHP-Standard and OHP-Plus in an attempt to alleviate the rising costs. Those enrolled in OHP-Plus include the mandatory coverage categories for the categorically needy as defined by 42 CFR Part 435 as well as select optional coverage groups. OHP-Standard serves those individuals who do not meet the mandatory federal Medicaid enrollment requirements, but who are otherwise unable to purchase private insurance. The eligibility changes which

[10] Oregon Department of Human Services. "DHS At A Glance," (November 2007
[11] Ibid.
[12] Ibid.

occurred in 2003 reduced OHP-Standard enrollment from 130,000 to 18,000 and created a copayment structure in order to counter some of the rising costs associated with the program.[13] In 2004, new enrollment for the standard plan was frozen; however, individuals eligible for Medicaid were still able to enroll in OHP-Plus. The demand for coverage remained high, and in early 2008, DHS setup a lottery system to add new enrollees to OHP-Standard to reach a monthly average of 24,000 total, enrolled individuals. More than 33,000 Oregonians signed up for the list during the first two weeks that DHS was accepting applications.[14] In total, DHS received over 90,000 applications for 3,000 openings,[15] increasing the current enrollment for OHP Plus and Standard to approximately 400,000, or 12 percent of the state's population.[16]

Addictions and Mental Health (AMH)

AMH is the primary source of funding for mental health programs and services in Oregon. Mental health services are delivered locally through community mental health programs and providers and through state-operated mental health hospitals. The 2007-2009 AMH mental health budget exceeded $645 million, and together with funds from OHP, the mental health care budget for Oregon was over $1 billion. The pie chart, Figure 3.1, illustrates the funding breakout in millions by AMH programs. This amount included $18.9 million for SCHIP Mental Health programs. While this study focuses primarily on the adult mental health system, some funds associated with SCHIP Mental Health programs serve transitional age youth as well as the families of children in the program. The AMH budget is comprised of several different funding sources including, General Fund dollars, lottery fund, tobacco tax, and federal funds, with General Fund dollars being the most significant contributor to the budget.



AMH is focused on providing high quality care to individuals through its two main

[13] "Oregon to hold a health insurance lottery," (4 March 2008) *United Press International*.
[14] "Thousands to seek a spot on state health plan reservation list," (4 February 2008) *Portland Tribune*.
[15] "Oregon to hold a health insurance lottery," (4 March 2008) *United Press International*.
[16] Oregon Department of Human Services. "DHS At A Glance," (November 2007).

adult mental health programs: community mental health and the state hospitals, both Oregon State Hospital (OSH) and Blue Mountain Recovery Center (BMRC). Services provided through community mental health are administered through contracts that AMH has with Mental Health Organizations (MHOs) and Local Mental Health Authorities (LMHAs). AMH oversees and administers the programs and services available through the state hospitals.

As Figure 3.1 illustrates, AMH spends a significant portion of its budget on community mental health services. The 2007-2009 budget for AMH community mental health was $358.8 million. 62.3 percent, or $232.6, came from General Fund dollars, with the remaining 37.7 percent coming from federal funds, tobacco tax, and other funding sources. Federal funds, which totaled $128.8 million, consisted of Medicaid Title XIX, Community Mental Health Services (CMHS) block grant, Project to Assist/Transition from Homeless (PATH) grant, and Real Choice System Change grant.[17]

The state hospitals receive a significant, but markedly lower, allocation from AMH. The 2007-2009 budget for OSH totaled $238.03 million, with more than 82 percent of the funding from General Fund dollars. The budget accounted for an additional 30 staff positions and 71 additional community placements as well as for the *Harmon v. Fickle* lawsuit settlement. BMRC received $23.7 million with $12.5 million, or 53 percent, from General Fund dollars, for 2007-2009.

In addition, the 2005-2007 Legislature approved an allocation of $458.1 million in order to facilitate the construction of the two new state hospital facilities. New budgetary and staffing estimates, however, suggest that an additional $124 million will be necessary in order to fill the additional 1,000 positions required to fully staff and operate the new facilities.[18] This addition would give OSH a total of 2,500 staff. In the Agency Request Budget document, DHS contends:

> If this package is not funded, it will not be possible to open the replacement treatment facilities, nor will it be possible to deliver a minimum of 20 hours of active psychiatric treatment per patient per week. Patient and staff safety will be in jeopardy and reduced lengths of stay will not be achieved. If the package is not funded the state's position in negotiations with the U.S.

[17] Oregon Department of Human Services (2007) *AMH Joint Ways and Means Committee Presentation 2007 Legislative Session.*

[18] Oregon Legislative Fiscal Office. (18 September 2008) "Department of Human Services: Acknowledge receipt of a report on the Oregon State Hospital replacement project."

> Department of Justice will be weakened, risking further federal action against the state and the hospital.[19]

The funds for the $458.1 million will come from bond initiatives that have been approved. Upon approval of the staffing adjustments, the $124 million necessary to cover the cost of additional staff has yet to be requested from the General Fund and will be phased in over time.

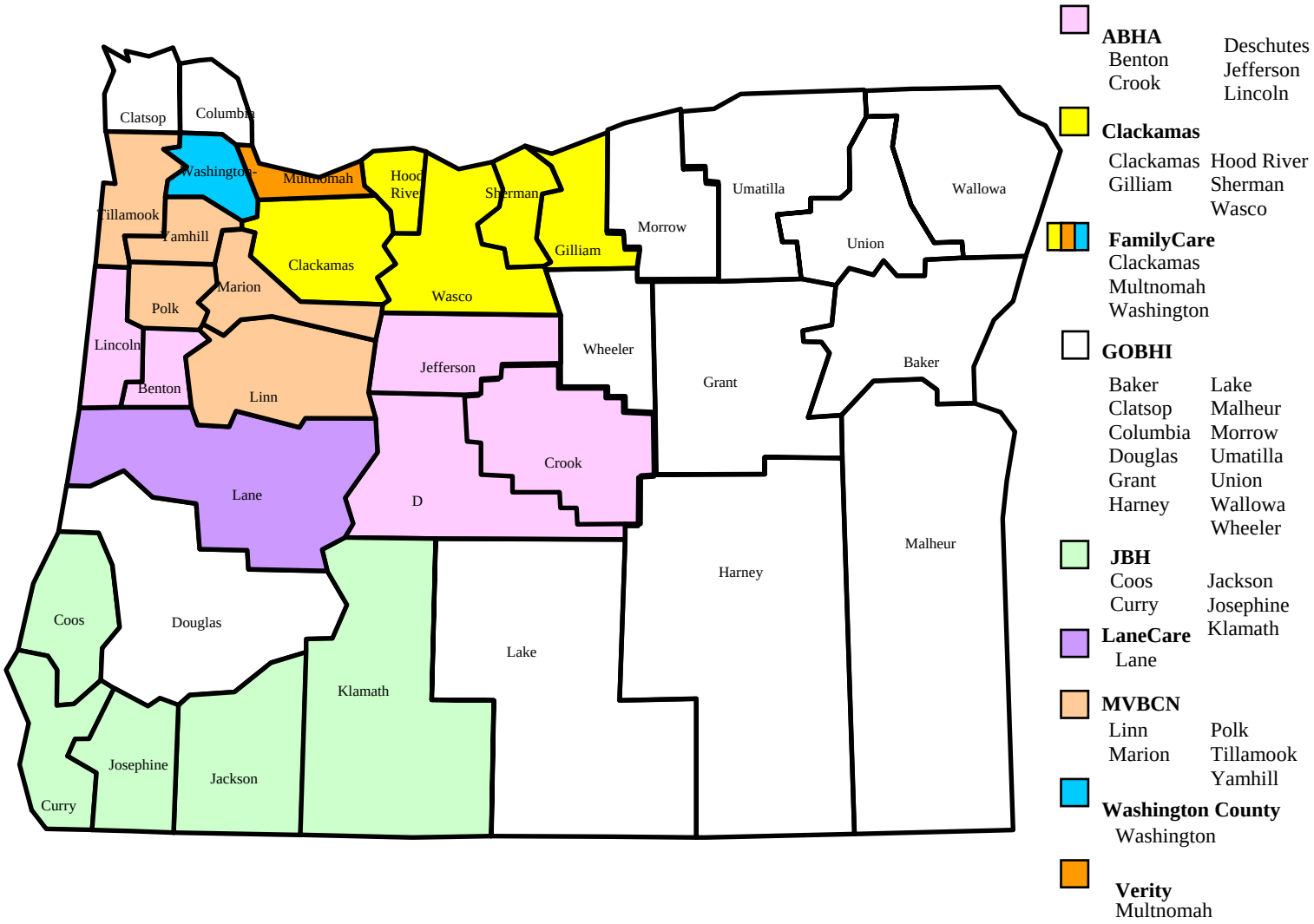
Community Services

The delivery of Community Services across the state is facilitated through contracts AMH has with MHOs, LMHAs and to a limited extent directly with individual providers. The following sections discuss the role of each party within AMH Community Services:

Mental Health Organizations (MHOs)
The MHOs are comprised of intergovernmental entities, counties, public benefits corporations, and one for-profit health plan. AMH contracts with these MHOs to oversee the delivery of services to OHP enrollees by mostly contracted providers under the authority of ORS 414.022. Currently, AMH has contracts with nine MHOs across the state. Figure 3.2 below illustrates the breakout of MHOs by county.

[19] Ibid.

Figure 3.2 MHO Geographic Areas



The organization of the MHOs across the state lends itself to a regionalized approach to care. Areas with smaller populations and fewer funds are able to pool resources in order to provide better accessibility to individuals in need. Counties like Multnomah, Washington, and Lane have larger populations and greater resources and therefore are able to operate as independent MHOs. The more populated counties surrounding Portland include more than one MHO to most effectively reach all enrolled OHP/MHO members.

Local Mental Health Authority and Community Mental Health Programs
Similar to the MHOs, AMH contracts directly with the LMHAs, who then designate providers through which all community level programs are administrated. As outlined in ORS 430.630(10), each LMHA, defined as a board of county commissioners, a tribal council, or a regional authority, that:

> Provides mental health services shall determine the need for local mental health services and adopt a comprehensive local plan for the delivery of mental health services for children, families, adults and older adults that describes the methods by which the local mental health authority shall provide those services. The local mental health authority shall review and revise the local plan biennially. The purpose of the local plan is to create a blueprint to provide mental health services that are directed by and responsive to the mental health needs of individuals in the community served by the local plan.[20]

The local plan includes the creation of Community Mental Health Programs (CMHP). These programs provide services to individuals who do not qualify for either of the OHP plans but who are still in need of publicly provided services. CMHPs are responsible for the planning and delivery of all services utilizing funding from partnerships with counties, tribes, the state of Oregon, and the federal government.[21]

There has been continuing effort at the state level to foster a strong community-based, consumer-driven system that provides a high level of care to some of Oregon's most vulnerable residents. Senate Bill 267 (2003) marked the next logical step as it effectively shifted the focus of community-based programs to incorporate more evidence-based practices (EBP) into their services. Provisions

[20] Oregon Revised Statute chapter 430, § 630, paragraph 10.
[21] Association of Oregon Community Mental Health Programs, "About Us" http://www.localcommunities.org/servlet/lc_ProcServ/GID=0139600115118451947309465 5&PG=0139600115118 4520378105326

included a requirement that for the 2005-2007 biennia 25 percent of public dollars be spent on EBPs, increasing to 50 percent for 2007-2009, and 75 percent for 2009-2011.

AMH uses fidelity tools in order to track and review the success of EBPs instituted by providers. The Fidelity Pilot Project, which ran from March to July 2007, provided AMH with invaluable information regarding the effectiveness of these new practices. Providers overall faced obstacles in successfully reaching high degrees of fidelity due to a lack of resources, personnel turnover, lack of wraparound services, and untrained staff.[22] The legislative initiative required a restructuring of policies and practices for providers; however, it did not provide any additional funding to assist in carrying out these new operations. Nevertheless, the move toward EBPs follows national trends in creating effective service delivery that focuses more on community-based care.

The overall cost savings associated with these new programs have not been fully realized; however, the preliminary numbers point to the marked success of specific programs and initiatives that incorporate treatments that are scientifically proven to be beneficial. For example, as of August 2008, 18 counties are currently offering supported employment programs that focus on providing individuals with the means necessary to obtain and maintain competitive employment. Of the 646 individuals currently participating in the programs, 39 percent have obtained competitive employment. This program together with the more than 40 other approved mental health EBPs places Oregon on the leading edge of the national initiative to implement consumer-driven, community-based, EBP treatments to individuals in need.

Subject to funding availability (except for costs associated with civil commitments), LMHAs are contractually obligated to establish a plan through which CMHPs provide the following levels of care to individuals in the community:

- 24-hour crisis services;
- Secure and non-secure extended psychiatric care;
- Secure and non-secure acute psychiatric care;
- 24-hour supervised structured treatment;
- Psychiatric day treatment;

[22] Oregon Department of Human Services. (6 December 2007) "Evidence-Based Practices in Mental Health and Addiction Services Report on the Addition and Mental Health Division Fidelity Pilot Project."

- Treatments that maximize client independence;
- Family and peer support and self-help services;
- Support services;
- Prevention and early intervention services;
- Transition assistance between levels of care;
- Dual diagnosis services;
- Access to placement in state-funded psychiatric hospital beds;
- Pre-commitment and civil commitment in accordance with ORS chapter 426; and
- Outreach to older adults at locations appropriate for making contact with older adults, including senior centers, long term care facilities and personal residences.

Over the last decade, budget cuts at the state and local levels have forced many CMHPs and providers to prioritize patients based on the severity of need. The National Alliance on Mental Illness (NAMI) estimates that less than 40 percent of Oregonians in need are able to access vital mental health programs.[23]

Figure 3.3 below outlines how this severity of need is prioritized and where an individual is seen at varying stages of the disorder.

Individual Seeking Care and Type of Medical Coverage	**Severity of Symptoms**		
	Occasional Stress to Mild Distress with No Impairment	*Mild to Moderate Distress with Mild or Temporary Impairment*	*Marked Distress with Moderate to Disabling or Chronic Impairment*
Private Insurance	Insurance accepted provider	Insurance accepted provider	Insurance accepted provider and/or State Hospital
Medicaid (OHP/MHO)	MHO participating provider	MHO participating provider	MHO participating provider[24]

[23] Korn, Peter, "Elsewhere, there are saner ways to help mentally ill," (27 February 2007) *The Portland Tribune*.
[24] Medicaid does not pay for state hospital services.

Uninsured	Free clinics, when available and providers with sliding fee scale	Free clinics, when available and providers with sliding fee scale	Community Mental Health Program, Community Hospital, or State Hospital

Not surprising, within the CMHPs no two programs are alike. Each county has its own unique demographics, population, geography, budgetary limitations, and general demand for services provided. In order to obtain a more accurate representation of this uniqueness, each county was surveyed to determine the availability of and accessibility to mental health services across the state. The list consisted of 25 core services with the option to identify any additional programs and services available. Each of the services, including those identified as "other" are defined below. The definitions are from the Substance Abuse and Mental Health Services Administration (SAMHSA) and supplemented with the AMH summary of funded mental health services, unless otherwise noted.

- **Acute Psychiatric Treatment Services**:
  Inpatient psychiatric services delivered to individuals suffering from an acute mental illness, or other mental or emotional disturbance posing a hazard to the health and safety of the individual and others. The services are delivered on an inpatient basis and are intended to stabilize, control, and/or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment at the earliest possible time. This includes patients who are admitted through the emergency room to psychiatric units at community hospitals.

- **Bridge Program (parolees)**:
  Programs that offer temporary Medicaid benefits and temporary income support to those recently released forensic clients who have pending federal benefits applications.[25]

- **Case Management**:
  A service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health,

[25] Bazelon Center for Mental Health Law, "An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration," http://www.bazelon.org/issues/criminalization/publications/buildingbridges/article6.htm.

vocational, transportation, advocacy, respite care, and recreational services, as needed. The case manager makes sure that the changing needs of the individual are met.

- **Community Support Services**:
  Services are provided to individuals in a community setting. Community services refer to all services not provided in an inpatient setting.

- **Crisis Team Services**:
  Services are available 24 hours a day, 7 days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

- **Day Treatment Facilities and Services**:
  Programs include special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy. It lasts at least 4 hours a day. Day treatment programs work in conjunction with mental health, recreation, and education organizations and may even be provided by them.

- **Early Intervention**:
  Programs used to recognize warning signs for mental health problems and to take early action against factors that put individuals at risk.

- **Emergency Shelter and Assistance**:
  Short-term, intensive help provided in a nonhospital setting during a crisis. The purposes of this care are to avoid inpatient hospitalization, help stabilize the individual, and determine the next appropriate step.

- **Extended Care Services**:
  Types of facilities included in the extended care system are: Oregon State Hospital and Blue Mountain Recovery Center, which provide intensive in-patient psychiatric treatment; and extended care programs, which provide residential care for patients following their release from a state hospital. Enhanced Care Services Programs, which are facilities that treat medical needs in addition to mental health needs (some of which are located in nursing homes); and Enhanced Foster Care Projects, which are private

homes or small group homes that provide residential services.[26]

- **Family Support Services**:
  Help designed to keep the family together, while coping with mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

- **Jail Diversion Programs**:
  Programs designed to redirect individuals to community-based care rather than to the criminal justice system. Law enforcement officers, judges, and attorneys must undergo training to enable them to pinpoint mental illness diagnoses and direct individuals to the proper course of treatment.

- **Jail Mental Health Services**:
  24-hour crisis intervention and suicide prevention teams provide onsite care to forensic clients. In some cases, screenings and assessments of newly incarcerated individuals take place upon entry.

- **Medication Management**:
  Complex community-based support, monitoring, and guidance offered to individuals receiving mental health medications.

- **Mental Health Courts**:
  This program offers community-based treatment and supervision rather than incarceration for criminals diagnosed with a mental illness. Typically only those who have committed misdemeanor crimes with no history of violence are able to participant in the program.

- **Outpatient Services**:
  A variety of services are available including family, group, and individual psychotherapy sessions as well as medication evaluations.

- **Residential Treatment Homes and Facilities**:
  Facilities that provide treatment 24 hours a day and can usually serve no more than 16 individuals at a time. Those with serious emotional disturbances receive constant supervision and care. Treatment may include

[26] Oregon Department of Human Services. "Mental Health and Developmental Disability Services Division – Records Retention Schedule."

individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Only those individuals who the county has determined to be unable to live independently without supervised intervention, training or support are eligible.

- **Seniors Mental Health Services**:
  Specialized geriatric mental health services are provided directly or indirectly to older and disabled adults in both community and hospital based settings.

- **Sub-Acute Treatment Services**:
  According to the definition developed by the American Health Care Alliance, the Joint Commission on Accreditation of Healthcare Organizations, and the Association of Hospital-Based Skilled Nursing Facilities, these treatment services provide intensive inpatient care designed for individuals with a mental health diagnosis who have not been hospitalized in an acute care facility. The care requires frequent and recurrent patient assessments during a short period of time in order to stabilize the individual.

- **Supported Employment and Education**:
  These supportive services include assisting individuals in finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities. Additionally, these services can assist individuals in furthering their education.

- **Supported Housing**
  Support for an individual living on his or her own. These services include therapeutic group homes, supervised apartment living, and job placement. Services teach how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others.

- **Transitional Housing**:
  Provides housing for individuals who are homeless or face a high risk of homelessness. Support-services and onsite mental health services are provided to residents.

- **Transitional Youth Services**:

Services offered to youth ages 16 to 21 who have principal mental, emotional, or behavioral conditions diagnosed as Axis 1. Services may be delivered, as appropriate, in clinic, home, school, or other settings familiar and comfortable for the individual.[27]

- **Other**:

  Assertive Community Treatment (ACT): provides comprehensive, community-based psychiatric treatment, rehabilitation, and support those with serious and persistent mental illness. Forensic Assertive Community Treatment offers similar treatment to forensic clients.

  Consumer-Run Services: peer-run programs that offer support to recipients through self-help and mutual support based services.

  Culturally-Specific Services: provides programs and services targeted to specific population groups such as African American, Latino, Native American, Asian American, etc.

  Early Assessment and Support Team (EAST): EAST was established in 2001 by Mid-Valley Behavioral Care Network. The program has been extended to other areas as Early Assessment and Support Alliance (EASA). The program primarily serves individuals aged 15-25 who suffer from their first episode of psychosis that may lead to schizophrenia. EAST/EASA offer individuals with the support services necessary to successfully manage their illness including the following:

    - Rapid access to psychiatric and counseling services;
    - Education about causes, treatment, and management of psychosis; rights in employment, school, and housing; and resources;
    - Support and education groups;
    - Support for vocational, educational, and independent living goals;
    - Mentor and volunteer opportunities; and
    - Events which are both educational and fun in nature.[28]

[27] Oregon Department of Human Services. (12 July 2006) "Summary of Office of Mental Health and Addiction Services Funded Mental Health Services."
[28] Early Assessment and Support Team, "About EAST," http://www.eastcommunity.org/home/ec1/smartlist_61/about_east.html.

Enhanced Outreach Services: provides support for individuals to enable them to successfully live in community-based facilities.

The availability of and accessibility to these services varies greatly across the state. As an example of this, Figure 3.4 below outlines the differences in service availability between two counties, Clatsop and Washington. Each county was given a survey listing the aforementioned programs. There is room for interpretation of the definitions, and therefore, there is potential for discrepancies within the data.

Clearly, counties with larger populations such as Washington County have the ability to offer a wider array of services in a larger number of locations than smaller counties such as Clatsop.[29] Please note that in the following chart, "*D*" indicates services offered directly by the County and "*C*" indicates services provided by a contracted provider.

Figure 3.4: Community-Based Services Available in Washington and Clatsop Counties

Services	Washington	Clatsop
Prevention Services	C, 50-locations	D, 2-locations
Outpatient Services	C, 15-locations	D, 2-locations
Day Treatment Facilities and Services	C, 3-locations	N/A
Residential Treatment Services	C, 2-locations, 29-beds	N/A
Acute Psychiatric Treatment Services	C, 7-locations	N/A
Medication Management	C, 15-locations	D, 2-locations
Case Management	C, 15-locations	D, 2-locations
Sub-acute Treatment Services	Children Only	N/A
Supported Employment	C, 5-locations	D, 1-location

[29] Using the most recent US Census Bureau data, Washington County has a population of 514,269 while Clatsop County has 37,315.

Services	Washington	Clatsop
Emergency Shelter and Assistance	C, 2-locations, 9-beds	C
Transitional Housing	C, 2-locations, 9-beds	D, 1-location
Group Housing and Support	C, 5-locations, 22-beds	N/A
Independent Living Services	C, Mobile Office	D, 1-location
Crisis Team	C, Mobile Office	D, 1-location
Seniors Mental Health Services	C, 1-location	D, 1-location
Transitional Youth Services	C, Mobile Office	D, 1-location
Extended Care Services	C, 6-locations, 24-beds	N/A
Mental Health Courts	D, 1-location	N/A
Jail Diversion Programs	C, Mobile Office	D, 1-location
Jail Mental Health Services	D, 1-location	D, 1-location
Bridge Program (parolees)	N/A	N/A
Supervised Housing	C, 6-locations, 63-beds	N/A
Family Support Services	C, 1-location	D, 2-locations
Community Support Services	C, 6-locations	D, 2-locations
Other (Please Specify)	Consumer-Run Services	ACT Team
Other (Please Specify)	Culturally Specific Services	Drop-In Center
Other (Please Specify)	Primary Care Setting	
Other (Please Specify)	Early	

Services	Washington	Clatsop
	Psychosis Services	
Other (Please Specify)	Forensic ACT	

Data Source: Public Consulting Group, Inc. administered survey to the counties

While it is clear that Washington County provides far more services in a greater number of locations than Clatsop County currently provides, the above table is somewhat misleading. Clatsop's lower availability and accessibility does not necessarily mean that residents are not receiving the care that they need. Washington's population is more than 13 times than that of Clatsop, and therefore the potential for demand is clearly greater in Washington. County funding for mental health services, similar to the general availability, is directly related to the population size. Section 4 - Gap Analysis gives a more detailed look at each county's level of demand and Section 5 - Investment Analysis expands upon the funding structures in greater detail.

State Hospital System

The state hospital system offers long-term psychiatric hospitalization for individuals who are no longer able to safely remain in the community. The system uses a combination of extended community care services and hospital campuses located in Salem, Portland, and Pendleton in order to address the needs of individuals. On an average day, more than 700 individuals reside in the state hospital system.

Oregon State Hospital

Oregon's long standing commitment to serving the mentally ill is evident through the Salem campus of OSH. Originally called the Oregon State Insane Asylum, the Salem campus was built in 1883 and many of the original buildings are still in use today. September 2008, however, marked a monumental change for long-term psychiatric care in Oregon with the groundbreaking for the new Salem campus. The new facility and the planned construction of a second hospital in Junction City will provide 620 and 360 beds, respectively. The current Salem and Portland locations provide a total budgeted capacity of 681 beds. 434 budgeted beds are reserved for the Forensic Psychiatric Services (FPS) and the remaining 247 budgeted beds serve the Psychiatric Recovery Services program (PRS). The Salem facility consists of more than 70 buildings and covers more than 970,000 square

feet. The Portland facility contains 61,250 square feet leased from Legacy Health System.

There is draft legislation for the 2009-2011 legislative session that seeks to establish an Oregon State Hospital Advisory Board. If established, this board will be responsible for the following:

- Conducting periodic, comprehensive reviews of federal and state laws concerning and administrative rules, policies, procedure, and protocols of the OSH related to the safety, security, and care of patients;

- Making recommendations directly to the superintendent of the OSH, the Director of Human Services, the Legislative Assembly or interim committees of the Legislative Assembly concerning:

    - Federal and state laws concerning and administrative rules, policies, procedures, and protocols of the hospital related to the safety, security, and care of patients;
    - Performance measure related to safety, security, and care of patients;
    - Goals for improvement in the safety, security, and care of patients of the hospital and improvements that are underway; and
    - Potential legislative proposals or budget packages related to the hospital; and

- Reporting annually to an appropriate committee of the Legislative Assembly regarding the activities of the board.

The OSH funding is split between the two main programs that serve civilly and forensically committed individuals. The PRS program offers treatment services to adults who have been civilly committed. Adult treatment services are offered at both the Salem and the Portland campuses. The program is broken out into several units in order to better serve patients' needs. Five units serve adults between the ages of 18 and 65 who have been civilly committed due to serious and persistent mental illness and are no longer able to safely function in a community-level environment. One medical unit serves all areas of the hospital and treats those who have co-occurring disorders or need additional medical attention. The remaining three units are broken into two groups, one that serves individuals who have suffered brain damage, and the other two serve geriatric patients aged 65 or older. The gero-psychiatric unit has 114 beds and serves individuals who are unable to safely function in a less restrictive nursing home environment.

The FPS program provides placement for individuals who are under the jurisdiction of the Psychiatric Security Review Board (PSRB) or who have been judicially committed because of their inability to aid and assist in their own defense. The units offer both maximum and medium security facilities with more than 300 beds allocated to the program. Civilly committed individuals who have been deemed unsafe to function in the general adult hospital population are also placed in the FPS program as it provides a more restrictive and structured environment. Treatment plans focus on the end goal of safely and successfully transitioning patients down to a less-restrictive community-based program.

In November 2006, the Department of Justice (DOJ) began an investigation of OSH in response to complaints about hospital conditions, care practices, and civil rights violations. The 1997 Civil Rights of Institutionalized Persons Act (CRIPA) provided the basis for the investigation and resultant report released in January 2008. The report concluded that OSH:

- Fails to ensure reasonable safety of its patients;
- Fails to provide adequate mental health treatment;
- Engages in the inappropriate use of seclusion and restraints;
- Fails to provide adequate nursing care; and
- Fails to provide adequate discharge planning.[30]

In preparation for the US DOJ review in July 2007, OSH contracted with two national experts and developed a preliminary continuous improvement plan. The plan was designed to comply with professional standards and elevate overall organizational performance. Continuous Improvement Plan (CIP) was based on six principles:

- Recovery and rehabilitation;
- Mutual patient and staff respect;
- A culture of non-violence and safety;
- Strengths-based and person-centered care and treatment;
- Psychosocial rehabilitation; and
- Integrated hospital and community services.

As a result of the US DOJ investigation, much has changed at OSH. Immediately

[30] Department of Justice, Civil Rights Division. (9 January 2008) *CRIPA Investigation of the Oregon State Hospital, Salem and Portland, Oregon.* Washington, DC: Department of Justice, Civil Rights Division.

upon the release of the report, DHS and AMH began working together with OSH in order to revise the CIP to address specifically the issues raised by the DOJ. DHS contends that the opening of the new facilities and the increase in staff will address many of the deficiencies.[31] AMH has been working more closely with community partners to ensure a more orderly discharge to lower and less restrictive levels of care. Supported employment and supported education programs are in place in many communities and provide incoming individuals with the means necessary to more successfully transition to lower levels of less restrictive settings. AMH has also entered into an agreement with the Oregon Health and Science University (OHSU). The partnership provides the state hospital system with six additional psychiatrists to better serve the psychiatric needs of individuals. The state hospital system anticipates adding an additional chief psychiatrist by the beginning of calendar year 2009.

Blue Mountain Recovery Center

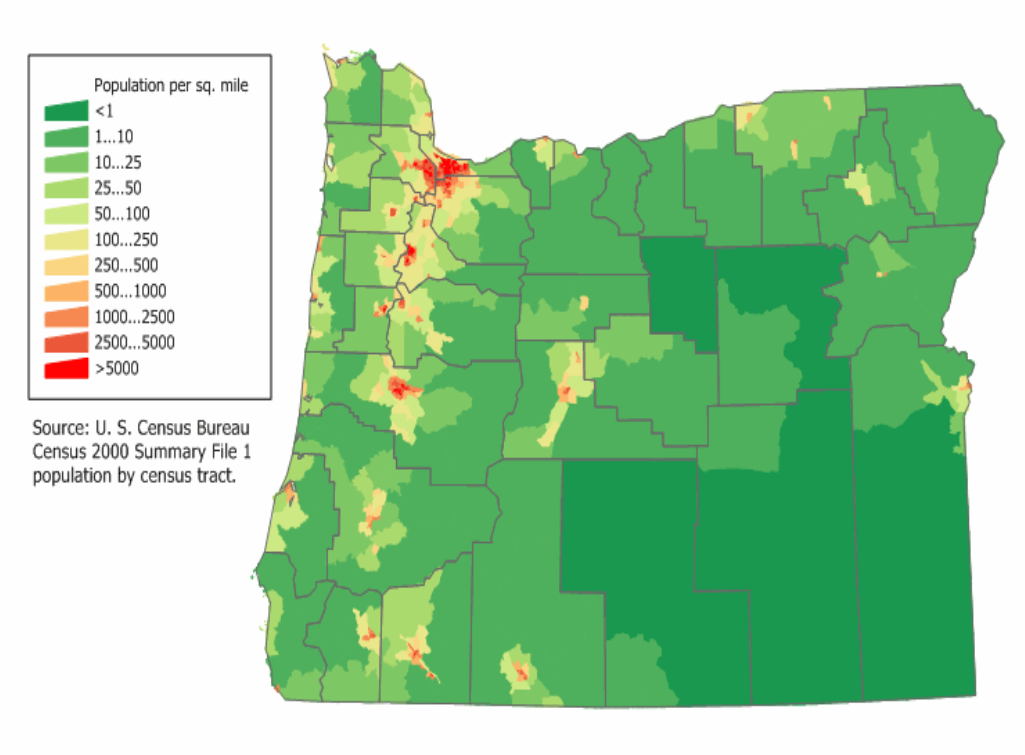
In addition to the two campuses in Salem and Portland, the OSH system operates an 89,822 square foot facility in Pendleton. The Blue Mountain Recovery Center (BMRC) serves the counties east of the Cascade Mountains. However, it offers services to considerably fewer individuals than the Salem or Portland campuses with two separate wards of 30 beds each. One serves a coed population with long-term care needs and the other provides intensive treatment for a male only population. Although it does not offer in-house non-psychiatric medical or skilled nursing care, BMRC offers an array of services to individuals. Patients receive behavioral and cognitive therapies, medication management, nutrition planning, and other life management skills programs. Nevertheless, because BMRC does not offer the full array of services available through OSH, there is no full service state, acute psychiatric care facility available east of the Cascades. The goal of recovery and reintegration into the community is at the forefront of care.

Demographics and the Oregon Mental Health System

To fully understand the mental health system in Oregon, it is important to take into account how the demographics of the state impact the structure of the system and the delivery of care. Oregon has a population of more than 3.7 million, the majority of whom live in the urbanized northwestern portion of the state. The concentration of population along the Interstate-5 corridor often translates to easier access and availability of services. Figure 3.5 illustrates the population dispersion

[31] Oregon Department of Human Services. (2008) "Oregon State Hospital System: Results of the 2006 U.S. Department of Justice review of conditions and practices at the Salem and Portland campuses of the Oregon State Hospital."

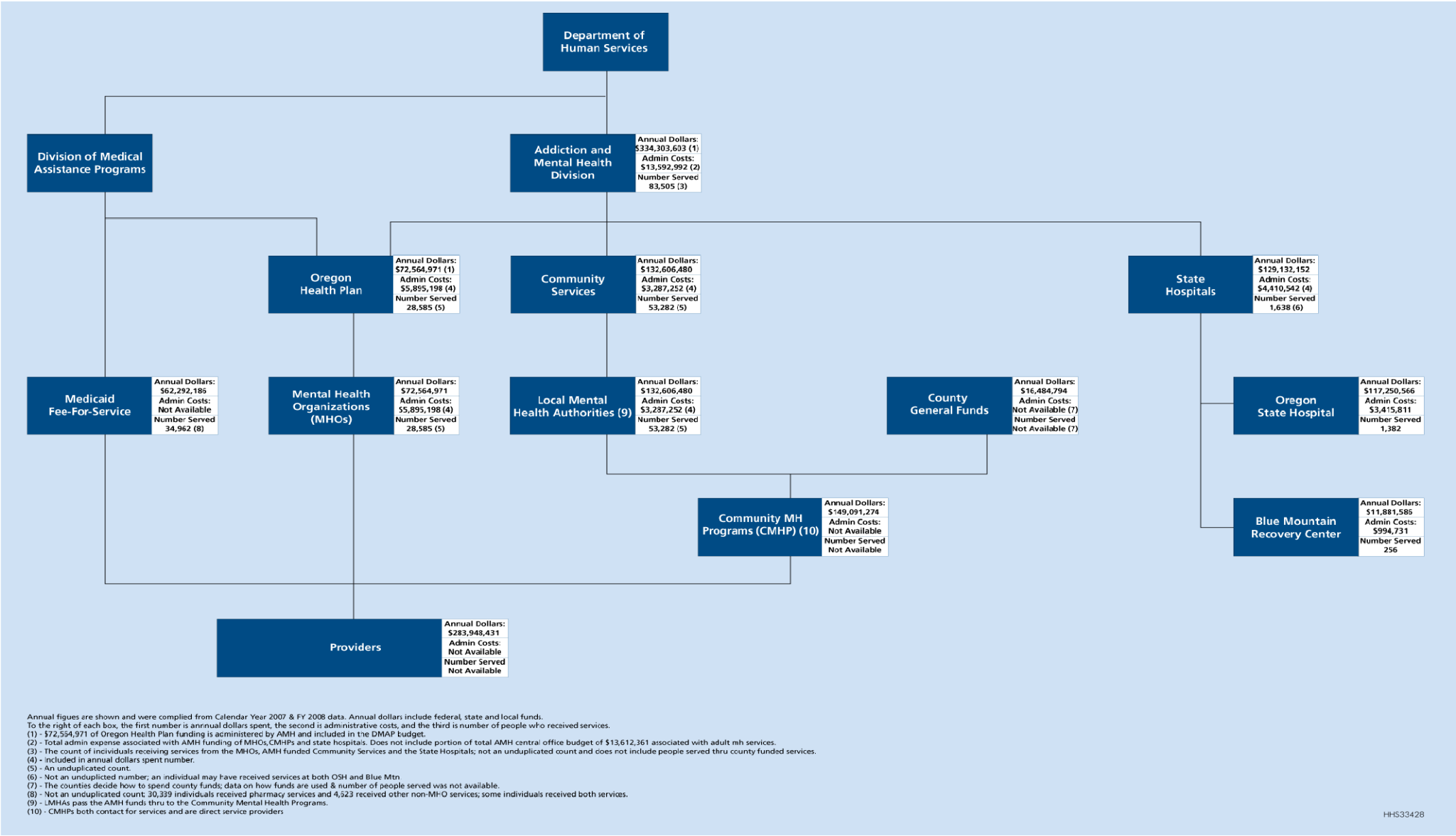
throughout the state. The sparsely populated, vast regions on the eastern side of the Cascade Mountains face obstacles to funding and availability of services. Many of the eastern counties, however, work closely with other counties to pool resources and programs in order to effectively reach a larger number of individuals in need.



The dichotomy between the urban and rural areas of Oregon increases the complexity of the system as the challenges associated with each area are vastly different. While there is often a broader array of service available in urban areas, it is often met with significantly higher demand for these services. In addition, urban areas are increasingly more culturally and ethnically diverse creating the need for highly specialized services. Consumers in rural areas of the state are faced with the difficulty of accessing services. Access is limited due to the increased travel distances required to obtain services as well as the limited availability of providers who have difficulty in attracting and retaining trained clinicians.

Figure 3.6 on the following page illustrates the organization of the DHS mental health system. Figure 3.6 also specifies the total funding, administrative costs, and number of individuals served, where applicable. Section 5 - Investment Analysis provides more detailed information about the funding streams.

Figure 3.6: DHS Mental Health System



Annual figues are shown and were complied from Calendar Year 2007 & FY 2008 data. Annual dollars include federal, state and local funds.
To the right of each box, the first number is annnual dollars spent, the second is administrative costs, and the third is number of people who received services.
(1) - $72,554,971 of Oregon Health Plan funding is administered by AMH and included in the DMAP budget.
(2) - Total admin expense associated with AMH funding of MHOs,CMHPs and state hospitals. Does not include portion of total AMH central office budget of $13,612,361 associated with adult mh services.
(3) - The count of incividuals receiving services from the MHOs, AMH funded Community Services and the State Hospitals; not an unduplicated count and does not include people served thru county funded services.
(4) - Included in annual dollars spent number.
(5) - An unduplicated count.
(6) - Not an unduplicted number; an individual may have received services at both OSH and Blue Mtn.
(7) - The counties decide how to spend county funds; data on how funds are used & number of people served was not available.
(8) - Not an unduplicated count; 30,339 individuals received pharmacy services and 4,923 received other non-MHO services; some individuals received both services.
(9) - LMHAs pass the AMH funds thru to the Community Mental Health Programs.
(10) - CMHPs both contact for services and are direct service providers

HHS33428

Psychiatric Security Review Board (PSRB)

The Oregon Legislature created the PSRB in 1977 to monitor and provide jurisdiction over individuals found guilty except for insanity. ORS 161.336(10) states:

> In determining whether a person should be committed to a state hospital or to a secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society.

The 2007-2009 budget for the PSRB allocated $1.035 million for the administration, adjudication, and monitoring of PSRB patients, of which 99 percent came from General Fund dollars. The 17 percent increase from the 2005-2007 budget accounted for the additional costs associated both with the juvenile panel of the Board and the additional hearing days added to the adult panel.[32]

Currently, 745 individuals are under the PSRB jurisdiction, with 368 residing in the Oregon State Hospital (OSH).[33] The remaining 377 individuals are held in numerous community-based facilities of varying degrees of security. The PSRB maintains a dramatically lower recidivism rate of 2.2 percent compared to DOC's rate of 31.4 percent[34]. However, the PSRB has considerably fewer clients to monitor. The entry to and exit from PSRB jurisdiction is determined by the judicial system; however, AMH directs the services and programs to these forensic clients housed in both the state hospitals and in community-based settings.

PSRB clients remain under the jurisdiction of the board for the maximum number of years punishable for the crime for which they were committed. For example, if an individual is found guilty except for insanity in a murder case, he or she will remain under the jurisdiction of the board for the remainder of his or her life. The level of security at which they are held may be reduced, but only after taking into consideration public safety. Individuals deemed to be dangerous are not conditionally released to the public under any circumstance. The PSRB also reserves the right to revoke the conditional release of any client who has violated their release in any way or is determined to be a danger to themselves or others.

[32] Psychiatric Security Review Board. (2 July 2008) "PSRB Factsheet."
[33] Ibid.
[34] Ibid.

Criminal Justice System

Public mental health systems often face the struggle between balancing the need to maintain public safety, while at the same time offering the best quality services to the highest number of individuals in need. With funding cuts across the board in traditional mental health programs, the criminal justice system consisting of both the Department of Corrections (DOC) and the county-run jails has begun to play a larger role as a mental health provider.

Oregon has the third fastest growing prison system in the country[35] and prison population data indicates that a significant number of Oregonians are accessing mental health care services and programs through this entrypoint. At the local level, the county-run jails have increasingly become the first step into the system. Local and state police officers are often the first to encounter an individual who is in crisis. Unfortunately, effective mental health training programs that provide officers with the proper tools to recognize and appropriately respond to these individuals do not exist widely throughout the state. As a result, untrained officers put both themselves and the individual in crisis at risk as they try to effectively respond to the situation.

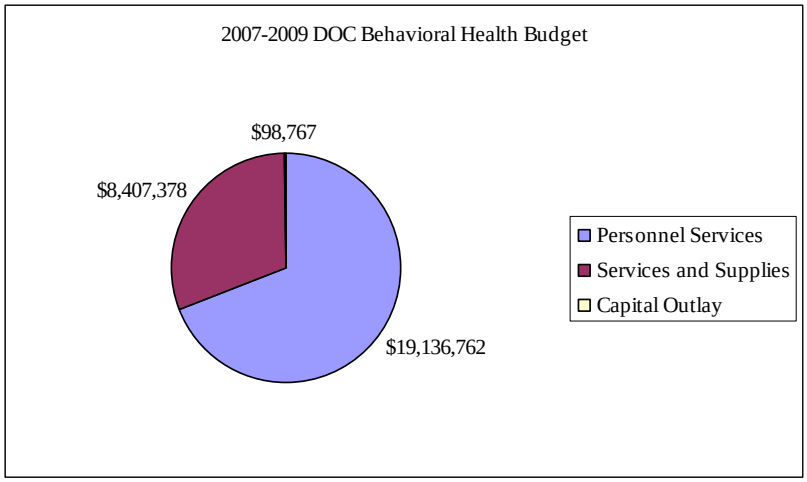
A 2006 statewide survey of 30 county-run jails found that nearly 9 percent of individuals incarcerated has a serious mental illness diagnosis.[36] Perhaps even more troubling, however, is the additional costs associated with incarcerating these individuals. Inmates with serious mental illness require additional prescription drugs, medical care, and staff time in order to ensure not only their safety but also the safety of those around them. As a result, the average cost for incarcerating these individuals is $100 per day versus $76 for individuals without such diagnoses.[37] With an average 6,100 individuals in the jail system on any given day, these additional costs both in monetary terms and in staff time have placed undue strains on county budgets. In the interest of public safety, the county jail system has had to take on a role for which it was not designed.

In recent years the DOC has taken on a similar, but larger, role than the county-run jails in ensuring public safety and providing mental health services to inmates. Of the more than 13,600 inmates currently incarcerated, approximately 5,600, or 41

[35] McDonald, Sherri Buri, "Changes in Prisons Urged," (28 January 2007) *The Eugene Register-Guard*.
[36] "Oregon Jail Survey Highlights Needs of Inmates with Mental Illness," (31 July 2006) *Salem-News*.
[37] Ibid.

percent, have an Axis I or II diagnoses. An Axis I diagnosis is defined as clinical disorders, including major mental disorders, as well as developmental and learning disorders. An Axis II diagnosis is defined as underlying pervasive or personality conditions, as well as mental retardation. As a result of these high numbers, the criminal justice system is quickly becoming one of the state's largest providers of mental health services.

This situation is further exemplified by DOC budgets which are forced to allocate millions of dollars to address the mental health needs of inmates. Outlined in Figure 3.7,, the 2007-2009 budget for DOC was over $1.3 billion, a more than $200 million increase from the 2005-2007 budget.[38] The Legislature cited several reasons for the increase, including the rising cost of medical and pharmacy services as well as new funding for permanent staff for mental health units.[39] The DOC budget relies almost entirely on General Fund dollars which comprise over $1.26 billion of the total allocation. Federal dollars and other funding sources contribute the remaining funds. Of the $1.3 billion total budget, nearly $28 million is spent on behavioral health services. Section 5 - Investment Analysis outlines in more detail the specific funding sources and amounts allocated to DOC.



Upon entering the prison system, inmates undergo a series of evaluations and assessments to identify any potential medical, security, mental health, or substance abuse risks that they may have. An individualized correction plan is created for each inmate, and those identified as having mental health risks are transferred to the appropriate facilities.

DOC staff monitor the mental health of inmates throughout their incarceration. Individuals with severe mental illness diagnoses are monitored more closely by

[38] State of Oregon Legislative Fiscal Office. (September 2007) "Budget Highlights: 2007-2009 Legislatively Adopted Budget."
[39] Ibid.

mental health case managers. Due to staffing constraints, the mental health specialist to inmate ratio hovers around 1:150. These staff members, however, work closely with contracted psychiatrists and psychiatric nurse practitioners who prescribe medication as appropriate and monitor inmates' progress. Treatment plans are adjusted and modified as the individual becomes more stabilized and no longer poses a danger to themselves or others.

In crisis situations, DOC relies upon Special Management Units to provide short-term stabilization of inmates. There are three units around the state located in the Oregon State Penitentiary in Salem, Snake River Correctional Institutions in Ontario, and Coffee Creek Correctional Facility in Wilsonville. The Challenge of Prison Experience (COPE) program in the Eastern Oregon Correctional Institution in Pendleton provides day treatment services for inmates in a less intensive environment than that provided by the Special Management Units. The goal of COPE is to provide inmates with the skills necessary to live and function in general population.

Mental Health and the Military

Currently, more than 7,500 members, or 25 percent, of the Oregon National Guard have been activated to serve in Operations Enduring Freedom and Iraqi Freedom.[40] In addition to these individuals serving overseas in hostile zones, the Department of Veterans' Affairs estimates that Oregon currently has nearly 352,000 veterans residing in the state.[41] National statistics suggest that the number of active duty military members suffering from mental health disorders has increased in the last decade. 1 in 5 meets the criteria for Post-Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), or Major Depressive Disorder (MDD).[42]

In recent years, the federal Department of Veterans Affairs has made a concerted effort to increase the availability and accessibility of mental health services to individuals in need. Overcoming the stigma associated with mental health disorders, however, has proved to be an obstacle for the Department. But, President Bush's establishment of the Task Force on Returning Global War on Terror Heroes put a spotlight on issues facing returning veterans. The report

[40] Oregon Military Department. (31 December 2003) "Annual Performance Report."
[41] Department of Veterans Affairs, "National Center for Veterans Analysis and Statistics," http://www1.va.gov/vetdata/docs/1l.xls.
[42] Constans, Joseph, *What we "know" about OEF/OIF vets*, http://www1.va.gov/scmirecc/docs/Constans_MIRECC_Retreat_2008WHATWEKNOW.ppt#259,1,Slide 1.

provided vital information regarding the gaps associated with the veterans' health care system and included a focus on behavioral health issues.

The Veterans Health Administration (VHA) is the federally funded and administered agency that oversees the health programs and services available to veterans. VHA offers a wide array of mental health programs and services including:

- Inpatient care;
- Residential care;
- Outpatient mental health care;
- Homeless programs;
- Programs for incarcerated veterans;
- Specialized post-traumatic-stress-disorder (PTSD) services;
- Military sexual trauma;
- Psychosocial rehabilitation and recovery services;
- Substance use disorders;
- Suicide programs;
- Geriatrics;
- Violence prevention;
- Evidence-based psychotherapy programs; and
- Mental health disaster response/post deployment activities.

With the rise in suicide rates among military members and the high occurrence of other behavioral health symptoms, it is crucial that the necessary services be available to active and returning members of the military. The Oregon Department of Veterans Affairs is in the process of launching a state suicide hotline similar to that launched recently by the federal Department of Veterans Affairs in an effort to help address the mental health needs of returning veterans. This hotline together with increased development of federal community based outreach clinics has increased the availability of services across the state. Section 4 - Gap Analysis takes a more detailed look at the specific issues facing this population.

Mental Health: Rules and Regulations

Oregon Revised Statute Chapter 430 establishes the framework for the publicly funded and administered mental health care system. The policy goals outlined in this chapter are directly in line with the national goals put forth by President

Bush's New Freedom Commission. The Governor's Mental Health Task Force Report took it a step further by outlining a series of values and principles necessary for any responsible mental health care system:

- Mental illness is treatable, often at low direct cost.
- Recovery is possible and is the goal of all mental health services. Recovery means that individuals with mental illness have control over their own lives and are able to have a meaningful role in their families and communities.
- Services are driven by the strengths and needs of consumers and their families, rather than by funding silos or the organization of service agencies.
- Services are cultural and age-specific, and delivered with respect for the integrity and dignity of consumers.
- Services are available in the communities where people live.
- Services are preventative and offered as early as possible.
- Services reflect evidence-based practices.
- Services are holistic and respond to a person's universe of strengths and needs.
- High quality services, including medications, are available without regard to ability to pay.
- For individuals who are dangerous to themselves or others, services must reflect public safety concerns, but always with the goal of returning these individuals to full participation in community life**.**
- Recovery from mental illness also requires recovery from substance abuse and physical illness, if present. Thus, coordination and integration of services is essential.
- Outcomes can be measured, both in terms of individual recovery and improved population health. In public health terms, the most important outcome is that a substantial number of individuals achieve recovery and function effectively as productive members of society.
- People who use or have used public mental health services in Oregon and their families are key stakeholders and must be included in meaningful ways at all state and local levels in decision-making and service provision. Meaningful inclusion goes beyond mere tokenism.[43]

[43] Oregon Governor's Mental Health Task Force. (September 2004) *Mental Health Task Force Report: A Blueprint for Action*.

This basic framework is expanded upon to meet specific needs of populations and programs through numerous additional Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs). Currently, there are 14 separate ORS and 22 OARs governing the mental health system. Each statute and rule has been categorized into three groups, *Commitment Laws*, *Patients' Rights*, and *Administrative and Business Practices*, listed below.

Commitment Laws
There are four ways in which an individual can be involuntarily committed:

- Civil commitment;
- Guilty except for insanity;
- Ability to aid and assist in a criminal case; and
- Guardian admission.

The civil commitment process requires an investigator from the CMHP to determine whether the individual meets the criteria to be involuntarily committed. This investigation typically occurs in a local community hospital; however, it can be conducted at the location of the patient in crisis. The investigator takes into account the criteria outlined in ORS 426:

1. Dangerous to self or others,
2. Unable to provide for basic personal needs,
3. diagnosed as having a major mental disability,
4. Has been committed or hospitalized twice in the last three years,
5. Is showing symptoms or behavior similar to that which caused the previous hospitalizations, or
6. Unless treated, will continue to deteriorate and become a danger to self and others.[44]

If the criteria are not met and the civil commitment hearing is not held, the individual is released. In instances where the individual meets criteria, a hearing is held and a judge makes a final determination of civil commitment.

The criminal commitment process involves individuals who have been found guilty except for insanity, fail to aid and assist in criminal proceedings, or are deemed sexually dangerous. ORS 161.295 states:

[44] Oregon Advocacy. "Mental Health Law in Oregon: A Guide for Consumer and Families Involuntary Hospitalization and Treatment."

> A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law…. The terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder.

Once the guilty except for insanity determination has been made, these individuals are placed under the jurisdiction of the PSRB.

ORS 161.360 outlines the criteria required to fail to aid and assist in criminal proceedings. The judge involved in the case makes the final determination for an evaluation based on whether the individual understands the charges levied against him or her, cooperates with counsel, or participates in his or her own defense. The statute allows for the individual to be held in a hospital setting for the length of the potential imposed sentence or up to three years.

Patients Rights

While institutionalized individuals reside in far more restrictive living situations, the US Constitution, federal laws and regulations, the Oregon Constitution, laws and administrative rules outline specific rights that patients must have. These rights may be limited in some cases, particularly if the health and safety of the individual or others is put at risk. In general, however, patients have the following rights:

- Communicate freely;
- Access the telephone;
- Send and receive mail;
- Access to a written up to date, individualized treatment plan;
- Given the opportunity to appropriately participate in devising the plan;
- Wear personal clothing;
- Practice or not practice a religion of his or her own choosing;
- Not forced to work unless part of the individualized treatment plan;
- If working is part of the treatment plan, given adequate and appropriate wages;
- Voice grievances and have them responded to appropriately;
- Receive representation by an attorney;

- Petition for a writ of habeas corpus; and
- Adequate access to Braille or American Sign Language services.

Administrative and Business Practices
Specific administrative rules direct the operations of all community and institutional based care including:

- CMHPs,
- Medicaid payments,
- Accounting practices,
- Programs for emotional disorders,
- Community treatment and support,
- Community Mental Housing Fund,
- Adult foster homes, and
- Intermediate and skilled nursing facilities.

During the 2007 Legislative Session, AMH outlined issues and concerns with the current state of regulations governing the mental health system. It was clear that the numerous ORS and OARs have created a framework wrought with redundancies and discrepancies. In the 2007 Joint Ways and Means Committee presentation, AMH outlined a plan to rewrite all OARs associated with CMHPs and providers of mental health services. The stated goal was:

> To increase critical accountability, remove conflicting rules, develop a single set of rules for addiction and mental health services, eliminate detailed process requirements, focus on evidence-based practices and outcomes, and finally, dramatically reduce the amount of time clinical staff spend on paperwork.[45]

With providers reporting that staff spend as much as 50 percent of their time meeting paperwork requirements, a restructuring to the regulations came as a welcomed change. The ambitious goal, however, met a series of obstacles along the way during 2007-2009, and many providers contend that the excessive paperwork requirements have not been reduced as much as AMH had promised.

Complicating matters further, the 2003 passage of Senate Bill 267 increased accountability for EBPs, but also increased administrative paperwork

[45] Oregon Department of Human Services, (2007) *AMH Joint Ways and Means Committee Presentation 2007 Legislative Session.*

requirements. By 2009-2011, 75 percent of public dollars funding the mental health system are to be spent on these practices, with each provider submitting reports to AMH outlining the progress and impact the programs are making. While the new focus on these practices is expected to increase accountability and improve the overall quality of care, the additional administrative burden is undeniable.

Community Residential Programs and Housing

The federal Fair Housing Act (FHA) prohibits any actions that may restrict housing choices or the availability of housing choices due to race, color, religion, sex, disability, family status, or national origin. Both physical and mental disabilities are included in the *disability* category. As clear cut as the Fair Housing Act may be, national studies suggest that often little is done to correct instances of discrimination. The US Department of Housing and Urban Development (HUD) found that 83 percent of Americans who believe that they have been discriminated against take no action to report the incident.[46]

The Governor's Task Force report recommended that the state "use every means available to continue…to develop specialized housing to match the needs of people with mental disorders."[47] AMH has made concerted efforts in recent years to address the issue of a lack of safe and affordable housing for individuals suffering from mental disorders. In the 2007 Ways and Means Presentation to the Legislature, AMH argued:

> Lack of appropriate housing keeps people in expensive, structured treatment environments longer than necessary to treat and stabilize their illness. This causes delays in discharging people from the state hospital and means people are staying in the most restrictive and expensive level of care longer than necessary.[48]

The lack of appropriate housing, however, is not necessarily related to low funding dollars. Currently, AMH has two housing funds, the Mental Health Services (MHS) Housing Fund and the Community Mental Health (CMH) Housing Fund, through which housing projects and initiatives are funded. Since its inception in 1989, the MHS fund has created housing for more than 1,200 individuals through

[46] HUD. (April 2002) "How Much Do We Know? Public Awareness of the Nations' Fair Housing Laws."
[47] Oregon Governor's Mental Health Task Force. (September 2004) *Mental Health Task Force Report: A Blueprint for Action.*
[48] Oregon Department of Human Services, (2007) *AMH Joint Ways and Means Committee Presentation 2007 Legislative Session.*

grants for more than 100 housing projects in 25 counties across the state. Since 2005 the CMH fund has awarded approximately $4.4 million for 20 housing projects in 13 counties.

Despite this progress, the stigma surrounding mental health disorders has created difficulties in securing locations to develop adequate, affordable housing sites. Recent events in Clackamas County highlight further the effects of this stigma. The Clackamas County Commissioners intended to provide funding and development assistance to Columbia Care Services, Inc (CCS) for a 15-bed supervised facility located in Milwaukie for patients transitioning from the state hospital system into community-based care. It was expected that half of the beds would be used for individuals under the jurisdiction of the PSRB.

With community activists' support, the City of Milwaukie purchased the intended property in order to prevent the development of the group home. In response to the purchase, CCS filed suit in federal district court in February 2008 alleging that the City had violated the Americans with Disabilities Act (ADA) as well as the FHA. The City of Milwaukie opted to settle the suit by allowing the property to be sold to CCS for the same price it was purchased. The next steps for CCS are not clear; however, this paves the way for the development of the site. This example is not limited to just Clackamas County; communities across the state have found themselves in similar situations in the recent past.

Pressing legal action is often not the ideal choice for any organization to resort to in order to ensure that adequate housing is available to disabled populations. The time and money spent to pursue such a course of action often times may put into jeopardy the ability to effectively develop the land if and when the case is won. Working closely with key stakeholders within the legal framework set up both by federal statutes and by Oregon statues, gives each member an opportunity to voice concerns and suggestions. This system is designed to serve the most vulnerable residents of Oregon and their voice is instrumental in ensuring that it provides the best quality and most effective continuum of care.

4 Gap Analysis

Summary of Key Findings

- Oregon ranks fifteenth in the nation for total per capita spending for mental health programs and services.
- Oregon's mental health programs are used at a higher rate than the national average.
- Use of community mental health program in Oregon is higher than the national average.
- Oregon mental health hospitalization and admission rates are markedly lower than national averages.
- Approximately 5.4 percent of Oregonians have been determined to have a serious mental illness.
- About 15,521 adults in Oregon have a serious mental illness and are not covered by insurance or otherwise treated by state programs.
- AMH has estimated that serving all individuals, adults and children, who have a serious mental illness, would cost approximately $579 million per biennium.
- Approximately 1,400 returning veterans from Iraq and Afghanistan received mental health services from the United States Veterans Health Administration (USVHA) during July 1, 2007 through June 30, 2008 at a cost of about $3.0 million.
- The geographical distribution of current and new (USVHA) hospitals and community outpatient clinics planned for the southern coast and eastern Oregon would appear to cover almost all of Oregon.
- There are noticeable estimation differences among studies containing prevalence data for older adults.
- There appears to be low utilization of mental health services by older adults including those served by the state's mental health organizations.
- There is a need to provide programs that encourage seniors to seek out mental health resources.
- Even though those with disabilities receive more mental health services, there appears to be a gap between the utilization rate of services that are provided and the prevalence.
- Black and Native American populations access mental health services at a rate comparable to other minority populations as well as to Caucasians populations.

- Hispanics represent the largest ethnic/minority population in Oregon; however, only 1.4 percent of Hispanics in need of mental health services access them.

Receiving Care vs. Needing Care

Extensive work has been completed over the past decade regarding the mental health needs of Oregonians. The purpose of this gap analysis is to provide a quantitative look at the number of individuals needing services versus the number receiving them building on the work of these previous studies.

Oregon compared to other states
As illustrated in Figure 4.1 below, Oregon ranks fifteenth in the nation for total per capita spending for mental health programs and services.[49]

Figure 4.1: Total Per Capita Spending on Mental Health by State FY 2005

States	Total	Rank	States	Total	Rank
District of Columbia	$404.40	1	Delaware	$89.19	26
Alaska	$269.64	2	Tennessee	$87.91	27
New York	$206.21	3	Indiana	$82.79	28
Pennsylvania	$204.92	4	Illinois	$80.15	29
Vermont	$175.16	5	Iowa	$79.44	30
Connecticut	$157.21	6	North Dakota	$74.39	31
Hawaii	$156.67	7	Colorado	$74.28	32
Arizona	$146.22	8	Virginia	$71.62	33
New Jersey	$139.84	9	Missouri	$71.59	34
Maryland	$139.75	10	South Dakota	$71.38	35
Maine	$137.15	11	South Carolina	$67.70	36
Montana	$134.03	12	Ohio	$66.10	37
Minnesota	$130.60	13	West	$65.56	38

[49] The National Alliance on Mental Illness produced a report in 2006 that stated Oregon ranked 40th in spending on mental health. This 2006 report used 2003 data from the National Association State Mental Health Research Directors. See National Alliance on Mental Illness, (2006) *Grading the States*, Arlington Virginia. Retrieved on 11-18-08 http://www.nami.org/content/navigationmenu/grading_the_states/full_report/full_report.htm

			Virginia		
North Carolina	$119.82	14	Utah	$64.34	39
Oregon	**$119.48**	**15**	Nevada	$62.62	40
California	$118.65	16	Nebraska	$60.56	41
New Hampshire	$118.65	17	Alabama	$60.31	42
Massachusetts	$106.64	18	Louisiana	$57.59	43
Mississippi	$105.68	19	Kentucky	$50.22	44
Wisconsin	$104.90	20	Georgia	$48.98	45
Wyoming	$98.79	21	Oklahoma	$44.67	46
Michigan	$96.40	22	Idaho	$37.81	47
Rhode Island	$95.55	23	Florida	$36.56	48
Washington	$93.96	24	Texas	$36.47	49
Kansas	$92.81	25	Arkansas	$35.60	50
			New Mexico	$24.23	51

Data Source: National Association State Mental Health Research Directors Research Institute 2008

Oregon and the National Averages

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) collects data from each state and compares the information to national statistics. This gives a standardized picture of where a state stands in comparison to the rest of the nation.

Figure 4.2 below contains data from 2005 and indicates that Oregon's programs are used at a higher rate than the national average. Approximately 30 per 1,000 Oregonians use the state's mental health services compared to a national average of approximately 20 per 1,000. Additionally, community utilization is higher than the national average as approximately 24 out of 1,000 Oregonians use community mental health services compared to a national average of 18 per 1,000. Oregon mental health hospitalization and admission rates are markedly lower at three-fourths to one-half of the national rates. This combination of results implies that, compared to other states, more individuals in Oregon are being served in the community instead of in hospitals. It is hard to evaluate this pattern without knowing if the treatment is appropriate for the individual's mental health needs. However, if it is assumed that individuals have in fact been referred to appropriate sources for treatment services, then this pattern would indicate that Oregon is doing better than other states in providing non-institutional, more community-

focused treatment.[50]

Figure 4.2: Comparison of Oregon to the United States

2006 CMHS Uniform Reporting System Output Table				
STATE MENTAL HEALTH MEASURES:				
STATE:	Oregon			
FY 2006	Oregon	Oregon	United States	United States
Basic Measures	***Number***	***Rate***	***Number***	***Rate***
Penetration Rate per 1,000 population	109,311	30.02	5,979,379	19.88
Community Utilization per 1,000 population	88,956	24.43	5,264,674	18.58
State Hospital Utilization per 1,000 population	1,628	0.45	171,125	0.60
Medicaid Funding Status	109,321	55.4%	3,285,758	61.8%
Employment Status (percent with employment data)	5,876	17%	622,219	22%
State Hospital Admission Rate	808	0.50	169,299	1.00
Community Admission Rate	37,715	0.42	2,840,575	0.62
State Hospital LOS Discharged Adult Patients		149 days		121 days
State Hospital LOS Resident Adult Patients		1014 days		869 days

Data Source: Substance Abuse and Mental Health Services Administration

Gap as the Difference between Prevalence and How Many Are Served

Oregon maintains prevalence data both at a statewide and at a county level. Data collected by SAMHSA indicates that Oregon's reported prevalence data on mental health is slightly lower than national averages. 11.24 percent of adults experienced serious psychological distress (SPD) versus the national average of 11.3 percent. SPD is defined by scores on SAMHSA's national testing scales.[51] SAMHSA data also show that 7.76 percent of Oregonians, compared to a national average of 7.3 percent, had at least one Major Depressive Episode (MDE), defined as a period of at least two weeks when an individual experiences a depressed mood or loss of interest or pleasure in daily activities and has a majority of the symptoms for depression.[52]

[50] Oregon has submitted 2007 data to SAMHSA; however SAMHSA has not released updated information.
[51] For a definition SPD see the references cited at http://www.oas.samhsa.gov/2K4State/ch6.htm. Retrieved on 10-21-08
[52] Substance Abuse and Mental Health Services Administration (SAMHSA), (2008) *2006 State Estimates of Depression & Serious Psychological Distress*, Office of Applied Statistics, Washington D.C., Retrieved on 8-18-08 from http://www.oas.samhsa.gov/2k6State/OregonMH.htm

At a county level, mental health prevalence data is maintained both by AMH as well as by The University of Texas Medical Branch (UTMB) for its ongoing study of state and county mental health statistics. The UTMB study projects county-level data on age, sex, marital status, education level, poverty status, and residence types. It provided estimates of the prevalence of Severe Mental Illness (SMI) and Severely and Persistently Mentally Ill (SPMI).[53]

To estimate the number of SMI in Oregon, AMH uses the national figure of 5.4 percent developed in the 1999 Surgeon General's report.[54] Figure 4.3 applies this 5.4 percent estimate to the adult population of Oregon counties.[55]

Figure 4.3: SMI Prevalence Estimates for Oregon Counties

County	Estimated Population in Need Based on 5.40%	Adult Population in 2007	County	Estimated Population in Need Based on 5.40%	Adult Population in 2007
Oregon	**154,867**	**2,867,908**	Lake	315	5,841
Baker	702	13,007	Lane	14,676	271,779
Benton	3,762	69,670	Lincoln	1,947	36,058
Clackamas	15,233	282,088	Linn	4,439	82,207
Clatsop	1,589	29,421	Malheur	1,268	23,484
Columbia	1,928	35,713	Marion	12,381	229,280
Coos	2,712	50,230	Morrow	479	8,870
Crook	1,049	19,431	Multnomah	29,853	552,841
Curry	960	17,771	Polk	2,817	52,162
Deschutes	6,758	125,144	Sherman	79	1,455
Douglas	4,431	82,056	Tillamook	1,122	20,787
Gilliam	80	1,484	Umatilla	2,895	53,606

[53] A review of the literature shows that there are different definitions of severely and persistently mental ill (SPMI) see http://www.srskansas.org/hcp/MHSIP/pdf/SPMI.pdf for one definition used by Kansas. See also New York definition at http://www.omh.state.ny.us/omhweb/chartbook/text.htm

[54] U.S. Department of Health and Human Services. (1999) *Mental Health: A Report of the Surgeon General* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved on 11-18-08 from www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html

[55] Portland State University, Population Research Center. See Table 10 of July 1, 2007 population estimates. Retrieved on 11-18-08 from http://www.pdx.edu/prc/annualorpopulation.html

County	Estimated Population in Need Based on 5.40%	Adult Population in 2007	County	Estimated Population in Need Based on 5.40%	Adult Population in 2007
Grant	318	5,894	Union	1,048	19,412
Harney	319	5,902	Wallowa	307	5,680
Hood River	851	15,755	Wasco	984	18,231
Jackson	8,462	156,705	Washington	20,160	373,333
Jefferson	850	15,746	Wheeler	68	1,255
Josephine	3,514	65,070	Yamhill	3,824	70,822
Klamath	2,685	49,721			

To ensure that the 5.4 percent prevalence was still a reasonable estimate to use, it is useful to examine what a peer-state has used in similar studies. The state of Washington has conducted several studies examining mental illness prevalence.[56] In 1993 and 1994, a telephone survey was made of 7,001 adults.[57] The 1994 telephone survey was followed by the Prevalence Estimates of Mental Illness and Need for Services (PEMINS) study in 2000. The 2000 PEMINS study came up with an estimate that 3.87 percent of the adult household and institutionalized population had SMI. Also in 2000 the National Alliance on Mental Illness (NAMI) conducted study that used the national estimate of 5.4 percent SMI to apply to Washington. The 2000 study was followed up by a two-year study that used a national advisory panel of mental health experts, did a national literature search, and estimated the SMI prevalence in households, community residential programs, prisons and jails, hospitals, homeless individuals, incarcerated children and children generally and came up with similar percents. A 2007 study of the Washington mental health workforce used a 3.9 percent SMI estimate.[58] This series of studies out of Washington could be interpreted to indicate that a statewide

[56]NAMI Washington (2000, September) Blueprints for an Effective Mental Health System in Washington State, Olympia, WA. Retrieved on 8-24-08 from http://www.nsmha.org/Reports/Blueprints.pdf. See also Joint Legislative Audit and Review Committee (JLARC), (2000, December 13), *Mental Health System Performance Audit Report 00-8*, State of Washington, Olympia, WA. Retrieved on 8-24-08 http://www.leg.wa.gov/Reports/00-8.pdf and Department of Social and Health Services, (2006, September) 2006 Washington State Mental Health Resource & Needs Assessment Study, Washington State's Mental Health Transformation Project, Olympia, WA. Retrieved on 8-24-08 from http://mhtransformation.wa.gov/pdf/mhtg/CMHP_RINA.pdf

[57] It was called the Washington State Needs Assessment Household Survey (WANAHS).

[58] Morrissey, Joseph, et al, (2007, August 29) Geographic Disparities in Washington State's Mental Health Workforce: Technical Appendix, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, NC

estimate of 5.4 percent for Oregon does not need to be adjusted upward and that a higher estimate is not appropriate.

Utilizing the 5.4 percent prevalence analysis above, it can be estimated that there are approximately 155,000 adult Oregonians who have a serious mental illness. Some of these individuals are served in the public sector through Medicaid and Medicare and others are served through private insurance. The individuals who have a serious mental illness and no insurance are at the greatest risk for not receiving treatment for their illness. The table below estimates the number of these individuals by county.[59] The 2007 Community Services Workgroup Report for the Oregon State Hospital Master Plan indicated that about 35.75 percent of individuals without insurance were served by the AMH. This percentage applied to the county-level data is outlined in the Figure 4.4 below.

The methodology used in Figure 4.4 produces an estimate that about 15,521 adults in Oregon have a serious mental illness and are covered by not insurance or otherwise treated by state programs.[60]

Figure 4.4: Estimates by County of the Number of Individuals with SMI who are not served by AMH or Insurance Programs

State and County	Estimated Adults with SMI Based on 5.40%	% Uninsured in 2006	Estimated Adults with SMI with no insurance	Estimated Adults with SMI Served by AMH	Estimated Adults with SMI not Served by AMH
Oregon	154,867	15.60%	24,159	8,639	15,521
Baker	702	14.60%	103	37	66
Benton	3,762	17.10%	643	230	413
Clackamas	15,233	14.70%	2,239	801	1,439
Clatsop	1,589	14.70%	234	84	150
Columbia	1,928	14.70%	283	101	182
Coos	2,712	15.80%	429	153	275
Crook	1,049	19.10%	200	72	129

[59] Office for Oregon Health Policy and Research, (2007, August), *Profile of Oregon's Uninsured, 2006,* Department of Human Services, Salem, OR. Table 1 contains county estimates of percent uninsured. Retrieved on 9-7-08 from http://www.oregon.gov/OHPPR/RSCH/docs/uninsuredprofile.pdf

[60] AMH has published a Fall 2008 Community Services Workgroup report that also contains estimates of the number of uninsured SMI that are not receiving AMH mental health services. Its numbers cover both adults and children, whereas these estimates are for adults only.

State and County	Estimated Adults with SMI Based on 5.40%	% Uninsured in 2006	Estimated Adults with SMI with no insurance	Estimated Adults with SMI Served by AMH	Estimated Adults with SMI not Served by AMH
Curry	960	15.80%	152	54	97
Deschutes	6,758	19.10%	1,291	462	829
Douglas	4,431	15.80%	700	250	450
Gilliam	80	14.40%	12	4	7
Grant	318	13.50%	43	15	28
Harney	319	13.50%	43	15	28
Hood River	851	14.40%	123	44	79
Jackson	8,462	15.80%	1,337	478	859
Jefferson	850	19.10%	162	58	104
Josephine	3,514	15.80%	555	199	357
Klamath	2,685	13.50%	362	130	233
Lake	315	13.50%	43	15	27
Lane	14,676	17.10%	2,510	897	1,612
Lincoln	1,947	14.70%	286	102	184
Linn	4,439	17.10%	759	271	488
Malheur	1,268	14.60%	185	66	119
Marion	12,381	17.10%	2,117	757	1,360
Morrow	479	14.40%	69	25	44
Multnomah	29,853	14.70%	4,388	1,569	2,819
Polk	2,817	17.10%	482	172	309
Sherman	79	14.40%	11	4	7
Tillamook	1,122	14.70%	165	59	106
Umatilla	2,895	14.40%	417	149	268
Union	1,048	14.60%	153	55	98
Wallowa	307	14.60%	45	16	29
Wasco	984	14.40%	142	51	91
Washington	20,160	14.70%	2,964	1,060	1,904
Wheeler	68	14.40%	10	3	6
Yamhill	3,824	14.70%	562	201	361

Data Source: Calculation by Public Consulting Group

Prevalence of Mental Health Episodes in Oregon by Age Group

Prevalence of mental health episodes in Oregon range by age group, with higher numbers seen for individuals aged 18-25. Those in this age group are twice as likely to have an episode of serious psychological distress in a year as those ages 26 and older. Individuals between the ages of 18-25 are also about 3 percent more likely to have at least one major depressive episode than those aged 12-17 and are about 4 percent more likely than those 26 and older.

Figure 4.5: Prevalence of Mental Health Episodes in Oregon

State of Oregon	Age Groups		
Rate of MH Incidence	12-17	18-25	26 or Older
Serious Psychological Distress in Past Year among Adults Aged 18 or Older	0.00%	20.77%	9.66%
Having at Least One Major Depressive Episode	8.13%	11.17%	7.19%

Data Source: http://www.oas.samhsa.gov/2k6State/OregonMH.htm#Tabs

Gap as the need for More or Additional Services

The February 2006 State Hospital Master Plan Phase II Report recommended significant investment in community mental health services and provided estimations of the need for additional residential beds. However, it was the 2007 Community Services Workgroup Report for the Oregon State Hospital Master Plan that outlined, by biennia, the additional community services needed and provided fiscal impacts for them. The 2007 Workgroup report also contained a detailed gap analysis of needs in three central counties: Crook, Deschutes, and Jefferson. Based on contributions from over 77 individuals, this report quantitatively and theoretically describes the estimated future needs for additional services for this region.

In the Fall of 2008 an updated Community Services Workgroup report was released. This report contained the estimation that, if everyone with a serious mental illness were provided services, approximately $579 million would be

needed on a biennial basis. The report is clear in saying that improvements would need to be phased in, but even after three to four biennia some resources, such as case management would still be limited.

Demand for Community Mental Health Care by Veterans and Services of the U. S. Veterans Health Administration

The federal government is responsible for taking care of the mental health needs of returning veterans who served in Iraq and Afghanistan. Publicly available data on the distribution of veterans' mental health services by Oregon locality is not readily available. State agencies do not track the number of veterans who receive mental health services, and there is a general reluctance to track such data as doing so might dissuade others from seeking services. Complicating matters further, veterans can obtain referrals or services from several different sources: the United States Veterans Health Administration, TRICARE, the Department of Defense's Military One Source, the Returning Veterans Resource Project NW, county services, or private insurance.

As of November 2008, there were 11,188 individuals who indicated that they lived in Oregon when they were released from active duty after serving in Iraq and Afghanistan. Data obtained from the U.S Department of Veterans Affairs indicates that 2,495 of these individuals have received a mental health service of some kind since their return. Data on the number of Oregonians wounded in Iraq and Afghanistan is not maintained by the Department of Veterans Affairs.[61]

Figure 4.6 below contains data for the period July 1, 2007 through June 30, 2008 from the U.S. Veterans Health Administration (USVHA) for the cost of services and the number of individuals using them. The data shows that 1,435 unduplicated veterans who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) received a mental health service during this period and that roughly 500 received services at more than one location.

[61] Pamela K. Embertson, Acting FOIA Officer, (2008, November), Information obtained from the U.S. Deapartment of Veterans Affairs, Northwest Healthcare Network, VISN 20 Portland, OR.

Figure 4.6: Mental Health Services Provided OIF/OEF Veterans Living in Oregon July 1, 2007 through June 30, 2008

Medical Center	Outpatient Clinic	Number Treated	Outpatient MH Costs	Inpatient MH Costs	Total MH Costs
Boise		13	$13,154	$13,655	$26,809
	Canyon City	1	$142		$142
Portland		526	$634,311	$195,336	$829,647
	Vancouver	581	$328,638		$328,638
	Bend	67	$55,760		$55,760
	Salem	114	$105,935		$105,935
	North Coast	3	$3,444		$3,444
	East Metro Portland	42	$69,517		$69,517
Roseburg		159	$435,662	$660,540	$1,096,202
	Eugene	207	$228,440		$228,440
	Bandon	32	$35,255		$35,255
	Brookings	6	$2,762		$2,762
Puget Sound		11	$4,313	$82,792	$87,105
	American Lake	4	$956		$956
Walla Walla		25	$42,664		$42,664
	Richmond	2	$97		$97
	La Grande	1	$75		$75
White City		140	$140,462		$140,462
	Klamath Falls	17	$8,618		$8,618
Total Served at each site		1,951	$2,110,205	$952,323	$3,062,528
Unduplicated Total		**1,435**			

Data Source: United States Veterans Health Administration

The demand for mental health services by veterans is complex to analyze. The stigma surrounding mental health is strongly seen through surveys conducted by the federal Veterans Administration. Data from surveys in 2006 and 2007 show the apprehension that members of the military have in discussing their mental health needs.[62] Their surveys show the filtering of demand by beliefs about its stigmatizing results.

[62] Constans, J. (2008, April 29), *What We Know about OEF/IEF Vets*, A PowerPoint presentation. Retrieved on September 9, 2008 from *www1.va.gov/scmirecc/docs/Constans_MIRECC_Retreat_2008WHATWEKNOW.ppt* Slide 38

Figure 4.7: Stigma Issues affecting Access to Veterans' Mental Health Care

Factors that affect your decision to receive mental health services	2006	2007
It would be too embarrassing	36.6%	32.0%
It would harm my career	33.9%	29.1%
Members of my unit might have less confidence in me	51.1%	44.8%
My unit membership might treat me differently	57.8%	52.1%
My leaders would blame me for the problem	43.0%	38.5%
I would be seen as weak	53.2%	49.8%

Data Source: United States Department of Veterans Affairs, MIRECC New Orleans

In March 2008, the Governor appointed a 27-person task force to review the reintegration services offered to veterans, their post separation access to services, and senior/retirement matters.[63] The task force held town hall meetings in June and July 2008 to collect comments from the public, and its report is due December 31, 2008.[64]

The Oregon Military Department is responsible for the National Guard, and it has an active reintegration effort for its members. It works with returning National Guard troops and provides assistance to them in housing, employment, education, and health services including mental health. Staff works closely with the veteran and his or her family in order to secure stable employment and housing and to identify any mental health issues the veteran may have.[65]

As of 2007, there were approximately 352,000 veterans in Oregon.[66] Approximately 7,500 Oregon National Guard and Army Reserve troops have served in Iraq and Afghanistan as of the summer of 2008. The Oregon Department of Veterans Affairs estimates of the returning veterans, between 30 and 40 percent will encounter mental health issues.[67] The numbers are lower than those found by

[63]For a copy of the Executive Order see retrieved on 9-10-08 http://governor.oregon.gov/Gov/docs/executive_orders/eo0808.pdf

[64] The schedule of the public meetings can be found at retrieved on 9-9-08 from http://www.oregon.gov/ODVA/docs/PDFs/TownHallSchedule.pdf

[65] Federal studies have shown the importance of work and personal relationships on the prevalence of mental health problems. *Levin, A., (2007,* September 21), Dramatic Increase Found in Soldier Suicides, *Psychiatric News Volume 42, Number 18, page 9. Retrieved on 9-13-08 from* http://pn.psychiatryonline.org/cgi/content/full/42/18/9

[66]See retrieved on 8-1-08 http://www1.va.gov/vetdata/docs/VP2007_state.htm

[67] Interview with Department of Veterans Affairs staff August 7, 2008. Constans reports that of some 235,000 OEF and IEF veterans who visited USDVA facilities since 2002, about 38% had a "mental disorder". Constans, J. (2008,

the USVHA. Each returning service member is subject to a mental health questionnaire. From those studies, the USVHA estimates that 19 percent of service members returning from Iraq and 11 percent of those returning from Afghanistan have a mental health issue.[68] However, the USVHA also reports that about 1 out of 3, or 35 percent, service members from Iraq were seen by the USVHA for a mental health visit within a year of their return. About a third of those seen were given a mental health diagnosis, and most were seen three times over the course of a year.[69]

At the federal level, the main source of mental health help is through federal USVHA hospitals and community based outreach clinics (CBOCs). Nationally, the USVHA has increased overall mental health resources by over $500 million in 2007 to meet the influx of veterans of all service eras with mental and emotional health care needs. For example, the USVHA hired additional suicide prevention counselors at each of its 153 medical centers to help support the national suicide prevention hotline, and it has instituted a program to screen all patients who served in the combat theaters of Afghanistan or Iraq for traumatic brain injury (TBI).[70] As of February 2007, the USVHA provides priority processing of all OIF/ OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/ OEF theatres.

In Oregon, the USVHA offers a substantial array of programs and services including the following:

- Outreach van providing clothing and sleeping bags to homeless veterans
- Vocational rehabilitation program for homeless veterans
- Residential beds available for homeless veterans
- Outpatient services
    - Basic mental health services for anxiety and depression

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April 29), *What We Know about OEF/IEF Vets*, A PowerPoint presentation. Retrieved on September 9, 2008 from *www1.va.gov/scmirecc/docs/Constans_MIRECC_Retreat_2008WHATWEKNOW.ppt* . See also VA Research Currents (2008, June) Veterans Health Administration Baltimore, MD which reported that 18.5 of 2,000 OEF/IEF veterans interviewed meet diagnostic criteria for post traumatic stress and depression.

[68] Hoge, C., et. al. (2006), *Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan*. Journal of the American Medical Association, 295, 1023-1032.

[69] United States Department of Veterans Affairs (2008) *An Overview of the Mental Health Effects of Serving in Afghanistan and Iraq*, Post Traumatic Stress Disorder Center, White River Junction, VT. Retrieved on 9-9-08 from http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/overview_mental_health_effects.html?opm=1&rr=rr1773&srt=d&echorr=true

[70] See http://www1.va.gov/vetdata/docs/Pamphlet_2-1-08.pdf

    - Post-Traumatic Stress Disorder clinics
    - Bi-polar clinics
    - Sexual trauma clinics
    - Women's health clinics
    - Substance abuse clinics
- Day treatment facilities and programs
- Intensive psychiatric community case management
- Emergency care
- Suicide prevention programs

There are four USVHA hospitals available to Oregonians: three medical centers located Portland, Roseburg, and Walla Walla, Washington and the Southern Oregon rehabilitation facility in White City. In addition to these four facilities, there are ten CBOCs located in Bandon, Bend, Brookings, Eugene, Gresham, La Grande, Klamath Falls, Ontario, Salem, and Warrenton. The VA is also opening an additional five in Burns, The Dalles, Grants Pass, Lincoln City, and Wilsonville/West Linn. The map below shows these existing and proposed locations and each location is marked by a circle with an approximate 30-mile radius.[71]

The map in Figure 4.8 shows that the existing and planned VHA medical centers and CBOCs cover substantial parts of the state. The coast is covered, with the exception of the Florence area where individuals needing service would be expected to travel to Eugene, Bandon, or Lincoln City. Portland, with 65 percent of all veterans enrolled in VA programs, is well covered and has access to programs and services. The population centers along the I-5 corridor from Portland to Ashland are also well covered. There are two facilities in the heart of eastern Oregon, one in Burns in Harney County, the other in LaGrande in Union County. Veterans also have the option to seek services outside the state through locations in Walla Walla, the part-time clinic in Ontario, and the VA Medical Center in Boise.

The expansion of the USVHA programs is helping to cover previously uncovered areas of the state some of which have small population sizes. For example, the U.S.

[71] The choice of a 30-mile distance is a compromise. Where the road network is not extensive, a 30-mile map distance could be considerably longer depending on where the highways are. On the other hand, in the I-5 corridor individuals could be willing to travel farther to obtain services. For example, approximately 53 percent of the veterans in Lane County travel the 60 miles to Roseburg to receive services at the VA Medical Center in Roseburg.

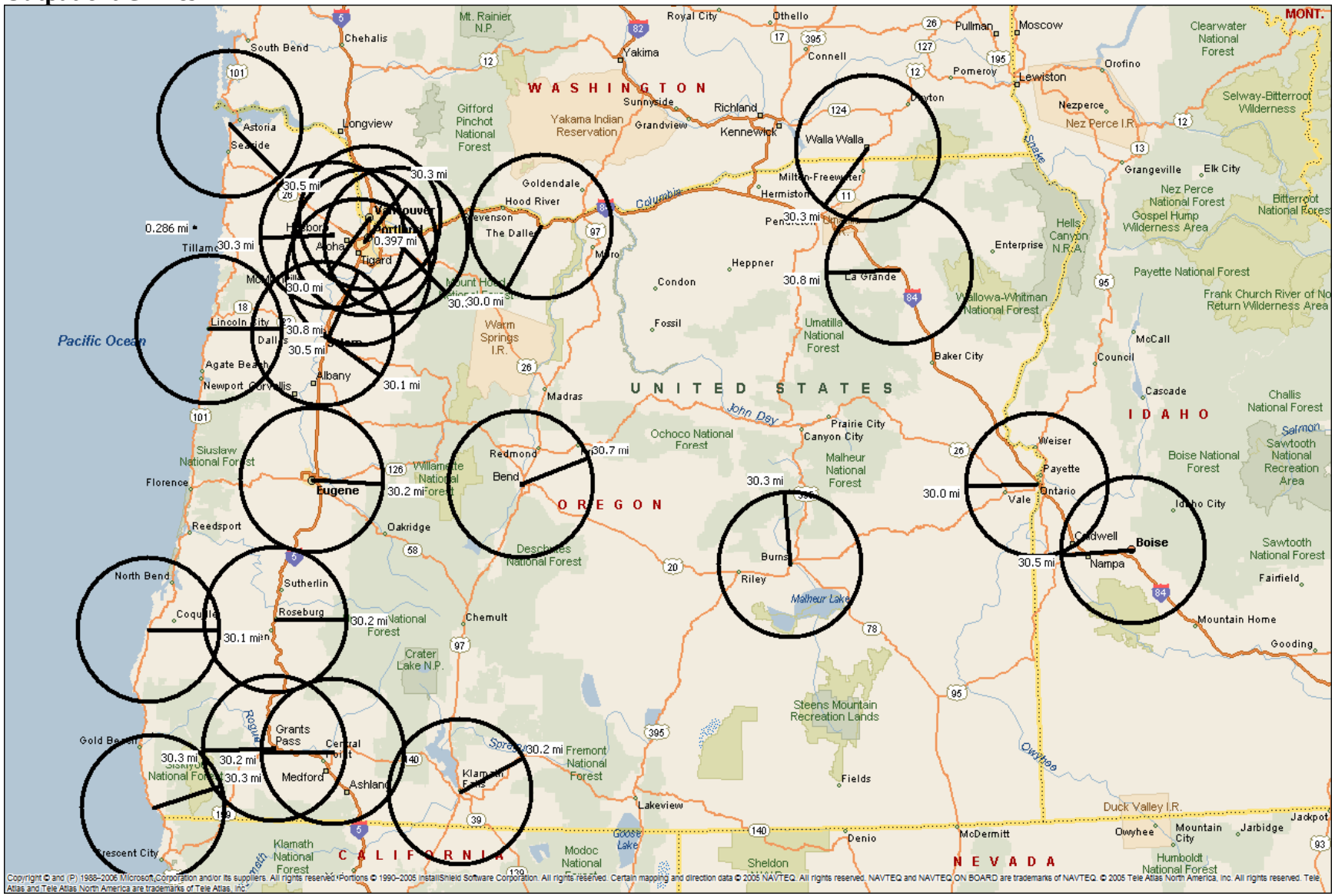
Census estimates that Harney County had 6,888 individuals in 2006.[72] Also, for 2006 the U.S. Census estimated that Union County had 24,345 individuals.[73] The Oregon National Guard has approximately 42 facilities.[74] All but three of these 42 facilities, Pendleton (35 miles), Baker (40 miles), and Hermiston (49 miles), are within 30 miles of a USVHA program. Generally speaking, members of the Guard who are stationed at these 42 locations and live in nearby areas are thus reasonably close to federal health programs or will be after the new programs are built. As the result of the expansion, the availability of mental health services to veterans should improve. At the same time, access to services, especially in rural areas, may continue to be a challenge for some veterans.

[72] See retrieved on 9-10-08 from http://factfinder.census.gov/servlet/DTTable?_bm=y&-geo_id=05000US41025&-ds_name=PEP_2006_EST&-_lang=en&-redoLog=false&-mt_name=PEP_2006_EST_G2006_T001

[73] See retrieved on 9-10-08 from http://factfinder.census.gov/servlet/DTTable?_bm=y&-geo_id=05000US41061&-ds_name=PEP_2006_EST&-_lang=en&-redoLog=false&-mt_name=PEP_2006_EST_G2006_T001

[74] For a list of the facilities see retrieved on 9-11-08 http://www.oregon.gov/OMD/Unit_Address.shtml

Figure 4.8: Location of Federal Veterans Health Administration Medical Centers and Federal Veterans Community Based Outpatient Clinics



The current distribution and planned expansion of federal health services is significant and covers those areas of the state where the Oregon National Guard has facilities and where guard units meet. The work of the Oregon Military Department is especially valuable. Its emphasis on personal contact with veterans and its focus on helping veterans secure employment, housing, and education aid the mental health of the veteran and reduce the stigma associated with expressing a need for mental health services. While the Oregon Military Department does not provide these services directly, it can be of substantial help to veterans in obtaining access to the services. Outreach and supportive contact with veterans is a key factor to ensuring both adequate access to mental health services and effective treatment plans. Interviews with county mental health staff also indicated that counties provide services to veterans also, but data is not maintained to estimate the depth and breadth of these services.

Older Populations

2005 Oregon vital statistics records report that, 121 individuals over the age of 65 committed suicide.[75] The prevalence of mental illness in older populations varies depending on what type of mental illness is being discussed. The Surgeon General's report on mental illness presented prevalence data on specific types of mental illness.[76]

Figure 4.9: Type of Mental Illness Prevalence, age 55+

	Prevalence (percent)
Any Anxiety Disorder	11.4
Simple Phobia	7.3
Social Phobia	1.0
Agoraphobia	4.1
Panic Disorder	0.5
Obsessive-Compulsive Disorder	1.5
Any Mood Disorder	4.4
Major Depressive Episode	3.8

[75] Oregon (2005) Vital Statistics Annual Report, Department of Human Services, Public Health Division, Salem Or. Table 6-6. Retrieved on 9-30-08 from http://www.dhs.state.or.us/dhs/ph/chs/data/arpt/05v2/chp6toc.shtml

[76] Office of the Surgeon General, (1999) *Mental Health: A Report of the Surgeon General*, U.S. Department of Health and Human Services, Washington, D.C. Chapter 5

	Prevalence (percent)
Unipolar Major Depression	3.7
Dysthymia	1.6
Bipolar I	0.2
Bipolar II	0.1
Schizophrenia	0.6
Somatization	0.3
Antisocial Personality Disorder	0.0
Anorexia Nervosa	0.0
Severe Cognitive Impairment	6.6
Any Disorder	19.8

Data Source: Office of the Surgeon General, 1999.

There are noticeable estimation differences among studies containing prevalence data for older adults. On the low end, SAMHSA's 2005 and 2006 National Surveys on Drug Use and Health (NSDUH) indicate that an annual average of 7 percent of adults aged 50 or older experienced serious psychological distress in the past year. Adults aged 50 to 64 were more likely to experience serious psychological distress than those aged 65 or older (8.8 percent and 4.5 percent, respectively). On the high end, a Tennessee study of Medicare-eligible individuals found that 5,339 of the 33,680 beneficiaries (15.9 percent) had a mental health diagnosis, and 1,343 (25 percent) were classified as having multiple mental health diagnoses.[77] The 2006 Texas Mental Health Assessment estimated that 22 percent of older adults experience mental disorders that are not a normal part of the aging process.[78]

Mental health prevalence estimates also appear to vary as a function of those older adults studied. One study of a low income, medically ill population found that 25 percent had an Axis I diagnosis.[79] While another study of older medically ill adults

[77] Husaini, B, et. al. (2000, October), Economic Grand Rounds: Prevalence and Cost of Treating Mental Disorders Among Elderly Recipients of Medicare Services, Psychiatric Services, 51:1245-1247. http://www.psychservices.psychiatryonline.org/cgi/content/full/51/10/1245

[78] Texas Transformation Working Group, (2006), *Voices Transforming Texas Assessment of Mental Health Needs and Resource*, Austin, TX . see http://www.mhtransformation.org/documents/MHTAssessmentFINAL9-2006.pdf retrieved on 9-25-08

[79] Areán, P. & Alvidrez, J. (2001), *The Prevalence of Psychiatric Disorders and Subsyndromal Mental Illness in Low-Income, Medically Ill Elderly*, The International Journal of Psychiatry in Medicine, Volume 31, Number 1.

found that of 1,775 assessments:

- 21 percent had diagnoses of Dementia/Alzheimer's, of those 3.4 percent also had depression
- 18 percent had diagnoses of CAD, of those 11 percent also had depression
- 16 percent had diagnoses of diabetes, of those 11.5 percent also had depression
- 16 percent had diagnoses of CVA, of those 14 percent also had depression
- 14 percent had diagnoses of Vision Impairment (legally blind, macular degeneration), of those 11 percent also had depression[80]

Across the state, the access to mental health programs designed specifically for seniors varies greatly by location. For example, some counties such as Multnomah and Deschutes have recognized reputations for providing mental health programs for older adults. With the exception of the Enhanced Care program, there has been an irregular focus on providing adequate access for older adults over the last decade. For example, there was a concerted effort during 2003-2004 to focus on older adult suicide prevention. Also, ORS 430.630(10)(b) requires each LMHA to develop a biennial plan for local mental health services, and in 2006 each county mental health program was required to address in plans as to how to provide mental health services for older adults. The Division of Seniors and People with Disabilities (SPD) has a joint program with AMH for enhanced care community placements in which approximately 200 individuals with mental health needs are served.[81] AMH has a coordinator who supports programs for older individuals and those with disabilities; however, there is not a specific office or program with multiple staff to support specific mental health issues for older adults and individuals with disabilities.

A review of surveys distributed by AMH finds a high level satisfaction with services received by individuals over the age of 65.[82] However, a review of MHO

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http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,2,9;journal,30,146;linkingpublicationresults,1:300314,1

[80] Lundgren, K. (2006, February 28) *Mental Illness and the LTCI Policy*, The 6th Annual Intercompany LTCI Conference, Anaheim. CA. www.soa.org/files/ppt/2006-anaheim-lundgren-42.ppt

[81] State of Oregon 2008-2009 Community Mental Health Services Block Grant Application Salem, OR. P. 61 see http://www.oregon.gov/DHS/mentalhealth/docs/block2007grant.pdf

[82] Addictions and Mental Health Division, (2008, January) *2007 Oregon Mental Health Statistics Improvement Project Survey for Adults* Oregon Department of Human Services Salem, OR p. 2 Retrieved on 9-25-08 http://www.oregon.gov/DHS/addiction/publications/adult2007survey.pdf

capitation and utilization data indicates that older adults use fewer services than their prevalence percentages indicate. The utilization data will be discussed in greater detail in Section 5 - Investment Analysis.

A comparison of Tables 2 and 5 in the October 2006 - September 2007 Oregon Health Plan Mental Health Utilization Report shows that across the four quarters, 3.90 percent of the approximately 27,000 individuals over the age of 65 who were enrolled in MHO received services contrasted with 13.15 percent of individuals aged 18-65.[83]

Figure 4.10: Adults Enrolled in Mental Health Organizations and Receiving Services October 1, 2006 through September 30, 2007

Mental Health Organizations	Individuals Aged 18-64				Average
	4th Q 2006	1st Q 2007	2nd Q 2007	3rd Q 2007	
Number Receiving Services	16,612	17,050	17,036	16,262	16,740
Number Enrolled	131,133	127,547	125,734	124,934	127,337
Percent of Enrolled Receiving Services	12.67	13.37	13.55	13.02	13.15

Mental Health Organizations	Individuals Aged 65+				Average
	4th Q 2006	1st Q 2007	2nd Q 2007	3rd Q 2007	
Number Receiving Services	1,048	1,074	1,095	1,006	1,056
Number Enrolled	26,835	26,868	27,182	27,307	27,048
Percent of Enrolled Receiving Services	3.91	4	4.03	3.68	3.9

The prevalence rates discussed earlier are higher than 3.90 percent and would be expected to be higher in a low-income Medicaid population. It is reasonable to assume that there is a gap in the services used by Medicaid-eligible older

[83] Addictions and Mental Health Division, *Oregon Health Plan Mental Health Utilization Report, October 1, 2006Through September 30, 2007*, Department of Human Services, Salem, OR retrieved on 9-25-08 http://www.oregon.gov/DHS/mentalhealth/publications/codebooks/ohp1006amh0907.pdf Tables 2 and 5

individuals, but the measurement of the gap depends upon what prevalence or utilization rate is contrasted against the 3.9 percent. For example, contrasting the 13.15 percent utilization rate of individuals aged 18-64 shows that the utilization of those over the age of 65 would need to increase another 236 percent to match the utilization rate of adults 18-64. An implication of this gap analysis is the need to improve efforts that encourage seniors to seek out mental health resources.

Individuals with Disabilities

The word "disability" has no common meaning.[84] Large national studies discussing mental illness and disability usually define mental illness itself to be a disability and do not discuss the prevalence of mental illness among individuals with a physical or intellectual disability.[85]

However, the prevalence of mental health issues among those with physical and intellectual disabilities has been extensively studied leading to the summary conclusion that individuals with intellectual disabilities tend to develop mental illness about twice as frequently as other individuals.[86] These same prevalence rates have been found in current studies.[87]

Due to current operational functionalities, there is the potential that a person with a disability who had a mental illness could be "shuffled" back and forth between programs. Anecdotal evidence suggests that this person would originally be seen by staff within SPD; however, upon being diagnosed with a mental illness, this person would then be shifted over to AMH program staff. AMH staff, then may argue that the person was really the responsibility of SPD because the person is disabled. Unfortunately, it is difficult to study if this in fact occurs, and if so, how often it occurs. Underlying the anecdotal impression, however, is the more basic

[84] Mashaw, J., & Reno, V.P. (1996). *Balancing security and opportunity: The challenge of disability income policy.* National Academy of Social Insurance, Washington, DC.
[85] See for example, U.S. Department of Health and Human Services, (1999) *Mental Health: A Report of the Surgeon General—Executive Summary*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, Rockville, MD. Retrieved on 10-6-08 from http://www.surgeongeneral.gov/library/mentalhealth/home.html. See also, New Freedom Commission on Mental Health, (2003) Final Report of the President's Commission on Mental Health, Rockville, MD. Retrieved on 10-6-08 from http://www.mentalhealthcommission.gov/reports/reports.htm
[86] Eaton, L., & Menolascino, F. *Psychiatric disorders in the mentally retarded: types, problems, and challenges* Am J Psychiatry.1982; 139: 1297-1303. For multiple references to this body of research literature see also Coelho, J. et al. (1993, April-June) *An experimental investigation of an innovative community treatment model for individuals with a dual diagnosis - DD/MI - mental retardation and mental illness*, Journal of Rehabilitation,
[87] Cooper, S. et. a. (2007), *Mental ill-health in adults with intellectual disabilities: prevalence and associated factors*, British Journal of Psychiatry, 190, 27-35.

observation that there needs to better coordination between the DHS divisions.

In Oregon, there are a significant number of individuals with mental illness who are served by Medicaid. As of December 2007, there were 32,783 individuals in Oregon receiving Social Security Disability Insurance (SSDI) payments due to a "mental disorder." Of these individuals, 7,364 were defined as having "retardation" and 25,419 were described as "other" implying a mental illness.[88] The National Association of Dually Diagnosed (NADD) argues that prevalence numbers may be as high as 33 percent.[89] More astounding, the 2004 Medicare Beneficiary Survey found that 53 percent of those with Medicare who were under 65 years of age and disabled report having been told that they have a mental or psychiatric disorder.[90]

An examination of rate cells forming the MHO capitation rates and the MHO utilization reports indicates that there is a substantial amount of Medicaid mental health spending for individuals who have a disability. It is difficult, however, to determine how many individuals with disabilities who are not on Medicaid also have untreated mental health issues. Oregon does not have specific programs that seek out and target these individuals.

Some states, including Washington, have targeted programs that assist individuals who have been dually diagnosed. For inpatient, Washington has 39 habilitation mental health beds in its two state hospitals. Staffs receive special training to provide services to those who have a dual diagnosis. At the community level, in 2008, Washington provided crisis stabilization services to 2,300 individuals through its developmental disability services. Each of the Washington developmental disability regions has a psychologist and staffs who provided 2,800 hours of training to community agencies and state staff about the mental health issues impacting individuals with disabilities.

Ohio also provides specialized mental health programs for individuals with intellectual disabilities. The Ohio Departments of Mental Health and Mental Retardation and Developmental Disabilities (MHMRDD) signed an interagency agreement in 2005 to work together on common projects and support a Center for

[88] Office of Policy Data, (2008 September), *Annual Statistical Report on the Social Security Disability Insurance Program, 2007*, U.S. Social Security Administration, Washington, D.C. Table 10 retrieved from on 9-29-08 http://www.ssa.gov/policy/docs/statcomps/di_asr/2007/index.html

[89] Communication from Dr. Robert J. Fletcher, Chief Executive Officer, National Association for the Dually Diagnosed (NADD), Kingston, NY. Received October 8, 2008.

[90] Communication with Mary C. Crenshaw, Dartmouth University, 9-30-08.

Excellence at Wright State University. The Ohio MHMRDD department is working on joint training with mental health staff, negotiating eligibility requirements for accessing mental health services, and expanding its contacts with local mental health boards.

Ethnic and Minority Populations in Oregon

Ethnic and minority groups make up roughly 14 percent of Oregon's population. In most cases these populations seek mental health service at a lesser rate than non-minority populations. The gap that is created from there being more people in ethnic and minority populations than services are available is also inflated due to the barriers that prevent people in populations from accessing and receiving services thus adding to the gap.

Figure 4.11: Ethnic and Racial Population in Oregon in 2000 and 2006[91]

Population by Race				
	2006		2000	
	OR	USA	OR	USA
Black	1.7%	12.4%	1.6%	12.3%
American Indian	1.8%	0.8%	1.3%	0.9%
Asian	3.7%	4.4%	3.0%	3.6%
Native Hawaiian	0.2%	0.1%	0.2%	0.1%
Two or More Races	3.0%	2.0%	3.1%	2.4%
Hispanic	10.2%	14.8%	8.0%	12.5%
White	86.1%	73.9%	86.6%	75.1%

Data Source: U.S. Census Bureau, 2006 American Community Survey

A lack of adequate health care coverage serves as a barrier to mental health services for many of those who make up the minority and ethnic populations. Those who are not Medicaid eligible have less available to them in the form of treatment options. A person who is not Medicaid eligible in need of mental health services must reach the point of crisis before he or she receive services while those who are Medicaid eligible have greater access to needed services available to them. Mental health services for specific ethnic and minority populations are perceived to be virtually non-existent, and the services that are available are capped at a certain

91 http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&_lang=en&_sse=on&geo_id=04000US41&_state=04000US41 Percentage's do not add up to 100% as Factfinder may double count due to bi-racial status.

amount.[92] In recent years, however, Oregon has made strides in trying to reach these ethnic and minority populations with one example being the Avel Gordly Center for Healing in Portland. The center is located in the heart of Portland where ethnic and minority populations are high. It is run by culturally competent mental health professionals who have made cultural understanding and sensitivity the major viewpoint of the facility. The center, which opened in February 2008, is staffed by 12 counselors and three psychiatrists and serves about 600 patients.[93] Although the percentage of ethnic and minority populations served may be comparable to Caucasian populations, the sheer number unique members served by Oregon's MHOs does not compare.

Figure 4.12: Number of Minority and Ethnic Adults who Receive Mental Health Services.

Ethnic Population Receiving Mental Health Services						
Adults	**Caucasian**	**Native American**	**Hispanic**	**Black**	**Asian**	**Total**
Adult Population	2,469,269	51,622	292,527	48,754	106,113	2,867,045
% of Total	**86.1%**	**1.8%**	**10.2%**	**1.7%**	**3.7%**	
Unique Served by MHO	227,790	5,653	13,749	3,986	8,091	259,268
Percent of Total	**87.9%**	**2.2%**	**5.3%**	**1.5%**	**3.1%**	
% of Ethnic Group Receiving Mental Health Services	**9.2%**	**11.0%**	**4.7%**	**8.2%**	**7.6%**	**9.0%**

Data Source: PCG computed table using information from Table 6 of July 2008 Oregon Health Plan Mental Health Utilization Report January 1, 2007 Through December 31, 2007 and US Census Data.

For adults, Hispanics receive the lowest percentage of mental health care services despite making up the largest minority group in Oregon at 10.2 percent. Native American and African American adults rank second and third behind Caucasians in service utilization at 11 percent and 8.2 percent, respectively, but combine for just 3.1 percent of the total population. Utilization percentage of mental health services

[92] Information from Interviews with NorthWest Senior and Disability staffs 9/30/2008.
[93] http://www.theskanner.com/index.php?action=artd&artid=6849

from these two ethic/minority groups are comparable that of Caucasians (9.2 percent) and adults (9.0 percent) in general.

Traditionally, funding, or a lack thereof, has created the largest gaps within the system. For centers that provide services to Native American populations, like that on the Warm Springs Reservation, a lack of funding hinders their ability to hire qualified staff. The salaries at the center at Warm Springs are the lowest in the state, and therefore, the center cannot hire professionals with adequate educational backgrounds to fill vacant positions. The center often instead trains unqualified applicants in order to fill spots. Further complicating matters, the center has a policy of giving preference first to hiring members of the tribe. Because of the close knit nature of the community, individuals in need often times to do not feel comfortable seeking services from fellow members of their community. They either go to facilities outside of the reservation, which the center pays for, or do not seek services at all.[94]

Other gaps in service for ethnic and minority populations may be created by cultural barriers and beliefs. Ensuring that individuals in Hispanic population seek the services they need is often an obstacle. Once access is available, interpreters are available to help with translation and break down barriers with these populations. Hispanics, who make up 10.2 percent of Oregon's population, are often harder to reach out to due to the cultural beliefs/differences of what they believe is actually causing the problem.

Figure 4.13 shows a breakdown of ethnic and minority groups for each county and the number of individuals who are not being served by AMH. The table was constructed by taking the estimated number not served by the county and using the ethnic percent of total population by county numbers used in the 2000 census[95] and then calculating a number not served by ethnicity.

[94] Info based on interviews with staff at Warm Springs Human Services Community Counseling Center on 10/17/2008

[95] http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo_id=04000US41&-_box_head_nbr=GCT-P6&-ds_name=DEC_2000_SF1_U&-redoLog=false&-mt_name=PEP_2007_EST_GCTT1R_ST2S&-format=ST-2

Figure 4.13: Ethnic and Minority Groups by County and Number of Individuals Who Are Not Served by AMH.

Geographic area	African American	American Indian	Asian	Native Hawaiian	Some other race	Two or more races	Hispanic
Oregon	**299**	**217**	**531**	**44**	**718**	**539**	**1373**
COUNTY							
Baker	0	1	0	0	0	1	1
Benton	4	4	23	1	10	13	24
Clackamas	11	11	40	3	37	40	79
Clatsop	1	1	2	0	2	3	6
Columbia	0	2	1	0	1	5	5
Coos	1	6	2	0	3	8	8
Crook	0	2	0	0	5	2	7
Curry	0	2	1	0	1	2	3
Deschutes	2	7	6	1	12	17	31
Douglas	1	6	3	0	4	11	14
Gilliam	0	0	0	0	0	0	0
Grant	0	0	0	0	0	0	1
Harney	0	1	0	0	0	1	1
Hood River	0	1	1	0	12	2	19
Jackson	3	9	8	2	25	25	57
Jefferson	0	14	0	0	10	3	16
Josephine	1	4	2	0	4	8	13
Klamath	1	9	2	0	8	8	17
Lake	0	1	0	0	1	1	1
Lane	17	23	41	4	39	68	95
Lincoln	0	5	1	0	3	5	7
Linn	1	6	4	0	9	12	21
Malheur	1	1	2	0	19	3	29
Marion	13	20	26	6	153	49	248
Morrow	0	1	0	0	9	1	11
Multnomah	207	36	207	15	145	149	273
Polk	1	6	3	1	14	8	27
Sherman	0	0	0	0	0	0	0
Tillamook	0	1	1	0	2	2	4
Umatilla	2	9	2	1	29	6	44
Union	0	1	1	1	1	2	2
Wallowa	0	0	0	0	0	0	0
Wasco	0	3	1	0	4	2	7
Washington	24	15	144	6	127	69	241

Geographic area	African American	American Indian	Asian	Native Hawaiian	Some other race	Two or more races	Hispanic
Wheeler	0	0	0	0	0	0	0
Yamhill	5	8	6	1	29	14	60

Data source: Public Consulting Group, Inc Computed Table

Of the counties listed above, those with the largest gap in services for ethnic populations were located in the same general geographical location. Figure 4.14 below lists the counties with have the largest number of people affected by the gap in services.

Figure 4.14: Counties with the most number of people affected by Gap

County	Number of People Affected by Gap
Multnomah	1,055
Washington	654
Marion	550
Lane	300
Clackamas	235

5 Investment Analysis

Summary of Estimated Annual Findings

- Oregon invests approximately $447 million annually of federal, state, and local dollars in public adult inpatient and community based mental health services for Oregonians.
- $303 million in total public spending (including DHS, DOC, etc) is attributable to 6 counties: Multnomah, Marion, Lane, Clackamas, Washington, Jackson. (Multnomah represents $127 million or 28 percent).
- The revenue streams used to purchase services include Federal Financial Participation (FFP) in the state Medicaid program, Federal grant dollars such as the Community Mental Health Block Grant, state appropriated funds, and county and municipal appropriated funds. The intermingling of these funding streams made it difficult to discretely identify funding by service.
- The identifiable administrative expenditures account for $13.6 million and represent a small fraction of the total costs.

DHS Highlights

- AMH expenditures for non-OHP adult community services, OSH, and BMRC represent $262 million of the total public mental health spending.
- 92 percent of $133 million in AMH Community Service Element funding relates to six service elements: Mental Health Resident Treatment, Adult Foster Care, Non-residential Adult MH, Enhanced Care, Regional Acute Psychiatric Inpatient, and Crisis Services.
- AMH's Client Processing Monitoring System (CPMS) data system only tracks episodes of treatment and does not track actual services provided.
- Approximately 59 percent of all AMH episodes of treatment involve a person who was Medicaid eligible during the episode, and 41 percent involved someone who was not Medicaid eligible during the period of service.
- $73 million in annual capitation payments are made to the MHO's
- In CY 2007, 191,796 individuals were enrolled in MHOs and 28,585 consumers enrolled in an MHO received a service.

Summary of Methodology

PCG has worked closely with many employees within Oregon state agencies and

county governments to determine the investment made in adult mental health services. Where possible, PCG has attempted to use state fiscal year (SFY) 2008 as a baseline time period. However, due to the limitations of the data received, the time period presented may vary, though it is consistently reported in annual intervals. For example, AMH utilization data for SFY 2008 was not complete during the summer of 2008 as the year had not yet come to a close; therefore, we used data for calendar year (CY) 2007.

Cost data, caseload data, and service utilization counts were requested from the various sources and the following questions provided the framework for our data requests:

- How many and what kinds of mental health services are funded by the state?
- How many units of service are paid for?
- What is the cost of the services?
- How many individuals received services and what were the characteristics of consumers?

The information presented in this report has been organized by the governmental agency or organization that distributes the funds to community providers. Although the funding has been presented in silos, the dollars typically purchase similar adult mental health services at the local community mental health program or in the community. For example, a portion of the capitation payments made to the MHO's is used to purchase outpatient therapy. AMH also funds outpatient therapy under Service Element 20, Adult Non-residential services. It is very likely that a community mental health program will receive funding for outpatient therapy from both of these sources. The information was aggregated into a database and analyzed at the county level to align findings with the county-based mental health delivery system established in Oregon. The analysis below focuses on the expenditures for adult mental health services.[96]

Summary of Public Funding for Adult Mental Health Services

The annual public investment for adult mental health services in Oregon is estimated to be $447 million. Approximately 75 percent or $334 million of the public funding is administered through AMH and is comprised of community

[96] In addition to isolating the dollar amount of investment, we attempt to estimate the number of people served with these funds and where possible to determine the amount and kind of services provided.

reimbursement for various service elements ($133 million), operating expenditures of the Oregon State Hospital and Blue Mountain Recovery Center ($129 million) and capitated payments to an MHO for OHP services ($73 million). As the reader will see, AMH's budget is comprised of both Medicaid and non-Medicaid funds.

DMAP spends approximately $62 million annually on adult mental health services or 13 percent of the total public investment, which is comprised of Medicaid state and federal matching dollars. Considering that AMH and DMAP funding constitutes the bulk of adult mental health funding, the majority of the analysis is devoted to these two areas.

The criminal justice system, including the Department of Corrections, county jails, and the judicial department, spends $33 million annually or 8 percent of the total. Finally, county governments contribute approximately 4 percent or $17 million for adult mental health services. Approximately, $303 million of the total annual expenditure for services is attributable to 6 counties: Multnomah, Marion, Lane, Clackamas, Washington, Jackson. (Multnomah represents $127 million or 28 percent).

The following tables summarize the dollars spent on adult mental health, the number of individuals served and the sources of the information for these data. Figure 5.1 is a graphical representation of the total expenditures by cost center. Figure 5.2 is a detailed breakdown of the public investment by governmental organization. Figure 5.3 is a detailed breakdown of public investment by county, and Figure 5.5 shows individuals served. The sections below explain in detail the methodology and data sources for compiling the cost information.

Figure 5.1: Breakdown of Public Investment in Adult Mental Health Service

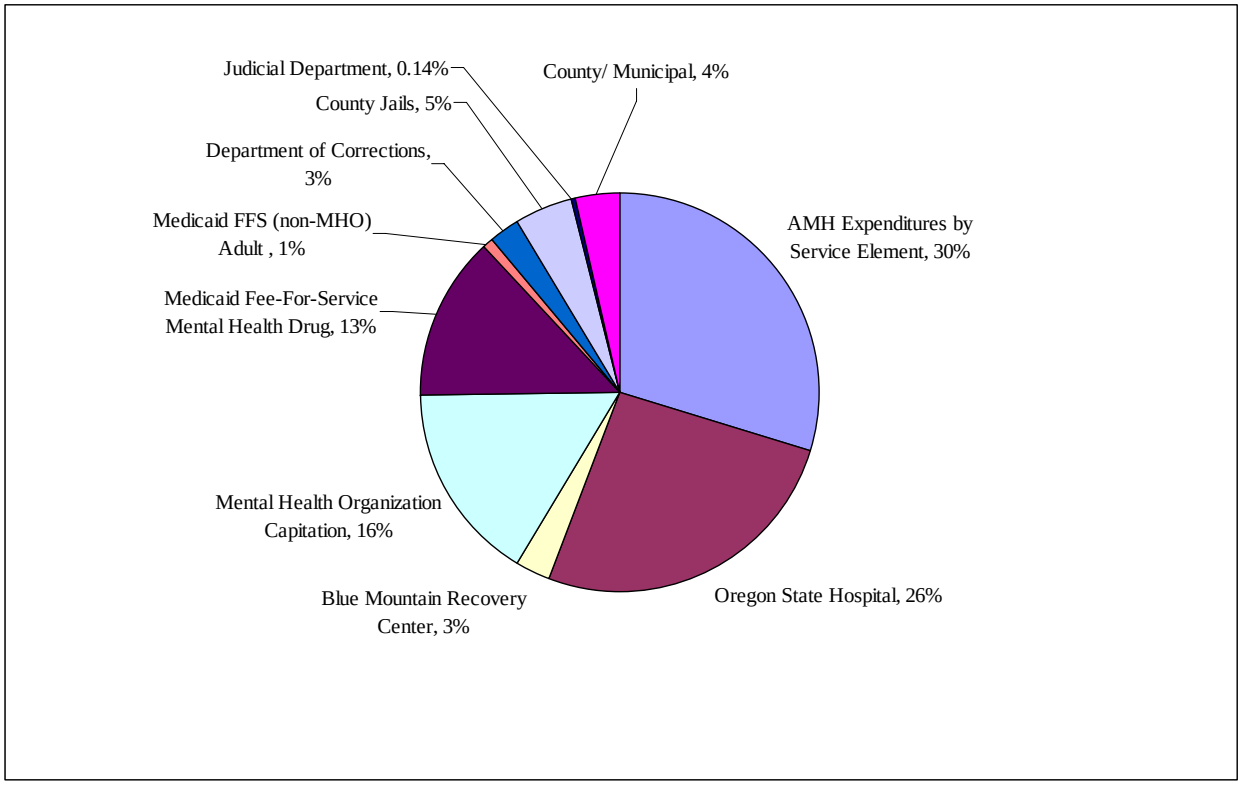

Figure 5.2: Investment Analysis Summary by Governmental Organization

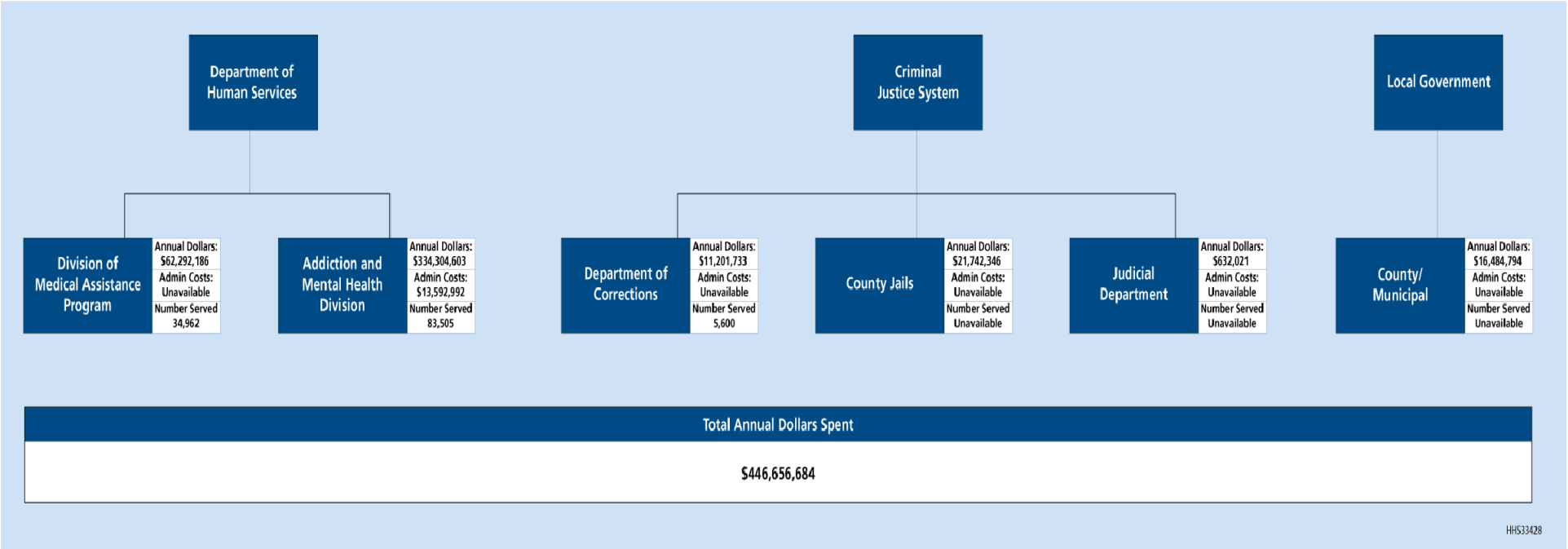

Figure 5.3: Summary of Annual Investment Analysis

	Addictions and Mental Health				*Division of Medical Assistance Program*		*Criminal Justice System*			*Local Government*	
	AMH Expenditures by Service Element	**Oregon State Hospital**	**Blue Mountain Recovery Center**	**Mental Health Organization Capitation**	**Medicaid Fee-For-Service Mental Health Drug**	**Medicaid FFS (non-MHO) Adult**	**Department of Corrections**	**County Jails**	**Judicial Department**	**County/ Municipal**	**Total Public funding**
County	**FY 2008**	**FY 2008**	**FY 2008**	**CY 2007**	**FY 2008**	**CY 2007**	**FY 2008**	**FY 2008**	**CY 2007**	**FY 2008**	
Baker	$330,531	$169,682	$371,300	$355,448	$240,076	$1,551	$52,880	$87,781	$394	$0	**$1,609,643**
Benton	$3,058,241	$1,611,983	$92,825	$925,988	$916,514	$4,082	$92,540	$328,135	$8,587	$209,577	**$7,248,471**
Clackamas	$9,323,677	$6,702,456	$464,124	$3,910,246	$5,894,368	$96,409	$731,506	$1,741,839	$53,174	$235,515	**$29,153,314**
Clatsop	$689,299	$1,781,666	$92,825	$674,263	$497,662	$594	$112,370	$223,614	$1,339	$0	**$4,073,632**
Columbia	$2,216,568	$1,272,618	$0	$722,552	$613,068	$72,920	$103,557	$0	$3,151	$0	**$5,004,434**
Coos	$2,266,279	$2,969,443	$139,237	$2,052,139	$1,246,970	$20,966	$158,640	$341,235	$9,453	$0	**$9,204,361**
Crook	$311,031	$254,524	$139,237	$330,564	$180,643	$192	$74,913	$144,140	$945	$0	**$1,436,190**
Curry	$1,203,801	$509,047	$0	$557,749	$295,559	$20,031	$39,660	$93,969	$867	$0	**$2,720,683**
Deschutes	$3,139,050	$2,884,601	$371,300	$1,579,038	$1,279,310	$75,096	$480,326	$810,831	$21,742	$407,528	**$11,048,822**
Douglas	$1,934,964	$3,393,649	$278,475	$2,622,208	$2,027,006	$5,362	$231,350	$555,276	$20,797	$0	**$11,069,085**
Gilliam	$31,073	$0	$0	$40,789	$11,840	$36	$2,203	$15,054	$0	$0	**$100,995**
Grant	$155,351	$169,682	$46,412	$129,751	$70,467	$830	$13,220	$68,758	$158	$0	**$654,629**
Harney	$1,465,817	$254,524	$139,237	$141,046	$146,940	$39,051	$28,643	$42,962	$236	$0	**$2,258,458**
Hood River	$270,290	$84,841	$46,412	$271,136	$127,153	$86,966	$22,033	$162,742	$788	$21,335	**$1,093,697**
Jackson	$9,484,199	$5,344,997	$696,187	$3,563,891	$1,996,843	$179,098	$486,936	$1,024,715	$38,443	$0	**$22,815,308**
Jefferson	$348,262	$339,365	$139,237	$652,005	$152,796	$0	$68,303	$417,802	$551	$0	**$2,118,322**
Josephine	$4,305,383	$1,696,824	$232,062	$2,423,214	$2,079,640	$37,705	$213,723	$378,000	$4,569	$0	**$11,371,121**
Klamath	$1,966,318	$2,884,601	$185,650	$1,683,120	$1,991,134	$16,893	$224,740	$270,106	$4,963	$0	**$9,227,525**
Lake	$840,175	$339,365	$46,412	$181,560	$95,519	$0	$17,627	$54,012	$236	$0	**$1,574,906**
Lane	$13,654,622	$13,065,548	$1,067,486	$9,059,303	$7,569,093	$154,871	$1,150,139	$1,631,696	$40,255	$167,371	**$47,560,383**
Lincoln	$1,099,789	$2,121,030	$92,825	$990,369	$772,288	$22,747	$154,233	$457,799	$1,260	$858,036	**$6,570,378**
Linn	$2,202,659	$4,072,379	$92,825	$2,893,824	$2,624,273	$11,249	$478,123	$663,073	$4,805	$0	**$13,043,209**
Malheur	$1,599,740	$509,047	$417,712	$613,448	$376,242	$15,673	$127,793	$144,403	$236	$0	**$3,804,295**
Marion	$11,913,682	$11,623,247	$510,537	$6,250,792	$4,979,144	$332,691	$1,573,178	$1,717,614	$42,775	$425,330	**$39,368,991**
Morrow	$659,610	$254,524	$92,825	$154,608	$36,511	$38,890	$17,627	$0	$236	$0	**$1,254,830**
Multnomah	$36,796,621	$34,700,059	$3,202,459	$17,492,159	$11,170,849	$967,077	$2,551,457	$6,802,136	$298,168	$12,500,000	**$126,480,984**
Polk	$2,463,383	$1,866,507	$92,825	$1,335,122	$623,806	$219,283	$191,690	$347,301	$5,514	$0	**$7,145,431**
Sherman	$24,758	$0	$0	$42,786	$466	$0	$2,203	$14,880	$0	$1,865	**$86,958**
Tillamook	$556,602	$1,102,936	$46,412	$475,244	$342,893	$5,305	$57,287	$230,024	$2,206	$54,000	**$2,872,909**
Umatilla	$1,509,842	$2,969,443	$1,160,311	$1,265,978	$859,401	$25,519	$180,673	$332,618	$1,969	$0	**$8,305,755**
Union	$389,411	$763,571	$464,124	$505,897	$290,590	$4,015	$39,660	$119,377	$394	$0	**$2,577,039**
Wallowa	$1,739,722	$84,841	$139,237	$135,924	$55,805	$28,748	$2,203	$0	$394	$0	**$2,186,876**
Wasco	$876,757	$763,571	$464,124	$645,866	$328,128	$27,529	$72,710	$181,429	$551	$24,070	**$3,384,736**
Washington	$10,866,574	$8,738,646	$464,124	$4,639,248	$8,271,363	$191,185	$1,185,392	$1,821,808	$60,658	$1,380,415	**$37,619,412**
Wheeler	$16,356	$0	$0	$20,434	$401	$0	$2,203	$0	$0	$0	**$39,395**
Yamhill	$2,896,070	$1,951,348	$92,825	$1,474,940	$866,335	$558,528	$191,690	$517,217	$2,206	$113,752	**$8,664,910**
Warm Springs	-$28	$0	$0	$0	$0	$0	$0	$0	$0	$86,000	**$85,972**
FamilyCare (tricounty)	$0	$0	$0	$1,752,322	$0	$0	$0		$0		**$1,752,322**
Unknown/OutofState	$0	$0	$0	$0	$0	$0	$68,303		$0		**$68,303**
Total	**$132,606,480**	**$117,250,566**	**$11,881,586**	**$72,564,971**	**$59,031,095**	**$3,261,091**	**$11,201,733**	**$21,742,346**	**$632,021**	**$16,484,794**	**$446,656,684**

Figure 5.4: Data Sources for Figure 5.3, Summary of Annual Investment Analysis

Cost Center	Time Period	Data Source - Dollars
AMH Expenditures by Service Element	FY 2008	AMH Office of Financial Services - Management Reporting Unit
Oregon State Hospital	FY 2008	AMH Budget Planning and Analysis
Blue Mountain Recovery Center	FY 2008	AMH Budget Planning and Analysis
Mental Health Organization Capitation	CY 2007	AMH Program Analysis and Evaluation (MMIS)
Medicaid Fee-For-Service Mental Health Drug	FY 2008	AMH Program Analysis and Evaluation (MMIS)
Medicaid FFS (non-MHO) Adult	CY 2007	AMH Program Analysis and Evaluation (MMIS)
Department of Corrections	FY 2008	Department of Corrections
County Jails	FY 2008	Oregon Sheriff's Jail Command Council
Judicial Department	CY 2007	Judicial Department Staff
County/ Municipal	FY 2008	County Budget Offices and County Mental Health Directors

Figure 5.5: Summary of Adult Individuals Served

	Addictions and Mental Health				*Division of Medical Assistance Program*	*Criminal Justice System*				
County	**AMH Non-Medicaid Eligible Clients Served**	**Oregon State Hospital**	**Blue Mountain Recovery Center**	**MHO Caseload received service**	**Medicaid FFS Unique Recipients**	**Department of Corrections**	**County Jails**	**Judicial Department**	**County/ Municipal**	**Acute Care Persons**
Baker	109	2	8	269	8	26				5
Benton	86	19	2	457	22	46				123
Clackamas	419	79	10	1,639	206	366				450
Clatsop	159	21	2	289	5	56				24
Columbia	77	15	-	343	97	52				59
Coos	71	35	3	806	52	79				190
Crook	102	3	3	103	6	37				18
Curry	51	6	-	197	54	20				29
Deschutes	577	34	8	753	94	240				287
Douglas	82	40	6	933	40	116				215
Gilliam	15	-	-	16	1	1				-
Grant	76	2	1	68	4	7				4
Harney	23	3	3	66	109	14				4
Hood River	56	1	1	127	31	11				3
Jackson	337	63	15	1,335	118	243				537
Jefferson	113	4	3	93	2	34				15
Josephine	145	20	5	614	49	107				39
Klamath	250	34	4	536	47	112				13
Lake	26	4	1	57	-	9				5
Lane	576	154	23	3,594	265	575				608
Lincoln	142	25	2	445	101	77				55
Linn	282	48	2	1,284	50	239				109
Malheur	51	6	9	261	8	64				2
Marion	880	137	11	2,436	527	786				384
Morrow	10	3	2	81	83	9				4
Multnomah	2,957	409	69	6,788	1,533	1,276				1,862
Polk	154	22	2	464	165	96				71
Sherman	2	-	-	18	-	1				1
Tillamook	145	13	1	173	16	29				21
Umatilla	127	35	25	515	85	90				5
Union	66	9	10	271	41	20				9
Wallowa	32	1	3	84	135	1				3
Wasco	53	9	10	206	94	36				3
Washington	1,203	103	10	2,114	358	593				287
Wheeler	6	-	-	2	-	1				-
Yamhill	163	23	2	610	217	96				50
Warm Springs	-	-	-	-	-					-
FamilyCare (tricounty)	-	-	-	538	-					-
Unknown/OutofState	386	-	-	-	-	34				-
Total	**10,009**	**1,382**	**256**	**28,585**	**4,623**	**5,600**				**5,494**

Figure 5.6: Data Sources for Figure 5.5, Summary of Individuals Served

Cost Center	Time Period	Data Source - Individuals
AMH Expenditures by Service Element	CY 2007	Client Process Monitoring System
Oregon State Hospital	CY 2007	Oregon Patient Resident Care System
Blue Mountain Recovery Center	CY 2007	Oregon Patient Resident Care System
Mental Health Organization Capitation	CY 2007	AMH Program Analysis and Evaluation (MMIS)
Medicaid Fee-For-Service Mental Health Drug	FY 2008	AMH Program Analysis and Evaluation (MMIS)
Medicaid FFS (non-MHO) Adult	CY 2007	AMH Program Analysis and Evaluation (MMIS)
Department of Corrections	August 2008	Department of Corrections
County Jails		*Data Unavailable*
Judicial Department		*Data Unavailable*
County/ Municipal		*Data Unavailable*

Department of Human Services (DHS)

As described earlier in this report, DHS is comprised of the following program divisions: Addictions and Mental Health (AMH); Children, Adults, and Families (CAF); Division of Medical Assistance Programs (DMAP); Public Health (PHD); and Seniors and People with Disabilities (SPD). The majority of funding used to purchase mental health services for adults occurs within the AMH and DMAP budgets. The combined AMH and DMAP total budget for all the services they provide accounts for 44.7 percent of the total $11.5 billion 2007-2009 Legislatively Adopted Budget for DHS.[97]

Addictions and Mental Health

AMH manages two distinctive parts of the mental health system. AMH manages funding for community mental health services and psychiatric inpatient services. AMH also manages the Medicaid program through the Oregon Health Plan for mental health services through contracts with the Mental Health Organizations (MHO). Since the MHO contracts are administered through AMH, the capitation payments made to the MHOs have been included here. However, DMAP's budget does include the capitation payments and both the capitation payments and encounter claims are processed through the Medicaid Management Information System (MMIS).

Longer term psychiatric inpatient services are primarily provided at the Oregon State Hospital (OSH) and the Blue Mountain Recovery Center (BMRC). Acute inpatient psychiatric services are being provided by community hospitals throughout Oregon.

The 2007-2009 Biennial Legislatively Approved Budget (LAB) for AMH contained $358.9 million in funding over the two year period for community mental health services, which is composed of state general fund dollars (GF), federal Medicaid matching dollars, and federal grant dollars. Over the same period, $238.03 million is allocated for OSH and $23.7 million for BMRC.

AMH staff provided multiple data reports which illustrated the amount of funding allocated for adult mental health services, numbers of individuals served, and, where available, the number of services provided. The primary data source used to determine the dollars spent was provided by the DHS's Financial Services –

[97] *DHS at A Glance – fast facts about DHS* (2007, November). http://www.oregon.gov/DHS/aboutdhs/docs/dhs-ataglance.pdf Accessed September 16, 2008.

Management Reporting Unit which supplied a report of fiscal year 2008 AMH Expenditures. The report summarized AMH expenditures by contract number including vendor name, fund title, and service element.

In some cases, a AMH contracts directly with a county LMHA and, as a result, these funds were directly attributed to the county receiving the funds. In other instances, the accounting records did not clearly identify which county benefited from the AMH expenditures. In these cases, PCG sought input from AMH and DHS staff to determine which county the dollars should be attributed to. When multiple counties were identified, PCG allocated the funding between the counties using caseloads derived from Client Process Management System (CPMS). If caseload figures were not appropriate to allocate funding, PCG used county population of adults older than 18.

Of the $133 million in AMH funding for adult mental health services, $83 million was allocated using caseloads or county adult population and $50 million was directly attributable to individual counties. Therefore, the financial data presented in this analysis represents an estimate of AMH expenditures attributable to each county.

Adult Community Mental Health

AMH expended approximately $133 million for adult mental health community service elements during FY 2008 of which approximately 64 percent was state dollars and 36 percent was federal funds. The percentage of state funds versus federal funds can vary across the service elements. The service elements defined in the paragraphs that following comprise 92 percent of the total dollars funded through AMH for adult community mental health services. The service element definitions are taken from county assistance agreements provided by AMH staff.

Service Element 28, *Mental Health Residential Treatment* and Service Element 34, *Adult Foster Care,* comprise 45 percent of AMH adult community mental health service expenditures and are funded with 41 percent State GF dollars and 59 percent Federal funds. Mental Health Residential Treatment includes residential care, treatment, and supervision services delivered on 24-hour basis to individuals 18 years of age or older with mental or emotional disorders who have been hospitalized or are at immediate risk of hospitalization.[98] Adult Foster Care Services are delivered to individuals with chronic or severe mental illness in need of continuing services to avoid hospitalization and who are unable to live by

[98] Summary of OMHAS Funded Mental Health Services. July 12, 2006.

themselves without supervision.

Service Element 20, *Non-residential Adult Mental Health* and Service Element 31, *Enhanced Care Services,* account for 27 percent of AMH expenditures for adult community mental health service expenditures and are funded with 72 percent State GF dollars and 28 percent Federal funds. Non-residential adult mental heath services are delivered to individuals diagnosed with serious mental illness or other mental or emotional disturbance posing a hazard to the health and safety of themselves or others.[99] These services may include transitioning individuals from inpatient facilities to the community, assisting those individuals with finding housing, medication monitoring, and evidence-based case management. The services, however, do not include outpatient therapy for the moderately depressed or anxious person.

Enhanced Care Services are mental health and psychiatric rehabilitation services delivered to individuals with severe and persistent mental illness or behavioral disorders residing in a nursing home, residential care facility, assisted living facility or foster home. These serviced are intended to avoid placement in the geriatric treatment wards at OSH. Service Element 201, Non-residential Adult Mental Health (Designated) has also been included in this category.

Service Element 24, *Regional Acute Psychiatric Inpatient,* accounts for 13 percent of AMH expenditures for adult community mental health service expenditures and is almost 100 percent funded through State GF dollars. There is a small amount of Medicaid fee-for-service billing. Acute psychiatric inpatient stays are covered under the MHO for Medicaid clients enrolled in OHP. This includes inpatient psychiatric services delivered to individuals suffering acute mental illness where services are intended to stabilize, control, and/or ameliorate acute psychiatric dysfunctional symptoms or behaviors in order to return the individual to a less restrictive environment at the earliest possible time.[100] These inpatient services differ from OSH as they are provided at acute care and other community hospitals. These funds are also used for regional coordination and enhancements to CMHP services geared toward diverting individuals from acute care and facilitating discharge from the hospital.

Service Element 25, *Crisis Services*, accounts for 7 percent of AMH adult community mental health funding. It is a general category, and it is not possible to

[99] ibid.
[100] ibid.

determine what service a person received by knowing he or she received a service in this category. The services may include: immediately available mental health crisis assessment, triage, and intervention services; pre-commitment services; or arranging admission to a hospital which could be either community acute hospitals or the state psychiatric institutions. The services are 100 percent funded through State GF dollars. Pre-commitment services comprise a significant proportion of crisis service expenditures. Crisis services can be provided to both adults and children, therefore the numbers presented in this report for Service Element 25 have been discounted by the number of children who receive a crisis services.[101]

In total, these service elements comprise 92 percent of the total dollars funded through AMH (non-MHO) for adult community mental health services. Furthermore, they account for 90 percent of the state funds expended and 95 percent of the federal funds. These are not preventative services nor are they services to individuals who have light to moderate mental health needs and would benefit from individual or group outpatient therapy. Rather, the funding supports services to those who are severely ill and create risks to themselves or others. The services have a heavy component of helping individuals through a commitment process, providing acute psychiatric inpatient or other residential placements, and then helping those individuals leave the inpatient and residential setting to return to their communities. If individuals are placed in a residential setting, a federal match is obtainable for those who are Medicaid eligible.

In FY 2008, AMH distributed $2.4 million in funding for special projects. Special projects may include a variety of programs including start up costs of new mental health services, county brokerage projects, drop-in center, gatekeeper projects, housing renovations, Lifeways Transportation project, contract registered nurse or personal care program, Peer Bridge Project, Peer Delivered Services, supported education, supported housing brokerage services, and transitional age youth programs. The following table provides more detail on funding for special projects:

[101] PCG discounted AMH funding by the percentage of CPMS episodes for clients under the age of 18 to account for adults receiving these services.

Figure 5.7: AMH FY 2008 Special Projects Funding

MHS 37 Special Projects	Funding
Transition Age Youth Supported Housing in Washington County	$6,400
Transitional Youth Housing RTH (Trillium-Albany)	$49,360
Trillium Young Adult Program	$53,197
Supported Employment (Start-up)	$114,338
Afro-Centric Program	$250,000
Early Psychosis Program	$375,000
Other Start-ups for Residential Use	$1,375,261
Peer Delivered Services	$80,636
Discharge Service Integration	$3,300
Supported Education	$90,000
TOTAL	**$2,397,492**

Data Source: AMH Staff.

The breakdown of state versus federal sources of service element funding is summarized in Figures 5.8 and 5.9, below.

Figure 5.8: AMH FY 2008 Adult Community Mental Health Services Funding (non MHO/OHP)

Service Elements	State Funds	Federal Funds	Total	Percentage of Total
01 Local Administration	$ 2,516,906	$ 770,345	**$ 3,287,252**	**2%**
20 Non Residential Adult Mental Health/ 31 Enhanced Care Services	$ 26,080,694	$ 9,910,483	**$ 35,991,178**	**27%**
24 Regional Acute Psych Inpatient	$ 16,626,358	$ 19,659	**$ 16,646,017**	**13%**
25 Crisis Services	$ 9,702,136	$ -	**$ 9,702,136**	**7%**
28 Mental Health Residential Treatment/ 34 Adult Foster Care	$ 24,802,609	$ 35,020,708	**$ 59,823,317**	**45%**
30 Psychiatric Security Review Board	$ 1,795,494	$ -	**$ 1,795,494**	**1%**
35 Older & Disabled Adult Mental Health	$ 571,491	$ -	**$ 571,491**	**0%**
36 Preadmission Screening & Annual Resident Review	$ 259,212	$ 760,070	**$ 1,019,282**	**1%**
37 Special Projects	$ 2,331,717	$ 90,000	**$ 2,421,717**	**2%**
38 Supported Employment	$ 762,503	$ 35,800	**$ 798,303**	**1%**
39 Community Support Homeless	$ -	$ 550,294	**$ 550,294**	**0%**
TOTAL	**$ 85,449,121**	**$ 47,157,360**	**$ 132,606,480**	**100%**

Data Source: FY 2008 AMH Expenditures, Office of Financial Services - Management Reporting Unit

Figure 5.9: Percentage of AMH Community Service Element Funding from State and Federal Resources (non-MHO/OHP)

Service Elements	State Funds	Federal Funds	Total
01 Local Administration	77%	23%	**100%**
20 Non Residential Adult Mental Health/ 31 Enhanced Care Services	72%	28%	**100%**
24 Regional Acute Psych Inpatient	100%	0%	**100%**
25 Crisis Services	100%	0%	**100%**
28 Mental Health Residential Treatment/ 34 Adult Foster Care	41%	59%	**100%**
30 Psychiatric Security Review Board	100%	0%	**100%**
35 Older & Disabled Adult Mental Health	100%	0%	**100%**
36 PASARR	25%	75%	**100%**
37 Special Projects	96%	4%	**100%**
38 Supported Employment	96%	4%	**100%**
39 Community Support Homeless	0%	100%	**100%**
TOTAL	**64%**	**36%**	**100%**

Data Source: FY 2008 AMH Expenditures, Office of Financial Services - Management Reporting Unit

Figure 5.10 shows the revenue sources used to purchase the $133 million in adult community mental health services. Based on how funding is categorized and accounted for in AMH accounting records, the funds are broken out into seven revenue sources. In the description of the revenue sources, the state and federal portions for Medicaid Administrative Claiming and Medicaid Fee-for-Service claiming are combined.

1. **State Only Revenue** represents state general fund dollars that are not used as the Medicaid state match.
2. **Medicaid Administrative Claiming – State/Federal Match** represents the dollars that the state spends on allowable Medicaid administrative activities. The Centers for Medicare and Medicaid (CMS) matches 50 percent of the cost related to allowable activities required to administer the state Medicaid program.
3. **Medicaid Fee-for-Service – State/Federal Match** represents reimbursement to providers for Medicaid allowable services that are not covered under OHP. In FY 2008, the Federal Medical Assistance Percentage (FMAP) for Oregon was 60.61 percent meaning CMS reimbursed Oregon 60.61 cents for every dollar spent on Medicaid covered services. These services are in the Medicaid State Plan and are in the AMH budget. Additionally, these services are separate and distinct from the services covered under the Mental Health Organizations and OHP fee-for-service expenditures accounted for in DMAP's budget.

4. **Community Mental Health Block Grant** is a federal grant administered by the SAMHSA.
5. **Assistance in Transition from Homelessness** is another federal grant administered by SAMHSA to fund services for homeless individual with mental health needs.

Figure 5.10: AMH FY 2008 Expenditures by Revenue Sources (non OHP/MHO)

Revenue Stream	State Only Revenue	Medicaid Administrative Claiming - State Match	Medicaid Administrative Claiming - Federal Match	Medicaid Fee-for-Service - State Match	Medicaid Fee-for-Service - Federal Match	Community Mental Health Block Grant	Assistance in Transitional From Homeless	Total
01 Local Administration	$1,746,561	$770,345	$770,345					**$3,287,252**
20 Non Residential Adult Mental Health/ 31 Enhanced Care Services	$21,263,822			$4,816,872	$7,508,912	$2,401,572		**$35,991,178**
24 Regional Acute Psych Inpatient	$16,613,726			$12,632	$19,659			**$16,646,017**
25 Crisis Services	$9,702,136							**$9,702,136**
28 Mental Health Residential Treatment/ 34 Adult Foster Care	$2,424,272			$22,378,337	$35,020,708			**$59,823,317**
30 Psychiatric Security Review Board	$1,795,494							**$1,795,494**
35 Older & Disabled Adult Mental Health	$571,491							**$571,491**
36 Preadmission Screening & Annual Resident Review		$259,212	$760,070					**$1,019,282**
37 Special Projects	$2,331,717					$90,000		**$2,421,717**
38 Supported Employment	$762,503					$35,800		**$798,303**
39 Community Support Homeless							$550,294	**$550,294**
TOTAL	**$57,211,723**	**$1,029,557**	**$1,530,416**	**$27,207,841**	**$42,549,278**	**$2,527,372**	**$550,294**	**$132,606,480**

A detailed figure showing AMH Community Funding for adult mental health services by the county receiving funds can be found in the Appendix at the end of the report. The top 17 counties have approximately 79 percent of the population and account for 91 percent of the total funding or approximately $122 million of the $132.6 million in community service funding. The figure shows the importance of Multnomah County which has 19 percent of the state's population, but receives one-third of the AMH funding for adult mental health services. .

The AMH record keeping and data processing system, known as the Client Processing Monitoring System (CPMS), is a large, mostly manual system. Its data entry unit receives approximately 6,500 forms a month.[102] Although it has an E-version, it still appears to be mostly a paper-based system that relies heavily upon hand written corrections. CPMS can provide data on the number of individuals receiving services and factual information about those individuals. However, CPMS is not a claims payments system and does not collect data on units of services provided or the costs of providing those services, rather it collects data on episodes of service, when treatment began and ended. CPMS also tracks episodes by AMH defined service elements. This system calls into question the ability to

[102] Addictions and Mental Health Division, (2008, March) **CPMS[1] Messenger,** Vol. 15, No. 3. Oregon Department of Human Services, Salem OR. See http://www.oregon.gov/DHS/addiction/publications/cpms-messenger/2008/cpms0308.pdf

provide an accurate representation of the number of individuals served. For example, Coos County billed 5,725 days of mental health residential treatment services to the MMIS in CY 2007; however for the same time period only three episodes of care were reported to CPMS for Service 28, *Residential Treatment Services* for Coos County. Additionally as of October 2007, over 30 percent of the mental health clients had been "open" in CPMS for three years or longer. It is often the case that clients leave treatment abruptly, but their CPMS files are never closed.[103] The planned upgrading of the Medicaid Management Information System (MMIS) and the installation of the new system for OSH both have the potential to minimize many of the data inconsistencies currently plaguing CPMS.

To the extent that this occurs, the data on individuals receiving services is biased upward resulting in an overestimation of the number actually receiving an AMH service. The only units of service collected in CPMS are bed days for residential services. The most common payment method for non-Medicaid AMH community mental health services is by contract and providers are not generally required to submit encounter claims of specific services.

CPMS data for CY 2007 shows that there were a total of 13,219 adults who had Medicaid eligibility sometime during the year and had an AMH service episode while they were not eligible for Medicaid. These episodes of service would not be paid for by Medicaid. There were 38,842 Medicaid clients who had at least one episode of an AMH service while they were Medicaid eligible during 2007. These episodes of service would be paid for by Medicaid. There were 9,840 unique adults with no Medicaid ID and had an AMH service episode in CY 2007.

The figure below shows statewide data on the number of episodes associated with individuals who were not eligible for Medicaid during a period of service and the number of episodes associated with individuals who were eligible sometime between the starting and ending dates of the episode of services. The table shows that, with the exception of crisis and pre-commitment services, the majority of services are received by Medicaid eligible clients. Residential services, Adult Foster Care, and Residential Treatment were 95 percent provided during a period of Medicaid eligibility which correlates to these services being 96 percent funded with Medicaid dollars. Adult basic outpatient, Enhanced Care services, Pre-Admission Screening and Resident Review Services (PASARR), and PSRB are

[103] Addictions and Mental Health Division, (2007, October) **CPMS[1] Messenger,** Vol. 14, No. 10. Oregon Department of Human Services, Salem OR. See http://www.oregon.gov/DHS/addiction/publications/cpms-messenger/2007/cpms1007.pdf

close to 70 percent or higher Medicaid related. The approximately 30,000 non-Medicaid episodes of care are concentrated in three areas: adult basic outpatient, crisis services, and pre-commitment services.

In 2007, the Oregon Judicial Department reported that there were 8,723 civil commitment investigations. There are less than 1,000 civil commitments each year. As the figure below illustrates, there were 8,013 episodes of care for Service Element 29 *Pre-Commitment Services* reported to CPMS. It appears as though almost 92 percent of the civil commitments show up in the CPMS system.

Figure 5.11: Episodes of Mental Health Service Associated with Individuals not Eligible and Eligible for Medicaid CY 2007

Episodes of Mental Health Service Elements	Non-Medicaid Episodes	Medicaid Episodes	Percent Medicaid
SE 20 Adult Non-Residential/ SE 31 Enhanced Care Services	13,233	31,540	70
SE 25 Crisis Services	11,268	6,166	35
SE 28 Residential Treatment/ SE 34 Adult Foster Care	79	1,446	95
SE 29 Pre-Commitment Services	5,198	2,825	35
SE 30 Psychiatric Security Review Board (PSRB)	78	277	78
SE 35 Older & Disabled Adult Mental Health Services	228	265	54
SE 36 Pre-Admission Screening & Resident Review Services (PASARR)	348	789	69
SE 39 Community Support Services for the Homeless Mentally Ill	206	261	56
Total	**30,638**	**43,569**	**59**

Data Source: Client Process Monitoring System

A detailed figure has been included in the appendix that shows episodes of treatment that individuals receive listed by county by service element. Approximately 59 percent of all episodes involve a person who was Medicaid eligible during the episode, and 41 percent involved someone who was not Medicaid eligible during the period of service. This varies considerably by county.

Twelve counties served more than 65 percent Medicaid, and four of these served more than 70 percent Medicaid.

The figure presented in the Appendix shows that 60 percent of all services are categorized as adult basic outpatient/enhanced care services and 23 percent as crisis services. Another 11 percent are Service Element 29, pre-commitment services. Those eligible for Medicaid also are involved in crisis and commitment situations but have residential options available to them that the non-Medicaid eligible clients do not have.

Oregon State Hospital and Blue Mountain Recovery Center
OSH has campuses in Portland and Salem and provides forensic psychiatric services and psychiatric recovery services. OSH expenditures in FY 2008 totaled $117 million. BMRC located in Eastern Oregon totaled approximately $12 million in expenditures during the same time.

Initiated in the 1981-83 biennium, the Oregon Patient/Resident Care System (OP/RCS) collects approximately 60 items of information on individuals admitted to the state psychiatric hospitals, developmental disability training centers, and psychiatric acute care facilities. Using data from OP/RCS, the total expenditures were allocated to the counties using the number served from each county illustrated below in Figure 5.12. The reader should note that these dollars are not transferred to the local mental health authorities, but the chart below illustrates the operating expenditures that are attributable to each based on the number of individuals served in OSH and BMRC for each county.

Figure 5.12: OSH and BMRC Costs and Individuals Served

	Oregon State Hospital		Blue Mountain Recovery Center	
County	Funding	Persons Served	Funding	Persons Served
Baker	$169,682	2	$371,300	8
Benton	$1,611,983	19	$92,825	2
Clackamas	$6,702,456	79	$464,124	10
Clatsop	$1,781,666	21	$92,825	2
Columbia	$1,272,618	15	$0	0
Coos	$2,969,443	35	$139,237	3
Crook	$254,524	3	$139,237	3
Curry	$509,047	6	$0	0
Deschutes	$2,884,601	34	$371,300	8
Douglas	$3,393,649	40	$278,475	6
Gilliam	$0	0	$0	0
Grant	$169,682	2	$46,412	1
Harney	$254,524	3	$139,237	3
Hood River	$84,841	1	$46,412	1
Jackson	$5,344,997	63	$696,187	15
Jefferson	$339,365	4	$139,237	3
Josephine	$1,696,824	20	$232,062	5
Klamath	$2,884,601	34	$185,650	4
Lake	$339,365	4	$46,412	1
Lane	$13,065,548	154	$1,067,486	23
Lincoln	$2,121,030	25	$92,825	2
Linn	$4,072,379	48	$92,825	2
Malheur	$509,047	6	$417,712	9
Marion	$11,623,247	137	$510,537	11
Morrow	$254,524	3	$92,825	2
Multnomah	$34,700,059	409	$3,202,459	69
Polk	$1,866,507	22	$92,825	2
Sherman	$0	0	$0	0
Tillamook	$1,102,936	13	$46,412	1
Umatilla	$2,969,443	35	$1,160,311	25
Union	$763,571	9	$464,124	10
Wallowa	$84,841	1	$139,237	3
Wasco	$763,571	9	$464,124	10
Washington	$8,738,646	103	$464,124	10
Wheeler	$0	0	$0	0
Yamhill	$1,951,348	23	$92,825	2
Total	**$117,250,566**	**1382**	**$11,881,586**	**256**

Data Source: Oregon Patient Resident Care System

Mental Health Organizations

As previously stated AMH manages and administers the contracts with the MHO's however the capitation payments are held in the DMAP budget and claims and payments are processed through the MMIS. In CY 2007 approximately 46.1 percent of individuals enrolled in an MHO were under 18 years of age, 52 percent were between 18 and 64 years of age, and 1.9 percent were 65 years of age or older. During CY 2008, the state provided approximately $73 million in capitation payments to the nine MHOs to provide mental health services to adult Medicaid-

eligible individuals. The distribution of these payments by county is shown below.

Figure 5.13: Capitation Payments Made to MHOs for Adults CY 2007

MHO	County	Capitation Payments Made to MHO's for Adults	Adults enrolled who received a service in CY 2007
	Benton	$925,988	457
	Crook	$330,564	103
	Deschutes	$1,579,038	753
	Jefferson	$652,005	93
	Lincoln	$990,369	445
Subtotal Accountable Behavioral		*$4,477,965*	*1851*
	Clackamas	$3,910,246	1639
	Gilliam	$40,789	16
	Hood River	$271,136	127
	Sherman	$42,786	18
	Wasco	$645,866	206
Subtotal Clackamas Mental Health		*$4,910,823*	*2006*
Family Care, Inc.	Tricounty	$1,752,322	*538*
	Baker	$355,448	269
	Clatsop	$674,263	289
	Columbia	$722,552	343
	Grant	$129,751	68
	Harney	$141,046	66
	Lake	$181,560	57
	Malheur	$613,448	261
	Morrow	$154,608	81
	Umatilla	$1,265,978	515
	Union	$505,897	271
	Wallowa	$135,924	84
	Wheeler	$20,434	2
Subtotal Greater OR Behavioral Health		*$4,900,909*	*2306*
	Coos	$2,052,139	806
	Curry	$557,749	197
	Douglas	$2,622,208	933
	Jackson	$3,563,891	1335
	Josephine	$2,423,214	614
	Klamath	$1,683,120	536
Subtotal Jefferson Behavioral Health		*$12,902,320*	*4421*
Lane Care MHO	Lane	*$9,059,303*	*3594*
	Linn	$2,893,824	1284
	Marion	$6,250,792	2436
	Polk	$1,335,122	464
	Tillamook	$475,244	173
	Yamhill	$1,474,940	610
Subtotal Mid Valley Behavioral		*$12,429,923*	*4967*
Multnomah Verity	Multnomah	*$17,492,159*	*6788*
Washington	Washington	*$4,639,248*	*2114*
Grand Total		**$72,564,971**	**28585**

Data Source: Addictions and Mental Health Division, Program Analysis & Evaluation

MHOs do not submit claims because they are paid on the basis of capitation rates, per member per month enrollment fee. However, MHOs do provide encounter claims that contain billed amounts. DHS Actuarial Services Units provided a report that calculated billed charges from fiscal 2007 MHO claims. The resulting percentage distribution by service was then applied to total capitation payments to MHOs for CY 2007 to arrive at an estimate of services paid for in the capitation rates. The capitation payments include both an administrative expense component and a provider tax component. MHOs are authorized an 8 percent administrative

cost. The service amounts in the table below include administrative costs that are then subtotaled at the bottom of the Figure 5.14.

The service with the highest percentage of expenditures is physician outpatient services, accounting for 26.20 percent of all expenditures. This is a general category and covers both diagnostic visits and treatment provided by physicians, psychologists, social workers, and other mental health providers outside of a facility.

The service with the next highest percentage of expenditure is case management with 19.35 percent. Approximately 16 percent of those enrolled in Oregon Health Plan receive assistance because they are blind or have a disability.[104] The PMPM case management expenses for these individuals are significantly higher than case management expenses for the other eligibility groups reflecting both the higher utilization of mental health case management services by this group and higher hourly billed charges.

The third highest service capitated in the mental health organizations rates is acute inpatient with approximately 13.48 percent of all expenditures. A review of the PricewaterhouseCoopers actuarial data on eligibility categories shows that individuals in the Aid to the Blind/Aid to the Disabled eligibility group who do not qualify for Medicare account for very high per member per month (PMPM) capitation rate. There is a ten-fold cost difference between those with and without Medicare implying that Medicare is providing services that reduce the need for Medicaid paid acute inpatient services.

Outpatient therapy performed at a facility has the fourth highest expenditure at 8.47 percent of total expenditures. Supportive day services are the fifth highest expenditure at 8.07 percent of total expenditures. This service is used mostly by the Aid to the Blind/Aid to the Disabled and Old Age Assistance groups.

Physician inpatient services are the sixth highest at 7.57 percent of all expenditures. This is another broad category containing all activities that may be performed within a facility ranging from assessment, treatment, medical record review, and medication management. The inclusion of medication management in this service indicates why only 1.46 percent of all expenditures are reported for medication management. Other services discussed above include fee codes that

[104] PricewaterhouseCoopers (2006, September) OREGON HEALTH PLAN MEDICAID DEMONSTRATION Analysis of Calendar Yeats 2008-2009 Average Costs, San Francisco, CA. Exhibit 1-B.

have medication management in their descriptions as medication management activities are subsumed in other physician-related expenditure categories. As with other services, the primary adult beneficiaries of the physician in-patient services are the Aid to the Blind/Aid to the Disabled.

Lastly, intensive therapy accounts for 6.91 percent of all expenditures. These services include psychiatric facility stays, partial hospitalization, and respite care. The figure below appears to indicate that the only recipients of this service are those who are in the Aid to the Blind/Aid to the Disabled eligibility categories and who do not have Medicare.

Figure 5.14: Estimated MHO Service Expenditures for Adult Mental Health

Services Provided by Mental Health Organizations	CY 2007 State Cost (MHO Capitation Payments)	Percent of Billed Service Cost FY 2007
Physician outpatient	$19,012,022	26.20%
Case management	$14,041,322	19.35%
Acute inpatient	$9,781,758	13.48%
Outpatient therapy	$6,146,253	8.47%
Support day program	$5,855,993	8.07%
Physician in patient	$5,493,168	7.57%
Intensive therapy services	$5,014,239	6.91%
Assessment & evaluation	$2,503,492	3.45%
Alternative to inpatient	$1,668,994	2.30%
Prevention, education, outreach	$1,451,299	2.00%
Medication management	$1,059,449	1.46%
Family support	$290,260	0.40%
Other outpatient	$166,899	0.23%
Interpretation services	$87,078	0.12%
Total mental health w admin	**$72,564,971**	**100%**
Administration not including provider tax	**$5,805,198**	
Total mental health without admin.	**$66,759,773**	

Data Source: Oregon Department of Human Services, Actuarial Services

This analysis of MHO services and eligibility group illustrates the importance of MHO services for those who are blind or have disabilities. Figure 5.15 below calculates the percentage of MHO dollars spent on the different Medicaid eligibility groups. The table show that roughly 47 percent, of all MHO expenditures for adults are spent on the roughly 16 percent of those in the two eligible groups who receive assistance through the Aid to the Blind/Aid to the Disabled programs.

Figure 5.15: Percent of MHO Population and Total Cost by Eligibility Category

Eligibility Category	Percent of MHO Population [105]	Percent of Total Cost [106]
Temporary Assistance to Needy Families	11.07	7.70
PLM Adults	2.35	0.55
PLM, TANF, and CHIP Children < 1	6.32	0.18
PLM, TANF, and CHIP Children 1 – 5	17.21	2.19
PLM, TANF, and CHIP Children 6 – 18	26.99	16.89
Aid to the Blind/Aid to the Disabled with Medicare	5.98	14.95
Aid to the Blind/Aid to the Disabled without Medicare	9.67	31.76
Old Age Assistance with Medicare	7.31	1.79
Old Age Assistance without Medicare	0.24	0.15
SCF Children	4.61	20.34
CAWEM (Citizen-Alien Waived Emergency Medical)	4.26	0.08
OHP Families	1.27	0.64
OHP Adults & Couples	2.73	2.78
	100%	**100%**

[105] PricewaterhouseCoopers (2006, September) OREGON HEALTH PLAN MEDICAID DEMONSTRATION Analysis of Calendar Yeats 2008-2009 Average Costs, San Francisco, CA. Exhibit 12-A.
[106] PricewaterhouseCoopers (2006, September) OREGON HEALTH PLAN MEDICAID DEMONSTRATION Analysis of Calendar Yeats 2008-2009 Average Costs, San Francisco, CA. Exhibit 13-D. Per capita costs are multiplied by percent of population to eligibility weights which is then used to determine percent of total cost per category.

Figure 5.15 above also indicates that those receiving Old Age Assistance comprise approximately 7.55 percent of all enrolled in MHOs and yet receive 1.94 percent of expenditures.

The Aid to the Disabled eligibility group has a sizeable proportion of individuals with mental disorders. In December of 2006, there were 48,963 individuals receiving Supplemental Security Income (SSI) who obtained SSI because of their disability and income. This group is automatically eligible for Medicaid. Approximately 40.5 percent, or about 19,830, were disabled by virtue of having a mental disorder – other.[107] While the utilization of the Aid to the Disabled group is grounded in mental illness prevalence, the data above raises the question as to whether expenditures on aged populations are too low.

AMH publishes Mental Health Utilization data on its website.[108] Table 5 of the report for FFY 2007 shows that the percentage of those served who are over 65 is about 4 percent compared to 12.70 percent to 13.50 percent who are aged 18-65

Figure 5.16: Individuals Served by MHO by Age Group

MHO	Age Group	4th Qtr. 2006	% Enrolled Served	1st Qtr. 2007	% Enrolled Served	2nd Qtr. 2007	% of Enrolled Served	3rd Qtr. 2007	% of Enrolled Served
ABHA	18-64	1,072	11.60	1,020	11.30	1,017	11.60	994	11.60
	65+	46	2.70	40	2.40	49	2.90	49	2.80
Clackamas	18-64	1,045	12.70	1,100	13.70	1,095	13.80	950	11.90
	65+	60	2.70	60	2.70	60	2.80	51	2.30
FamilyCare	18-64	293	6.90	276	6.90	314	7.90	326	8.30
	65+	2	0.40	4	0.90	4	0.90	4	0.90
GOBHI	18-64	1,231	11.50	1,282	12.50	1,264	12.50	1,203	12.10
	65+	77	3.40		4.00		3.40		3.20

[107] U.S. Social Security Administration, (2007, September) S*SI Annual Statistical Report, 2006* Office of Policy, Washington, D.C. Table 25
http://www.socialsecurity.gov/policy/docs/statcomps/ssi_asr/2006/
[108] http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml#mho

MHO	Age Group	4th Qtr. 2006	% Enrolled Served	1st Qtr. 2007	% Enrolled Served	2nd Qtr. 2007	% of Enrolled Served	3rd Qtr. 2007	% of Enrolled Served
				90		77		74	
JBH	18-64	2,761	11.00	2,808	11.50	2,805	11.60	2,595	10.80
	65+	123	2.70	126	2.80	131	2.90	113	2.50
LaneCare	18-64	2,283	15.60	2,294	16.10	2,295	16.30	2,256	16.10
	65+	79	3.90	76	3.60	79	3.70	77	3.60
MVBCN	18-64	2,732	11.60	2,808	12.20	2,865	12.60	2,772	12.20
	65+	162	3.60	167	3.70	170	3.70	175	3.80
Verity	18-64	3,960	14.80	4,196	16.00	4,112	16.00	3,937	15.30
	65+	389	6.10	387	6.00	397	6.10	360	5.40
Washington	18-64	1,235	14.10	1,266	15.00	1,269	15.40	1,229	15.00
	65+	110	4.10	124	4.60	127	4.70	103	3.80
Total Served	**18-64**	**16,612**	**12.70%**	**17,050**	**13.40%**	**17,036**	**13.50%**	**16,262**	**13.00%**
	65+	**1,048**	**3.90%**	**1,074**	**4.00%**	**1,094**	**4.00%**	**1,006**	**3.70%**

Data Source Mental Health Utilization Report October 2006 - September 2007, Table 5

Division of Medical Assistance Programs: Medicaid Fee-for-Service Mental Health Claims for Adults

DMAP is charged with overseeing the Oregon Health Plan for physical health and maintains the budget for the entire OHP program. AMH has primary responsibility for policy and operational management for the OHP mental health services. Approximately 8 percent of the Medicaid clients receive services outside of the managed care organizations.[109] Therefore, Medicaid pays approximately $3.3 million for FFS claims for those who are not enrolled in an MHO and pays for OHP services that are not covered by an MHO for those who are enrolled. These services are in addition to Medicaid services that are covered through county allocations made by AMH. The following table provides a summary of the

[109] Interview with DMAP staffs August 2008.

Medicaid FFS payments, individuals served, and the units of services provided:

Figure 5.17: Medicaid FFS Payments, Person Served, and Units of Services

Service Category	Payments	Unique Persons Served	Units of Service
PRTS A/E	$ 4,654	23	171
Assessment & Evaluation	$ 64,156	504	840
Case Management	$ 49,189	372	1067
Community Support Services	$ 66,569		302
Family Therapy	$ 5,244	80	107
Group Therapy	$ 55,051	359	851
Individual Therapy	$ 212,318	743	5154
Individual Therapy w/ Med Management	$ 16,751	113	224
Medication Management	$ 132,686	767	2479
PASRR	$ 360,131	612	612
Residential Rehabilitation	$ 1,287,593	184	10061
Skills Training	$ 800,835	713	41367
Treatment Foster Care	$ 202,941	75	161
Total	**$ 3,261,091**		**63755**

Approximately 40 percent of FFS mental health dollars, close to $1.3 million, are spent for residential rehabilitation which are "secured rehabilitative services and 24/7 crisis services delivered to individuals residing in specified residential treatment services."

"Skills training" is the second highest service in terms of expenditures. Similar to residential rehabilitation, skills training is not a capitated service. $800,000 was billed in services in ten different procedure codes representing the mixed collection of services provided under "skills training." FFS expenditures for skills training account for nearly one-quarter of the total In the AMH expenditures examined earlier, there appears to be no equivalent to the skills training received by these Medicaid enrollees. This is a set of mental health services that has the appearance of being only offered to Medicaid clients.

Preadmission screening and resident review (PASRR) is the third highest expenditure comprising 11 percent of the total or approximately $360,000. The procedure code is often used for mental health screening for nursing home residents. It counts more as payment for a federally required administrative activity than it is a benefit to mentally ill individuals in the community.

Payments for individual therapy are the fourth highest expenditure for services to Medicaid recipients comprising 6.51 percent or $212,000. Individual therapy is paid for through more 36 different procedure codes representing the variety of

places, length of therapy, and whether medication management is necessary at the same time. There is no direct equivalent comparison for AMH services discussed earlier and these Medicaid FFS expenditures. The AMH service descriptions are at a higher, more aggregated level than the more specific fee codes used by Medicaid. Because of this lack of specificity, it is difficult to determine if more individual therapy is provided to Medicaid eligible individuals.

Approximately 30 percent of the $3.2 million or $967,000 in Medicaid FFS under the DMAP budget is attributable to Multnomah County. Yamhill County receives $558,000 and Marion County receives $332,000 to round out the top three counties receiving Medicaid FFS. A detailed figure by service and county can be found in the Appendix.

The service utilized by the largest number of individuals, 767, was medication management closely followed by individual therapy at 743 and skill training at 713. A PASRR was completed for 612 consumers, 504 had an assessment and evaluation, 372 received case management services, and 184 consumers received residential rehabilitation. The number of Medicaid eligible adults who received a FFS mental health service during CY 2007 is summarized in Figure 5.17. Nine services were used by fewer than twenty clients and were excluded from the table. These services were child and family team meetings, community support services, day treatment, interpretive services, outpatient therapy, psychiatric residential treatment services assessment/evaluation, respite care, sub-acute care, and wraparound services. A detailed table of service provided by county can be found in the appendix.

Skills training had the highest number of units of service submitted with 41,367. The procedure codes used bill for 15 or 45 minute increments, and thus the 41,367 units of service would represent at a minimum 10,342 hours of service. Residential rehabilitation received the second highest number of billed units of service. The units of service reported for residential rehabilitation represent 10,061 days of service. Individual therapy was the next highest numbers of units of service. Twenty-four different procedure codes are used to bill for individual therapy, and the codes differ in the amount of time billed for; therefore, they cannot be readily converted to hours of therapy without a code-by-code analysis.[110]

[110] In a rate setting context, PCG would customarily perform such analyses and work at the individual procedure code level. There is Oregon data available to calculate hours of service even using fee codes that do not have a time increment in them. See MCPP Healthcare Consulting, Inc. (2008 April), *Oregon Health Plan Mental Health Organization Outpatient Unit Cost Study for Fiscal Year 2007*, Seattle, WA

There are eleven medication management procedure codes of which three are frequently used codes are for 15-minute increments. These units of service may represent approximately 2,500 15-minute increments of medication management. There are nine case management procedure codes and not all are specific as to time.

A detailed table can be found in the appendix showing the number of units of service submitted for Medicaid eligible adults who received a FFS mental health service during CY 2007. Six services had fewer than 50 units of service billed and were excluded from the table. These services include: PRTS assessment and evaluation, child and family team meetings, day treatment, interpretive services, outpatient therapy, respite care, and sub-acute care.

Federally Qualified Health Centers

There are twenty-six "parent" Federally Qualified Health Centers (FQHCs) that provide services in 144 locations throughout Oregon. Multnomah County, providing services through its 52 locations, is the largest FQHC. The state reimburses FQHCs through an "encounter rate". This is commonly referred to as a Prospective Payment System or PPS rate. This is a bundled rate that covers all services.

FQHCs do not submit claims for each unique service provided. The only clinic that has a separate rate for mental health is Lincoln County Community Health, which is $157.44 while its medical PPS rate is $245.51. All other FQHCs currently bill their PPS rate for all mental health and medical encounters alike. They collect part of the rate through FFS billing to DMAP or through encounters submitted through a managed care plan. DMAP then pays the difference between these FFS claims and managed care payments, and the guaranteed rate. That difference amount is paid in a lump sum and cannot be partitioned into mental health or physical health dollars. AMH staff believed that it probably amounts to a very small proportion of total dollars spent.

FQHC fee for service claims are captured in the MHO FFS dollars reported in this

investment analysis, but their amount is not reported separately.

Medicaid Mental Health Drug Expenditures

Medicaid's pharmaceutical program pays approximately $59 million for mental health-related drugs in two main pharmaceutical categories: standard therapeutic class 7 (Ataractics, Tranquilizers) and standard therapeutic class 11 (Psychostimulants, Antidepressants).

Figure 5.18: Class 7 and Class 11 Medicaid Drug Expenditures and Number of Claims State Fiscal Year 2008

County	Total Class 7 and Class 11	Number of Claims	Duplicated Yearly Total	Average Recipients per Month
Baker	$240,079	2,710	1,716	143
Benton	$916,535	9,028	5,202	433
Clackamas	$5,894,453	61,025	32,619	2,718
Clatsop	$497,671	4,974	2,731	228
Columbia	$613,078	6,828	3,744	312
Coos	$1,246,985	18,708	10,538	878
Crook	$180,649	2,741	1,697	141
Curry	$295,564	3,923	2,393	199
Deschutes	$1,279,348	16,920	9,769	814
Douglas	$2,027,030	26,051	14,579	1,215
Gilliam	$11,841	175	106	9
Grant	$70,469	1,067	634	53
Harney	$146,942	1,693	929	77
Hood River	$127,158	1,922	1,171	98
Jackson	$1,996,891	28,481	17,307	1,442

County	Total Class 7 and Class 11	Number of Claims	Duplicated Yearly Total	Average Recipients per Month
Jefferson	$152,800	2,734	1,660	138
Josephine	$2,079,660	24,762	14,012	1,168
Klamath	$1,991,149	17,933	9,250	771
Lake	$95,520	1,449	829	69
Lane	$7,569,174	84,610	45,557	3,796
Lincoln	$772,299	10,869	6,229	519
Linn	$2,624,298	29,581	15,927	1,327
Malheur	$376,249	4,387	2,764	230
Marion	$4,979,214	53,931	29,313	2,443
Morrow	$36,514	489	310	26
Multnomah	$11,171,017	133,680	75,679	6,307
Polk	$623,821	7,795	4,663	389
Sherman				-
Tillamook	$342,899	3,418	2,113	176
Umatilla	$859,418	9,920	5,954	496
Union	$290,596	4,273	2,627	219
Wallowa	$55,807	844	576	48
Wasco	$328,133	4,934	2,959	247
Washington	$8,271,477	70,394	31,982	2,665
Wheeler				-
Yamhill	$866,356	10,919	6,530	544
Total	**$59,031,095**	**663,166**	**364,069**	**30,339**

Data Source: Addictions and Mental Health Division, Program Analysis & Evaluation

The average cost of the 663,166 prescriptions was approximately $89. In an average month, approximately 30,339 individuals submitted a prescription. Prescription benefits are not a capitated service, thus these individuals may either be enrolled in an MHO or receive FFS services. These expenditures are a minimum estimate as there are a few other pharmaceuticals that can be prescribed for mental health services that are not categorized in standard therapeutic classes 7 and 11. Because Medicare payments are not captured in these data, the information is best used to understand what the state pays for mental health related pharmaceuticals. If individuals have concurrent eligibility in both Medicaid and Medicare, then Part D of Medicare will pay for their drugs. The data cannot be used to capture a full representation of mental health costs related to pharmaceuticals.

Oregon Department of Corrections and County Jails

The Oregon Sherriff's Jail Command Council concluded that, "it is a fact that about 20 percent of all jail inmates suffer from significant mental illness."[111] The Governor's Mental Health Task Force went further to say:

> Too many persons with mental illness are in prisons and jails. The number of Oregonians with mental illnesses who are in county jails and State prisons has increased dramatically to approximately 16-20 percent of all inmates.[112]

At the county level, the Clackamas Sherriff contends that "about 30 percent of offenders booked at the Jail suffer from some sort of mental illness."[113] With the county jails and the state prison system are quickly becoming large providers of mental health services, it is important to better understand how funding is allocated to these programs.

Figure 5.19 below shows prison admissions by county and estimates the mental health dollars spent on prison and jail inmates. The prison dollars are directly taken by looking at the distribution of prison admissions from counties and allocating the prison's behavioral health budget using the distribution of admissions. County jail dollars are taken by using county expenditures for jails

[111] http://www.osjcc.org/
[112] Governor's Mental Health Task Force, (2004, September), *A Blueprint for Action,* Report to The Governor and Legislature, Salem, OR
[113] http://www.clackamas.us/sheriff/jail/cit.htm

and assuming that 9 percent of the jail admissions are individuals with a serious mental illness. The 9 percent figure is taken from the 2005 survey and is a conservative minimum estimate. The figure shows that about $33 million is spent in prisons and jails as a direct result of mental illness.

Figure 5.19: Prison Admissions by County and Estimates of Mental Health Dollars spent on Prison and County Jail Inmates

County	Prison Admission by County SFY 2007	Behavioral Health Spending in Prisons	2007 County Jail Statistics	Assume 9% MH related
Baker	24	$52,880	$975,344	$87,781
Benton	42	$92,540	$3,645,945	$328,135
Clackamas	332	$731,506	$19,353,765	$1,741,839
Clatsop	51	$112,370	$2,484,600	$223,614
Columbia	47	$103,557	$0	$0
Coos	72	$158,640	$3,791,503	$341,235
Crook	34	$74,913	$1,601,553	$144,140
Curry	18	$39,660	$1,044,095	$93,969
Deschutes	218	$480,326	$9,009,237	$810,831
Douglas	105	$231,350	$6,169,738	$555,276
Gilliam	1	$2,203	$167,262	$15,054
Grant	6	$13,220	$763,975	$68,758
Harney	13	$28,643	$477,360	$42,962
Hood River	10	$22,033	$1,808,247	$162,742
Jackson	221	$486,936	$11,385,719	$1,024,715
Jefferson	31	$68,303	$4,642,248	$417,802
Josephine	97	$213,723	$4,200,000	$378,000
Klamath	102	$224,740	$3,001,174	$270,106
Lake	8	$17,627	$600,131	$54,012
Lane	522	$1,150,139	$18,129,951	$1,631,696
Lincoln	70	$154,233	$5,086,658	$457,799
Linn	217	$478,123	$7,367,479	$663,073
Malheur	58	$127,793	$1,604,473	$144,403
Marion	714	$1,573,178	$19,084,603	$1,717,614
Morrow	8	$17,627	$0	$0
Multnomah	1158	$2,551,457	$75,579,291	$6,802,136
Polk	87	$191,690	$3,858,899	$347,301
Sherman	1	$2,203	$165,334	$14,880
Tillamook	26	$57,287	$2,555,820	$230,024
Umatilla	82	$180,673	$3,695,751	$332,618

County	Prison Admission by County SFY 2007	Behavioral Health Spending in Prisons	2007 County Jail Statistics	Assume 9% MH related
Union	18	$39,660	$1,326,407	$119,377
Wallowa	1	$2,203	$0	$0
Wasco	33	$72,710	$2,015,879	$181,429
Washington	538	$1,185,392	$20,242,316	$1,821,808
Wheeler	1	$2,203	$0	$0
Yamhill	87	$191,690	$5,746,859	$517,217
Unknown/Out-of-state	31	$68,303	$0	$0
Total	**5,084**	**$11,201,733**	**$241,581,616**	**$21,742,345**

Data Source Department of Corrections, Oregon Sheriff's Jail Command Council[114]

Oregon Judicial Department

In CY 2007, the Oregon Judicial Department participated in 8,723 mental health civil commitment hearings. The Department estimates that the average hearing involves 27 minutes of a judge's time and 79 minutes of judicial staff time. Staff time included 3,925 judge hours and 11,485 staff hours. Based on the costs of staff and judge salaries plus fringe benefits, the Department spent $325,019 on judges and $307,002 on staff to adjudicate these commitment hearings.

County and Municipal Appropriations

At their discretion, county governments may choose to appropriate county general funds to compliment state and federal funds that are used to provide adult mental health services. The funding may be used to provide services in several areas including: medication management services, crisis teams, mental health courts, jail diversion programs. Each county was surveyed in order to gain a clearer picture of county general funds used to provide adult mental health services.

The data presented in Figure 5.20 represents the self-reported county general fund appropriations for adult mental health services in FY08. The data was collected initially in the survey noted above with follow-up by OR DHS. It should be noted that the Hood River and Wesco County numbers include some funding of children's mental health services. Also, the Lane County figure is for FY09 due to

[114] PCG allocated the NORCOR facility expenses by the populations of the counties in the intergovernmental agreement.

a significant cut in the general fund appropriation for adult mental health services between FY08 and FY09.

Figure 5.20: County General Fund Appropriated for Adult Mental Health Services FY2008

County	FY 2008
Baker	$0
Benton	$209,577
Clackamas	$235,515
Clatsop	$0
Columbia	$0
Coos	$0
Crook	$0
Curry	$0
Deschutes	$407,528
Douglas	$0
Gilliam	$0
Grant	$0
Harney	$0
Hood River	$21,335
Jackson	$0
Jefferson	$0
Josephine	$0
Klamath	$0
Lake	$0
Lane	$167,371
Lincoln	$858,036
Linn	$0
Malheur	$0
Marion	$425,330
Morrow	$0
Multnomah	$12,500,000
Polk	$0
Sherman	$1,865
Tillamook	$54,000
Umatilla	$0
Union	$0
Wallowa	$0
Wasco	$24,070
Washington	$1,380,415
Wheeler	$0
Yamhill	$113,752
Warm Springs	$86,000
FamilyCare (tricounty)	
Unknown/OutofState	
Total	**$16,484,794**

Data Source: County Self Reporting

Other Public Funds

As of December 2007, there were 32,783 individuals receiving Social Security Disability Insurance (SSDI) payments due to a mental disorder. Of these, 7,364 were defined as having retardation and 25,419 were described as *other* implying a mental illness.[115] Nationally, the monthly average benefit received by an individual with a mental disorder other than retardation was $969.90[116]

Throughout conversations with stakeholders in the adult mental health system, we heard anecdotally that there are additional public funds beside those noted here that are used to purchase mental health services. The project team attempted to collect and analyze as much as possible to determine the total investment in adult mental health services. For the following areas data was not readily available to estimate expenditures: uncompensated care provided in hospitals; public safety at the county and municipal level (city police); TANF funds used to purchase mental health services for adults; and school education funding for transitional age youth.

Transitional Age Youth

The majority of the costs associated with transitional age youth are embedded in the summary numbers of the various funding sources and are difficult to discretely identify. However, AMH does provide discrete funding for special projects targeted at this population. Bases on the exhibit MHS-37, AMH County Financial Assistance agreement, the special projects for transition age youth is described as mental health services for older adolescents and young adults with severe emotional, behavioral, and/or mental disorders to assist individuals in making success transition to adult treatment and vocation services. An example of a transition age youth program is the Early Assessment and Support Team (EAST) which is a transitional program serving young people experiencing psychosis between the ages of 12 and 25. In response to the Community Services

[115] Office of Policy Data, (2008 September), *Annual Statistical Report on the Social Security Disability Insurance Program, 2007*, U.S. Social Security Administration, Washington, D.C. Table 10 retrieved from on 9-29-08 http://www.ssa.gov/policy/docs/statcomps/di_asr/2007/index.html

[116] Office of Policy Data, (2008 September), *Annual Statistical Report on the Social Security Disability Insurance Program, 2007*, U.S. Social Security Administration, Washington, D.C. Table 7 retrieved from on 9-29-08 http://www.ssa.gov/policy/docs/statcomps/di_asr/2007/index.html

Workgroup, the Oregon State Legislature appropriated $4 million to fund a statewide expansion of the Early Assessment and Support program. In addition, AMH provided start up funding for Transitional Age Youth Supported Housing in Washington County, Transitional Youth Housing (Trillium-Albany), and a Trillium Family Services' Young Adult Program.

Administrative Costs

The following table, Figure 5.21, illustrates three identifiable areas of administrative costs related to contracted community adult mental health services, MHO's, and state hospitals. The first area, AMH Service Element 01 Local Administration, relates to AMH funding distributed to local mental health authorities to cover the administrative costs of delivering and contracting for adult mental health services. In FY 2008, there was $3.3 million for local administration at the county mental health programs. This represents 2 percent of the $133 million AMH funding for various community service elements.

Approximately 50 percent of the local administrative funding relates to Medicaid administrative claiming which is used to cover the necessary administrative activities for delivery of the state Medicaid program. The federal government matches Medicaid Administrative allowable expenditures at 50 percent.

The second area relates to the Mental Health Organizations which were reimbursed approximately $6 million in CY 2007 for administrative expenditures incurred as part of the mental health managed care program.

The final area of administrative cost relates to operation of the state hospitals. Administrative costs amount to 3 percent of the $129 million spent annually at the state hospitals

In addition, the AMH central office budget for FY2008 was $13.6 million for all service areas, not exclusively adult mental health. AMH central office includes all of the functions at the state level related to administering the county-based mental health system. Examples of these functions include AMH accounting, contract administration, quality improvement, and program analysis and evaluation. AMH Central Office administrative expenses accounts for 5 percent of the total $262 million in AMH expenditures for adult mental health.[117]

[117] Please note: the central office costs are not included in $447 million.

Figure 5.21: Administrative Expenses Related to Adult Mental Health Services

Administrative Expense Category	Time Period	Dollar Amount	Percent of Total Expenditures
AMH Service Element 01 Local Admin	FY2008	$3,287,252	2%
MHO Admin	CY2007	$5,895,198	8%
State Hospital Admin	FY2008	$4,410,542	3%
Total Administrative Costs		$13,592,992	4%

6 Catalogue of Information and Outcomes

Summary of Key Findings

Outlined in this section is a catalogue of information that state agencies and local governments use to evaluate the performance of mental health organizations and providers of community mental health care, including the performance measures and outcomes that are tracked by AHM and local government.[118]

Currently, there are several mechanisms in place in Oregon for evaluating the performance and outcomes associated with the delivery of mental health care services. At the same time, AMH's internal capacity to monitor the performance of the MHOs and the CMHPs is weaker than it should be. In addition, AMH does not have a data management system in place that is efficient, effective, and timely in supporting monitoring activities and facilitating data driven management decisions.

- The contract between AMH and the Mental Health Organizations (MHOs) contains specific provisions related to the evaluation of MHOs' performance.
- An intergovernmental agreement in used by AMH in providing funds to counties for the delivery of mental health services. Performance and outcome related measures are not specifically prescribed within the document itself.
- AMH produces an annual quality improvement work plan.
- AMH's quarterly Mental Health Utilization reporting focuses on enrollment, services, and hospitalization data.
- AMH reports on National Outcome Measures (NOMS) to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its Mental Health Block Grant reporting. This results in Oregon statistics being comparable with statistics from other states.
- Each MHO produces an annual quality improvement work plan and/or quality reports that contain specific performance measures.

[118] For a description of work done by Oregon staff on mental health performance measures in the earlier part of the decade, see Johnson, D. (2002, May 29) *Performance Indicators Project Report: Evaluating the Performance of the Mental Health Organizations (MHO)s under the Oregon Health Plan (OHP)Department of Human Services, Salem, Or*. Paper presented at 2002 National Conference on Mental Health Statistics, Renaissance Mayflower Hotel. Retrieved on 10-23-08 from http://www.mhsip.org/DarcieJohnson02.pdf

- Individual CMHPs have developed their own systems for monitoring performance and outcomes.

Mental Health Organization (MHO) Contract Requirements

The responsibilities of the MHOs are prescribed at length in the 204-page contract.[119] The contract language is very direct in what AMH requires and it provides ample opportunity for the performance review of any aspect of an MHO's operations. Any contractual requirement can be used to evaluate the performance of the MHO by examining whether or not the MHO has fulfilled the specific requirement. The 2008 contract outlines several criteria by which the performance of an MHO can be evaluated, including the following:

- The capacity of an MHO to provide services, including ratios of types of providers to number of individuals served, waiting times for services, distance traveled to services, and availability of 24-hour care (page 14 of the contract);

- The practice guidelines established by the MHO and the rationale behind the guidelines.(page 37);

- Within the Treatment Parameters or Utilization Guidelines, the description of an appeal process that allows for an independent clinical review of the decision by one or more qualified mental health professionals (QMHPs);

- The processing time of appeals by the MHO in relation to the timelines specified in the contract (page 38); and

- Compliance with accessibility and continuity of care standards (page 39-40).

The kind of needs assessment the MHO must make in planning out its service delivery system is itemized in a series of requirements that could be checked. (page 42)

The contract identifies the components of a service delivery system: services coordination, preventive and early intervention services, rehabilitative treatment services, 24-hour urgent and emergency response system, post-stabilization

[119] Retrieved on 10-22-08 from http://www.oregon.gov/DHS/mentalhealth/mho/mho-contract2008agreement.pdf

services, involuntary psychiatric care, acute inpatient hospital psychiatric care, special health care needs, and child and adolescent services. (page 43) Each of these services is spelled out in detail in the contract and contractual language is specific enough to be the basis of a performance evaluation of each of the services.

The contract requires prompt and fair payment to licensed providers. (page 51)

The contract considers at length the issue of how to control coordination for non-covered services and considers each type of mental health provider and what an MHO should do in regard to this provider type. The detailed specification of actions could be used as the basis of an evaluation. (pages 52-56)

The contract requires a minimum 25 percent consumer representation on the MHOs' quality improvement committees, policy-making bodies, and decision-making boards. (page 56) The degree to which this level of representation has been achieved is a method of evaluating performance.

Approximately ten requirements are outlined in the contract regarding service delivery capacity. (page 57) In conjunction with other elements of the contract, including needs assessments, these provisions would form the basis of a study as to the degree of capacity that the MHO has been able to attain.

Quality Assessment/Performance Improvement (QA/PI) requirements are discussed at length in the contract. The Code of Federal Regulations at 42 CFR 438.200 through 438.242 requires extensive quality assessment and program improvement efforts. This part of the MHO contract specifies what they are and how they shall be carried out. For example, the contract requires implementation of a minimum of two performance improvement projects (PIP) annually and requires that the MHO submit a written QA/PI work plan within 45 days of obtaining the MHO contract. (pages 56-59)

Credentialing of providers by MHOs is discussed for two pages within the contract, and the list of requirements is specific and detailed. For example, requirements for credential checks, staff training, and notification of providers are specific and could be used as the basis for a performance review of MHO credentialing activities. Exhibit K on pages 149-150 also contains provider related requirements. (pages 60-61)

The contract contains eight pages of language governing the conduct of the MHO in regard to the individuals enrolled in the MHO. The topics cover information

materials and education, member rights, grievances, enrollment and disenrollment, identification cards and marketing. Pages 160-173, Exhibit N MHO Grievance Log spell out in detail how grievances should be handled. Again, the contractual language is prescriptive and lays out in measureable detail what the behavioral expectations are of the MHOs. (pages 62-70)

The list of various reports and financial forms that the MHO must submit is outlined in detail within the contract. These pages could form of the basis of a compliance review to determine if required reports are being submitted in a timely manner. This review would be an evaluation of the administrative efficiency of the MHO. (pages 72-79)

There is a one paragraph requirement that the MHO maintain a health information system. The characteristics of the information system are clearly specified. Schedule 1 on pages 174-175 of the contract requires the MHO to send data to the Client Process Monitoring System (CPMS). The paragraph and pages 174-175 could be the basis for a discrete study of the adequacy of the health information system. (page 80)

The contract contains provisions requiring the cooperation of the MHO in research, evaluation, and contract monitoring activities. The responsiveness of the MHOs and their participation in such activities could be the focus of a performance review. (pages 80-81)

The middle section of the MHO contract is long and consists of standard contractual and financial reporting language. While the contract language is specific in its requirements, this specificity is more relevant to measures of contract compliance than service-delivery performance evaluation and program improvement efforts. (pages 82-131)

Exhibit H and its attachments are concerned with encounter data reporting. This area could serve for possible performance evaluations as problems with the submission of encounter data are endemic in state managed care programs. The provisions of the contract are explicit and can be used to conduct a performance review of the accuracy of the encounter data submitted. (pages 133-142)

County Contract Requirements

An “Intergovernmental Agreement for the Financing of Mental

Health, Developmental Disability and Addiction Services" is the vehicle through which AMH provides funding to county government for the delivery of mental health services. This agreement is oriented to legal and financial matters and does not prescribe specific requirements related to performance and outcomes associated with mental health service delivery. While the agreement does reference statutes and administrative rules that address specific operational expectations, counties have considerably more discretion than MHO's in how they manage service delivery.

The general terms and conditions included in the Intergovernmental Agreement address the following:

- Disbursement and recovery of financial assistance
- Representations and warranties
- Use of financial assistance
- Award adjustments
- Appointment of county financial assistance administrator
- eXPRS access
- Amendments proposed by Department
- Provider contracts
- Provider monitoring
- Records maintenance, access, and confidentiality
- Alternative formats and translation of written materials, interpreter services
- Reporting requirements
- Operation of CMHP
- Department reports
- Technical assistance
- Payment of certain expenses
- County default
- Department default
- Termination
- Effect of termination
- Effect of amendments reducing financial assistance
- Resolution of disputes over additional financial assistance owed county after termination
- Resolution of disputes

The two contract provisions that are most closely associated with performance and outcomes monitoring are "Provider Monitoring" and "Reporting Requirements". These provisions very general in nature and do not prescribe specific requirements or expectations.

Addictions and Mental Health

AMH is responsible for monitoring contractual compliance and the performance of MHOs and the counties. It is also responsible for receiving and analyzing data associated with mental health services provide by or through the MHOs and the counties.

AMH's ability to monitor and establish accountability regarding MHO and county contracts is not as strong as it should be. AMH has limited administrative resources for fulfilling all of its responsibilities. In the case of working with the counties, the combination of limited resources coupled with the fact that there are thirty-six counties makes compliance monitoring problematic. As the result, there are situations where contractual terms are not being met.

Annual Quality Improvement Work Plan
AMH publishes a Quality Improvement Work Plan annually. The 2007 Work Plan contained a table outlining the general goal used to measure how well the objective was attained, and it further created a benchmark that the results of the indicator could be used compare to. For 2007, the following indicators were used to measure performance:

- 50 percent of individuals discharged from a psychiatric hospitalization for mental illness will receive other treatment services within seven days of discharge date.[120]

- Audit sample reviewed for each provider achieves 80 percent or higher score.

- The readmission rate within 30 days shall not go above 10 percent.[121]

[120] Benchmark based on OMHAS Program Analysis and Evaluation Team, "MHO Utilization Summary Report for Oct 2004-Sept 2005 Reporting Period," Figure 9. (Average rate for this measure for all contractors for Q4'04–Q3'05: 53.8%)
[121] Benchmark based on OMHAS Program Analysis and Evaluation Team, "MHO Utilization Summary Report for Oct 2004-Sept 2005 Reporting Period," Table 17. (Average rate for this measure for all contractors for Q4'04–

- Overall percentage of medical records screened by individual contracted MHOs meets or exceeds 80 percent.

- 50 percent of members screening positive for behavioral health needs will receive a care coordinator telephone assessment and referral phone call.[122]

- 30 percent of members contacted will accept referral to behavioral health services.

- 100 percent of Maternity Care participants will be screened for depression.

- 80 percent of members reporting a diagnosis of diabetes on the HIF will be screened for depression.

Data from the plans was collected on these indicators and results were reported by quarter.

Mental Health Utilization Report

AMH publishes a quarterly Mental Health Utilization Report for children and another report for adults. The report for adults contains enrollment, service and hospitalization data. This report reflects only Medicaid members who were eligible, enrolled, and who received mental health services during the reporting period. As an example of what the report includes, there are four hospital-related utilization measures showing admission and days and four outcome measures dealing with readmissions and timely outpatient services.[123]

- Unique Hospital Admissions per 1,000 Members Enrolled
- Unique Hospital Admissions: Age Groups per 1,000 Members Enrolled
- Average Hospital Days of Service
- Average Hospital Days by MHO/Age Group
- Percent of Hospital Re-Admission within 30 days
- Total Hospital Re-Admission within 180 days

Q3'05: 12.2%) Methodology for calculating the 30 day readmission rate: Data on inpatient psychiatric admissions is entered in a manual database (AFU), aggregated manually, and checked against an eligibility database (EZ CAP) to verify continuous enrollment. Data on residential and chemical dependency admissions is excluded.

[122] Benchmarks based on past performance.

[123] Addictions and Mental Health Division, (2008, April), *Oregon Health Plan Mental Health Utilization Report October 1, 2006ThroughSeptember 30, 2007*, Program Analysis and Evaluation Team, Salem, OR. Retrieved on 10-21-08 from http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml#mho

- Total Seen by Outpatient within 7 Days of Hospital Discharge
- Whether Seen by Outpatient within 7 Days of Hospital Discharge

On-Site Inspections
AMH conducts on-site inspections of the CMHPs every three years. There are review teams that inspect all aspects of the CMHP's operations. The results of the inspections are provided to the CMHPs and a correction action plan is developed. If the resources were available, more frequent inspections would be worthwhile.

External Quality Review
A private contractor performs an External Quality Review (EQR) for AMH of the delivery of mental health services to OHP enrollees. Federal law requires such a review in states such as Oregon that use a managed care approach to provide Medicaid services. The report summarizes the EQR results in three major areas: assessment of the MHOs' performance improvement projects; review of AMH's managed care quality strategy to assess its compliance with federal standards; and, validation of the statewide performance measures that AMH uses to assess care provided by MHOs.

National Outcome Measures (NOMS)
AMH reports NOMS to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its Mental Health Block Grant reporting. NOMS are reported by all states to SAMHSA and this permits national comparisons across states. AMH uses its Client Processing Management System (CPMS) to collect data on these NOMs.

SAMSHA is still in the process of refining NOMS with some of the measures that will need to be reported still in the developmental stage. All states report on some of the NOMS, and general reporting is increasing as states become better able to collect and capture the required data elements.[124] In general, states have lower rates of reporting on educational and criminal justice data.[125]

[124]For comparative NOMs data on the states see the SAMHSA website retrieved on 10-21-08 http://www.nationaloutcomemeasures.samhsa.gov/

[125] For a discussion of national results for each NOM see Lutterman, T., (2008, February) *Mental Health Planner Perspective on URS from Maryland*, State Data Infrastructure Coordinating Center , NASMHPD Research Institute, Inc. Alexandria, VA A PowerPoint display retrieved on 10-21-08 from http://www.nri-inc.org/SDICC/SDICC07/2008_Six_Years_of_URS_Reporting.pdf

NOMS are organized into ten domains. Within each domain there are specific measures and items that need to be reported on. The domains include:

- Reduced Morbidity
- Employment/Education
- Crime & Criminal Justice
- Stability in Housing
- Social Connectedness
- Access/Service Capacity
- Retention
- Perception of Care
- Cost Effectiveness
- Use of Evidence Based Practices

AMH is using the following data sources in reporting NOMS to SAMHSA:

- Administrative data and reports available from the Community Mental Health Programs;
- Mental Health Statistical Improvement Project (MHSIP) Adult Outpatient Consumer Survey;
- Oregon Patient/Resident Care System;
- Oregon Department of Corrections Data system; and
- CMHS adult severe mental illness prevalence information for adults from the state mental health data systems.

Mental Health Statistics Improvement Project

AMH contracts with a private company to do an annual survey of individuals who used AMH services.[126] The study mailed questionnaires to individuals who had received mental health services after June 2006 and has satisfaction data on those who responded. The results cannot be generalized to all 12,000 individuals sampled by the questionnaire because the returned questionnaires are not based on a random sample. However, information is available on the 2,675 individuals who did respond.

Evidence Based Practices

[126] Addictions and Mental Health Division, (2008, January) *2007 Oregon Mental Health Statistics Improvement Project Survey for Adults*, Work performed under Contract #120923, Department of Human Services, Salem, OR. Retrieved on 10-21-08 from *http://www.oregon.gov/DHS/addiction/publications/adult2007survey.pdf*

As described earlier in this report, Oregon is a national leader in the implementation of evidence based practices in the provision of mental health care services. AMH oversees the program and provides progress reports to the legislature. The intention behind the program is to provide the best possible services to individuals by emphasizing practices that have been proven to be effective. In the absence of a system for actually monitoring outcomes, this approach is a major step forward in creating performance accountability.

Mental Health Organizations: Internal Systems

Quality assurance and professional improvement activities by the MHOs goes beyond simply adding NOM related material to CPMS and contributing to the AMH's Quality Improvement Work Plan. Indeed, the MHO would not be meeting its contractual obligations if it only did this. Each of the MHOs has quality improvement staff. They hold periodic statewide meetings, coordinate with AMH, and publish an annual quality improvement work plan.

Discussed below are two examples of these MHO annual reports. The Verity Integrated Behavioral Healthcare Systems (VIBHS) which serves Multnomah County was the first report reviewed.[127] In April 2006, Verity moved to requiring its providers to report fee-for-service data using procedure codes. The report indicates that this is a continuing multi-year effort and training of providers was still being completed in 2007. In 2006, Verity agencies also moved to using a level-of-care assessment instrument for adults and a level-of-care instrument for children. In taking these two actions, implementing the use of procedure codes and assessment instruments, Verity has increased its ability to monitor its performance.

Verity requires its contracting providers to use an outcomes instrument and report performance measures. Its annual report contains a "Dashboard" with 26 clinical data elements, 17 of which have four years of data reported for them. These 26 utilization, penetration, and outcome measures are:

- Total Member Months
- Unique Adults Served

[127] Verity Integrated Behavioral Healthcare Systems, (2008, March 14) 2007 Verity Annual Quality Report, Multnomah County Department of Human Services, Portland, OR. Retrieved on 10-21-08 from http://www.co.multnomah.or.us/dchs/mhas/2007mhasd_annualreport.pdf

- Unique Children Served
- Adult Penetration
- Child/Adolescent Penetration
- Adult Hospital Discharges Per Thousand Members Per Month (PTMPM)
- Adult Inpatient Days PTMPM
- Adult Hospital Average Length of Stay (ALOS) Days
- Adult Hospital Readmissions in 30 Days (includes readmissions in 0-7 days)
- Child/Adolescent Hospital Discharges PTMPM
- Child/Adolescent Inpatient Days PTMPM
- Child/Adolescent Hospital ALOS
- Child/Adolescent Hospital Readmission in 30 Days (includes readmissions 1-30 days)
- Psychiatric Residential Treatment Services (PRTS) Admissions PTMPM
- Intensive Evaluation Services (IES) Admissions PTMPM
- PRTS Days PTMPM
- IES Days PTMPM
- PRTS Average Length of Stay (Days)
- IES Average Length of Stay (Days)
- Percent of Intensive Community-Based Treatment Services in home/community
- Clients who have a second outpatient visit within 14 days of the first visit
- Clients who have four visits within the first 44 days
- Total Crisis Line calls received
- Total Crisis Line calls answered
- Average speed of answer
- Abandonment rate of calls

The other report reviewed was the Jefferson Behavioral Health (JBH) Quality Improvement Work Plan 2008.[128] The 11-page 2008 Work Plan of Jefferson Behavioral Health defines very specifically the performance indicators it uses. Below is a sample of these performance indicators:

- Increase access to services by older adults;
- Increase the number of geriatric specialists in the JBH region;

[128] For a copy of this report see, retrieved on 10-23-08 from,

http://www.jbh.org/shop/images/JBH_Quality_Improvement_Work_Plan_2008.pdf

- Increase the number of Hispanic members served;
- Submit a capacity study to the state and Jefferson Behavioral Health stakeholders;
- Adopt a minimum of 2 clinical practice guidelines;
- Begin working with seniors and people with disabilities to develop a satisfaction survey with allied geriatric professionals;
- Standardized Prevention, Education and Outreach (PEO) definitions shared with all counties;
- Distribute a semi-annual newsletter;
- Order and distribute educational brochures on mental illness, chemical dependency, physical issues related to mental dysfunction and stigma; and
- Development of plan to increase volunteers.

CMHPs Quality Monitoring Efforts

Some CMHPs have developed their own systems for monitoring the performance and outcomes associated with the delivery of mental health services they provide either directly or though contracts with service providers. As would be expected, there is considerable variability in the approach taken by counties in this area of operations.

Data Systems

Data on individuals with psychiatric and emotional disorders and the services they receive is collected and stored in three primary databases:

- The Medicaid Management Information System (MMIS) provides information on those who receive health insurance benefits under the Oregon Health Plan.

MMIS includes information on eligibility status, services rendered and fee-for-service actual or capitation payments. MMIS also includes information about chemical dependency, pharmacy, dental, and physical health service expenditures. MMIS data is accessed via a decision support surveillance utilization review system known as DSSURS.

- The Oregon Patient/Resident Care System (OP/RCS) includes records for all

publicly funded psychiatric inpatient care delivered in the State Hospital and in regional acute care units. OP/RCS also serves as the primary resource for tracking individuals who have been civilly or criminally committed to mental health treatment.

Each of these systems contains unique client level identifiers. The AMH Program Analysis and Evaluation Unit uploads data from each of the systems to a central server, matches the identifying information, and creates a unique inter-system identifier that allows analysts to track and summarize service utilization and population.

- The Client Process Monitoring System (CPMS) contains episodic records of care in community mental health programs and intensive treatment programs. The CPMS also includes records of care in chemical dependency and developmental disability programs.

CPMS is submitted on various standardized forms and entered by the AMH Data Support Unit into a mainframe system. Forms are submitted at the beginning and the end of a service episode and monthly during an episode of service.

The CPMS data entry unit receives approximately 6,500 forms a month. It remains to be mostly a paper-based system that relies heavily upon hand written corrections. CPMS can answer the question of how many individuals are served. However, it cannot answer the questions of how many services of what kind are provided, who provides them, how many Medicaid services are provided to this person, or what the costs are of providing services to the person. CPMS has on-going issues with data inconsistency.

Unlike the MMIS which has significant reporting capacities, CPMS has limited reporting capacity due to the nature of the data in the system, the system architecture and the antiquated nature of the system. As the result, CPMS has limited ability to collect and generate reports that are timely and accurate and that provide valuable data for use in making management decisions.

7 Strengths and Weakness Analysis

This section focuses on an analysis of strengths and weaknesses of the Oregon mental health care delivery system. Knowing the strengths and weaknesses of the system is important in giving policymakers the information needed to plan, prioritize, and implement strategies to ensure that the best efforts possible are made to meet the mental health needs of Oregon's residents.

The focus of this section is:

- Access and availability of mental health services and supports;
- Coordination of services across agencies and programs;
- Quality of services provided; and
- Cost effectiveness of the system.

In discussing strengths and weaknesses, it is important to define the context within which Oregon's mental health delivery system is operating.

Resources to address the mental health needs of all Oregon's residents in need are not and have not been sufficient for some time. This has been generally recognized at least since the early 2000s. This is reflected in the numerous studies of the system that have been conducted over the past eight years, including the work completed by two Governors' Task Forces in 2000 and 2004 and the Community Services Workgroup Report for the Oregon State Hospital Master Plan. This study itself, which was commissioned by DHS at the direction of the State Legislature, is another example of the recognition that the system is not working at a desirable level.

While resources have been limited, the need for services continues to grow. The current downturn in both the state and national economies are predicted to create a greater need for public or charitable services. While the federal government is working hard to meet the mental health needs of veterans returning form Iraq and Afghanistan, undoubtedly some of the needs of veterans and their families will have to be met through the use of state and local resources. In addition, the needs

of some cultural and ethnic groups as well as the need for mental health services by seniors and people with physical and intellectual disabilities continue to go unmet.

Another manifestation of the convergence of limited resources and increasing need is the orientation of the system from being proactive to reactive. More resources are focused on crisis points in the system with less discussion of prevention. The discussions around mental health services are increasingly focused on overcrowding in hospital emergency rooms, state psychiatric hospitals at or exceeding capacity, challenges associated with mental health issues being faced by our public safety system, and the percentage of people in jails and prisons with mental health diagnoses and needing treatment.

The current financial situation that Oregon and the United States as a whole face is only likely to exacerbate matters. The funding of mental health services will be increasingly difficult in the face of challenging state and federal budgets. In Oregon, this comes at a time when changes in the timber tax payments to counties may make it more challenging to increase or sustain current spending on mental health services. On the state level, the expenses associated with the construction and staffing of the new state hospitals may influence the availability of funding for community based mental health services.

While Oregon has many people involved in mental health services who are thoughtful, creative, and committed to the work that they do, the shortage of resources has influenced the nature of relationships among key players and constituencies within the system. As noted by an interviewee, "When there is a shortage of food, table manners suffer." Under stress, there is a tendency to become defensive and that tendency is present within the mental health system in Oregon. While the importance of working constructively and cooperatively is certainly recognized, people's patience and generosity are frayed.

At the same time, the public plays an uneasy role in the mental health system. While there is general acceptance of mental health challenges as a legitimate medical condition, there remains a stigma attached to having a mental illness. This influences the willingness, or in some cases the unwillingness, of communities to host some types of mental health services and the degree of funding provided for mental health services at the local, state, and federal levels of government.

This analysis of strengths and weaknesses is based on interviews and the review of previous studies. Interviews were conducted with a wide variety of stakeholders including state legislators, DHS and other state government staff, representatives of community hospitals, staff of Community Mental Health Programs and Mental Health Organizations, individuals receiving mental health services, and advocates.

Oregon's Mental Health Delivery System Strengths and Weakness Analysis	
Measure	**Issues Noted**
Access & Availability	**Strengths** o People who qualify for coverage through the Oregon Health Plan have access to a number of mental health services. o By statute, the Local Mental Health Authorities are responsible to provide basic mental health care services and alternatives to hospitalization for people needing mental health services. o The Community Mental Health Programs offer a variety of mental health services to people in need. o In many counties, a combination of state, local and federal funding is available to support the availability of mental health services. o Crisis intervention services are available in all parts of the state. o Thirteen community hospitals have inpatient psychiatric units that provide short term stabilization of acute care episodes of mental illness. The Community Mental Health Programs have adapted to limited funding availability and developed a number of innovative and resourceful programs in order to meet the needs of local residents. o The construction of new state psychiatric facilities will improve the quality and availability of psychiatric hospital services. o Recent AMH initiatives have established or increased the availability of housing, supportive employment, and support for people with dual diagnoses. o A Cultural Competency Plan has been developed to increase access to quality mental health services for certain ethnic and cultural groups. o Evidence-based practices are being utilized to a much greater degree than in the past, particularly in outpatient settings. o New community residential programs have been developed and the funding is available to develop more. o A concerted effort is being made at the federal and state levels to meet the mental health needs of Iraq and Afghanistan veterans and their families.

Access & Availability	**Weaknesses** o The mental health system in Oregon is seriously underfunded. o Access to mental health services is very limited for people who do not qualify for Medicaid services. o In most counties, access and adequacy of public mental health services is not sufficiently funded to meet all mental health needs. o Access and the adequacy of services vary from county to county. o Access to crisis intervention and stabilization services and other mental health services is problematic in some portions of rural and frontier areas of Oregon. o The capacity of community hospital based acute care psychiatric units has decreased by twenty-three percent in the last eight years. o The availability of acute inpatient services is at risk of further reduction because community hospitals are not getting paid enough to cover the cost of services. This situation is made worse by the fact that payments by the counties in some instances are not made at all, are delayed or are for amounts that are less than the hospitals' believe the counties are obligated to pay. o The focus within the mental health care delivery system in recent years has shifted from prevention to crisis management. o In rural and frontier areas within Oregon, access to mental health services in affected by geography and the ability to attract qualified staff. o The area east of the Cascades does not have access to state psychiatric hospital placements within the region and no or limited acute care capacity. o Some individuals needing residential mental health services may be in hospital emergency rooms for days awaiting placement. The number of people in jails and prisons with mental health diagnoses continues to rise. o The shortage of residential sub-acute and step-down programs negatively affects both the front door and the back end of the mental health care system. o Community opposition to the siting of residential mental health programs within their neighborhoods is a significant factor in limiting the development of new residential mental health programs. o The mental health needs of people from certain ethnic and cultural groups are not being met due to the lack of availability of services in some areas as well as the absence of culturally or ethnically sensitive services. o The mental health needs of seniors and individuals with physical and intellectual disabilities are not being met. o The capacity of state psychiatric hospitals to meet the state's need is being compromised by the need for this placement by increasing numbers of forensic placements. o Due to the current funding and community attitudes toward community mental health services, a certain amount of criminalization of mental illness is taking place. o The availability of housing and supportive employment opportunities is inadequate to meet the need. o Better data management systems are needed in order to make informed resource allocation decisions.

Coordination	**Strengths** o The regionalization of mental health service delivery has proven to be effective in some parts of Oregon and reflects a public-private partnership that includes community hospitals. o There are on-going efforts within DHS to improve the internal coordination of service delivery among traditionally "siloed" programs. o In some counties, CMHPs are working in coordination with the delivery of other community services, particularly public safety, in providing mental health supports to people in need. **Weaknesses** o There is a need for a clear vision of what the mental health delivery system in Oregon should entail. o The roles of the major components of the mental health delivery system, including the state hospitals, the MHOs, the CMHPs and community hospitals need to be well defined. o AMH needs to play a stronger leadership role in managing the community mental health delivery system. o Within DHS, internal coordination of efforts among different program areas that have been traditionally "siloed" needs to be improved. o Opportunities to simplify and coordinate administrative requirements associated with the delivery of community mental health services should be pursued. o The responsibility for the payment of community hospitals for emergency room and inpatient psychiatric unit services should be clearly defined and accountability for making those payments clearly established. o Trust among the various components of the mental health care delivery system needs to be reestablished. o Increased coordination of service delivery needs to take place. o Lack of transparency on how funding provided to the CMHPs by AMH is spent creates uncertainty strains relationships with other components of the community mental health system. o AMH needs to be more vigilant in holding contractors (MHOs, CMHPs and others) more accountable to the terms of their contracts. o AMH needs to play a more active role in improving business practices within the community mental health system to order to create greater uniformity and consistency.

Quality	**Strengths** o There is a reporting system in place to monitor the quality of services, including the monitoring of MHOs and CMHPs. o Individual MHOs and CMHPs have developed their own internal mechanisms for measuring quality, however not all have comprehensive systems. o State legislation has created a structure to mandate greater use of evidence based practices. o Latest surveys indicate that the use of outpatient evidence based practices and fidelity are meeting legislative requirements. o Standard of Care of community mental health systems is spelled out in statutory language defining the obligations of the Local Mental Health Authorities in meeting the needs of the community. o Standard of Care of community mental health systems is also defined through the service element definitions included in AMH contracts. **Weaknesses** o The shortage of administrative resources and effective data management systems limit the effectiveness at the state and county quality monitoring systems. o There is wide variability in the approaches to quality assurance taken at the county level. o The CPMS is of limited usefulness in its current form. o Desired patient outcomes need to be more clearly defined to increase the effectiveness of quality management efforts. o The implementation of the evidence based practice program needs to be improved in order to maximize the benefits of the program. For example, training needs to be funded to ensure the fidelity of approved practices. Also, relevant practices need to be developed for all settings within which mental health services are provided, for example hospital emergency rooms. o Evidence based practices need to be established for state psychiatric hospital services.

Cost Effectiveness	**Strengths** o The mental health system in Oregon appears to be providing a reasonable amount of services at a reasonable cost given the availability of resources. o Administrative costs appear to be reasonable. o In those areas of Oregon where it seems to be working well, regionalization appears to foster informed resource allocation decision-making. **Weaknesses** o More people are accessing higher cost services for mental health supports, such as emergency rooms, hospital inpatient psychiatric services, and state psychiatric hospitals and experiencing longer lengths of stay then would be the case if a more robust system of community supports was in place. o The absence of good data makes resource allocation decisions more challenging. o The complexity of the existing mental health delivery system results in administrative inefficiencies and the need clearer guidelines in order to successfully navigate the system. o The delays in establishing more community based residential programs cause people to stay in more expensive settings, including emergency rooms, hospital inpatient psychiatric services, and state psychiatric hospitals longer than clinically necessary. o The absence of better programmatic coordination within DHS leads to unfortunate and expensive crisis situations. o There is a lack of transparency of provider costs and productivity that is needed to ensure that the most cost effective treatment options are being utilized.

8 Recommendations

1. Oregon should establish a regional approach and contract with regional authorities for the delivery of mental health care services. The regional entity would be responsible for both Medicaid and non-Medicaid services.

The benefits of a regional approach include:

- A simplified mental health care delivery system with greater cross county portability;
- Greater uniformity in the availability of mental health services across the state;
- Increased consistency and efficiency in the service delivery system;
- Enhanced transparency and accountability; and
- Reduced administrative costs at the state and local levels.

Streamline the MH Service Delivery System

The current structure of Oregon's mental health care delivery system is complex and fragmented. There are multiple sources of funding, multiple contractual relationships with different accounting, reporting, and quality assurance requirements, 33 Community Mental Health Programs, and 9 Mental Health Organizations. The existing mental health care delivery system has done well recognizing that the system has not received the necessary funding to serve all individuals in need. In many counties, there are numerous examples of creativity and innovation in providing excellent services with limited resources.

At the same time, there is a lack of uniformity in the availability of mental health services across the state which needs to be addressed. Also, while the administrative costs associated with the current mental health delivery system are modest, there is a need to make changes to promote increased consistency and efficiency in the delivery system along with greater transparency and accountability. While modest administrative costs are an indicator of efficiency, insufficient administrative oversight can create unintended consequences.

The current challenges within the mental health system must also be taken into context of the surrounding economic situation. The State is facing increased challenges as a result of difficult budgetary times coupled with a significant unmet need for services, which is likely to increase in response to the challenging financial times that we face. As the result, there is a compelling need to ensure that the available resources are utilized as efficiently and effectively as possible.

A regional approach provides the opportunity to consolidate organizational structure and functionality at both the local and state levels. This would create a simplified and more efficient approach to service delivery. This would further eliminate the need for multiple contractual and administrative structures for both the procurers and providers of services. While we believe administrative efficiencies can be achieved, it should be noted that existing or newly created regional organizations will require appropriate administrative infrastructures to address the new challenges facing a coordinated regional system. As a result, some of the administrative savings must be reinvested in the regional administrative infrastructure in order to achieve the goals of regionalization.

A regionalized approach could be implemented using the existing MHO structure as the template for regionalization. Because this structure already exists, there is no need to start from scratch. In fact, GOBHI and the Mid-Valley Behavioral Care Network are cited as good examples of effective regional cooperation.

The regional approach that we recommend would have the following characteristics:

- AMH would contract with the same regional organization for both OHP and non-OHP mental health care services. In the event that it is not possible to use the same contract for all services, the separate contracts would follow the same contractual requirements. This would eliminate the need to have duplicate systems to meet variations in contractual requirements in areas such as accounting, oversight, reporting, and quality assurance.

- A global budgeting approach would be implemented, whereby the regional organization would prepare a two year service delivery work plan that would serve as the basis for funding.

- The regional organization would be responsible for the delivery of all mental health care services within its catchment area with the exception of services currently provided within the state hospital system, although state hospital utilization will be a performance indicator for each organization.

    - The regional organization would be responsible for the development of community based residential programs, including sub-acute and step-down services.

    - In regards to the state hospital system, staff of the regional organizations would be part of a discharge planning team assembled for every person upon admission to the hospital and would be active participants in discharge decision making.

    - The regional organization would include a structure for participation by all community hospitals within its jurisdiction. The regional organization would be responsible for paying community hospitals for all mental health services provided including emergency rooms and acute care units.

- DHS, including AMH, DMAP, and SPD would identify opportunities to increase organizational efficiency and effectiveness in light of the implementation of a regional service delivery system.

    - The opportunities to consolidate functionality would be identified. Any savings that may result could be invested in services and/or developing increased organizational capacity, if justified.

    - The opportunities to eliminate variations in contractual requirements would be identified.

    - The specifications for a data driven, decision support system would be developed including the specifications of a consolidated data management system.

- A review of all relevant state statutes and regulations would be undertaken to identify those changes needed to implement a regional approach to service delivery, as well the consolidation and elimination of statutory and regulatory requirements that do not contribute in a meaningful way to the efficient and effective delivery of mental health care services.

- The opportunities to promote greater coordination and effectiveness in meeting the mental health care needs of vulnerable populations, including seniors and individuals with disabilities, would be identified.

The implications of taking a regional approach to mental health care delivery include:

- Make statutory changes that either establish regional mental health authorities to replace existing local mental health authorities including the transfer of responsibilities or require the LMHAs to designate a regional authority to serve their populations.

- Review the Oregon State Hospital Master Plan to determine whether the construction of the new facility at Junction City is the best approach in light of the new commitment to a regional approach to service delivery.

2. The emphasis in mental health program and funding priorities must be on increasing access to and strengthening community supports, including prevention and early engagement.

Over the past ten years, eligibility, programmatic and funding changes in Oregon have resulted in decreased access to community based mental health care services. The decreased access to these services is often attributed to increases in the census at state psychiatric hospitals, increases in the number of individuals involved with the criminal justice system who have mental health diagnoses, and increases in the use of emergency rooms for reasons associated with mental health issues. These trends are not clinically appropriate, cost effective, nor financially sustainable.

As noted in the Oregon State Hospital Master Plan (February 2006), "Without enhanced community services, the demand for Oregon State Hospital beds will substantially exceed projections of size and cost."

The Community Services Workgroup Report for the Oregon State Hospital Master Plan (Fall 2008) estimates the need for additional funding of approximately $579 million biennially to provide services to all individuals who have a serious mental illness and are not otherwise cared for now. This is consistent with estimates of unmet needs that have been developed in the past. Prevention, screening and assessment, case management, crisis, and acute care services, as well as more supportive services such as housing and employment, have long been identified as a need. The estimated need for additional funding also includes expanded jail diversion programs to keep people with mental illness out of the prison system.

In 2007, the Legislature approved approximately $18 million to improve support for the community mental health services. This increase came in response to a request for a $105 million increase in the biennial budget recommended by the Community Services Workgroup Report. This funding is targeted to improve access to services for individuals without Medicaid when they are in a crisis and/or need acute hospital treatment, and to fund evidence-based services to divert individuals from jail, assist in employment, housing stability and case management.

Expanding eligibility to the Oregon Health Plan would increase access to needed mental health services. Individuals without insurance, including Medicaid, often do not have the means to be proactive in addressing their mental health needs. The community hospital emergency room for some is the only available service option. These episodes are often crisis driven. Opening up enrollment in the Oregon Health Plan would ensure a more coordinated and comprehensive access to mental health services to those in need. While under the current economic environment, expansion of eligibility to pre-2003 levels is not likely, a smaller, more targeted expansion should be explored. This expansion should be considered in order to ensure that the most vulnerable Oregonians have access to the care that they need.

Oregon, like many states in recent years, has shifted funding for non-Medicaid services to Medicaid as a way to stretch available general fund dollars. At the same

time, there are some services, for example peer supports, supportive housing, supportive employment, and supportive education services, that are needed as part of the continuum of community mental health services. While some of these programs do not meet federal Medicaid regulations or support uninsured patients, the benefits these programs provide have been well documented. For example, there are evidence based practices that do not meet Medicaid standards as they address non-medical approaches to care. To appropriately address the complex needs, the Legislature should consider funding non-Medicaid mental health services to ensure that the system of services in Oregon includes all the necessary components.

3. Oregon should define the System of Care model that it is committed to implementing.

There is currently an absence of a well defined System of Care that Oregon embraces. The State established significant statutory and regulatory lists of mental health services that should be made available to individuals in need. However, existing language does not provide a comprehensive picture of what a System of Mental Health Care should look like including a statement of values, the identification of the specific services that should be available statewide, and the measures by which the performance of the system will be evaluated.

- The system should reflect a commitment to the development of a strong community based system of services with institutional services being the option of last resort.

- The evolution of Oregon's mental health care system will occur incrementally. Having a defined System of Care with defined measures of system performance will assist the executive and legislative branches of government understand how incremental decisions of a policy and budgetary nature fit into and affect an overall system vision.

- The "Report to the Governor from the Mental Health Alignment Work Group" (January 2001) includes a description of an "Ideal Mental Health System" which is a good point of departure in looking to define a System of Care.

The System of Care must include the elimination of programmatic silos and the identification of institutional and legal barriers to attaining the vision.

4. Coordination of efforts among the DHS, the Criminal Justice System, and Local Governments needs to be strengthened at the State and local levels.

In recent years Oregon's public safety system at the State and local levels has been increasingly challenged by individuals with mental health conditions. In fact, the Department of Corrections has become one of the largest providers of mental health services in Oregon. In the long run, the most appropriate and cost effective approach to meeting individuals' mental health needs is through an effective community mental health care delivery system that emphasizes prevention and treatment. In the short term, from a public safety and financial perspective, there is a need for greater communication, cooperation, and coordination among the state and local mental health, public safety, and criminal justice systems.

Ironically, the demand for state hospital placements by individuals within the criminal justice system has placed pressure on the state hospital system to accommodate this increasing need. The forensic census at the state psychiatric facilities continues to increase. While DHS is responsible for managing the state mental health hospital system, it has little control over the number of forensic individuals with mental health conditions who enter and leave the system. In other words, DHS has limited control over the front and back doors at the state hospitals. The judicial system is assuming greater control over who is served by the state hospitals.

The most appropriate and cost effective approach to meeting individuals' mental health needs is through an effective community mental health care delivery system that emphasizes prevention and treatment. In the short term, from a public safety and financial perspective, there is a need for greater communication, cooperation, and coordination among the state and local mental health, public safety, and criminal justice systems. Steps that should be made include:

- Implementing new jail diversion programs and the increased use of mental health courts;

- Improved training of public safety officers in managing situations with people with mental illness;

- AMH should establish a correctional release discharge planning process to ensure that, when an individual diagnosed with severe mental illness is released from a correctional facility, a community transitional plan is in place and that needed services and supports are immediately available.

The Multnomah County Joint Access to Benefits program (JAB) is cited as an example of the kind of program that AMH should promote statewide. The JAB program helps individuals obtain medications, make clinic appointments, attend alcohol and drug treatment programs, and access other services such as Medicaid. Multnomah County staff obtain a list of individuals from the state's Criminal Information System (CIS) who are being released. County staff work closely with DOC's mental health specialists and coordinate a plan about the inmate being released.

Given the high risk nature of the individuals being released from prison and the fact that these individuals are known to have severe mental illness and have a treatment history, it is imperative that community supports be provided to them. Many counties do not have the resources to initiate these programs on their own, provide medications, or maintain the necessary case management follow-up. As a result, AMH must exercise leadership in creating new programs with approval and funding from the legislature.

AMH needs to work closely with the PSRB in finding appropriate community placements for individuals while at the same time balancing public safety consideration against treatment considerations. This is particularly challenging during this period when public confidence in the effectiveness of community mental health system is lacking. The PSRB has identified more than 80 individuals who are ready for community placement, but no placements are currently available. The discharge of these individuals from the state hospital would be helpful in freeing up capacity at the state hospital in order to meet the needs of others who are awaiting placement. AMH and the PSRB need to continue

to coordinate efforts to ensure that individuals do not remain at the state hospital longer than is necessary.

5. The mental health needs of underserved populations should receive more attention.

As noted in Section 4 of this report, the Gap Analysis, the mental health care needs of seniors, individuals with physical and intellectual disabilities, members of cultural and ethnic groups, and Native Americans are not being met. This disparity in the availability of mental health services must be addressed

Mental Health services need to be available in ways that connect with underserved populations in regards to the locations where services are available, the language used to communicate the availability of services, and the way services are presented in light of cultural differences and the stigma associated with receiving mental health services.

The "silo" effect in the management of DHS programs also influences the availability of mental health services to underserved populations. There is a tendency for programs to maintain a narrow focus on their primary constituency. This tendency is exacerbated during periods of limited funding. As the result, for example, providing mental health services to seniors is often viewed as the responsibility of senior services rather than adult mental health services. This deflection of responsibility results in some of the individuals with the greatest need, for example those with multiple disabilities, falling through the cracks in the system.

Opportunities to address this area of concern include the following:

- Implement the "Cultural Competency Plan" prepared by DHS in 2007.
- Continue the development of pilot projects at both the state and local levels in an effort to reach out to underserved populations.

- Develop a workgroup within DHS to identify ways to foster greater cross program coordination of efforts.

6. DHS should interface with the reintegration efforts of the Oregon National Guard and the US Veterans' Administration in meeting the needs of returning veterans.

The mental health care needs of veterans returning from duty in Iraq and Afghanistan are well documented. The United States Veterans Health Administration is an established source of mental health funding for those veterans who need mental health supports. Given the availability of services for individuals in need, it is important that DHS assist veterans in gaining access to available services.

AMH should work with the reintegration mission of the Oregon National Guard. This successful reintegration effort has hosted at least seven "summits" discussing the needs of returning veterans. AMH can play an expanded role in this effort by assigning a permanent liaison or funding the participation of full-time working state and/or county staff to the team's efforts.

7. Funding for housing and supportive employment and education programs for individuals with mental illness needs to be increased.

The importance of providing good housing options and supportive employment and education opportunities to individuals with mental health challenges cannot be overstated. The benefits of publicly funded mental health care services will not be fully realized until individuals have both a stable, comfortable, and healthy place to live and the supports necessary to be engaged in meaningful employment or other equivalent activity. In order to shift to a recovery based system, access to housing, employment and educational support is imperative.

Oregon has implemented initiatives to increase the availability of housing and supportive employment and education services in recent years. In fact, the Oregon State Hospital is the first state psychiatric hospital in the United States to provide

supportive education, and 20 percent of OSH patients are currently enrolled in the program. At the same time, there is additional need for these services that is not currently being met. Expansion of housing, supportive employment, and education services needs to take place. The Community Services Workgroup Report provides an estimate of the additional funding necessary to meet the unmet need.

8. The availability of community residential treatment programs needs to be increased.

The limited availability of community residential treatment programs, whether sub-acute or step-down units, is creating serious problems within Oregon's mental health care delivery system. Individuals are remaining in community hospital emergency rooms or in acute inpatient units longer than necessary because of the lack of less expensive and more appropriate community residential placements. In some cases, individuals end up in the state hospital system because other options are not available. In addition, there are individuals who stay at the state hospital system for periods of time longer than necessary due to a lack of appropriate community placements.

These situations are undesirable from both a financial or treatment perspective.

- Adequate funding needs to be maintained in support of further development of community residential treatment programs.

- State officials should work closely with community-level partners such as the local hospitals and the CMHPs to secure the necessary community support to allow further development of these programs to take place.

- The Legislature should adopt legislation that mirrors the federal Fair Housing Laws in order to improve the ability to develop community based residential programs without putting the community at risk.

9. The integration of physical and behavioral health needs increased emphasis.

Those with a mental illness often do not seek out treatment for medical conditions until the conditions become very serious. Even when treatment is sought, compliance with treatment recommendations often does not occur. Studies are increasingly demonstrating that those with serious behavioral health conditions experience earlier deaths as a result of undertreated medical conditions. It is often a challenge for any individual, but particularly those suffering from mental illness, to coordinate his or her own health needs within a fragmented health care system.

It is important, then to examine the effectiveness of integrating mental and physical health services in order to reduce unnecessary costs associated with misdiagnosed illnesses. Recent studies suggest that the coordination of both physical and mental health programs can improve the delivery of health care services and improve the overall effectiveness of treatment plans. Coordinating these two elements reduces the challenges associated with a fragmented system of care.

Service integration should include providing educational resources to clinicians to facilitate referrals, co-locating clinicians in the same setting, coordinating care across providers and systems, collaborating and jointly deciding on treatment, and jointly planning and financing services.

In Oregon within the past few years, there are a number of integration efforts that have been initiated at the county level. In counties that have FQHCs, the integration of physical and behavioral health services is making significant progress. At the same time, there are areas within Oregon where little progress has been made in the integration of services.

AMH needs to take a leadership role in creating greater integration of physical and behavioral services for individuals with mental illness. Barriers to integration need to be eliminated, incentives and accountability for integration need to be established, and greater consistency in integration across all counties in Oregon needs to be achieved.

10. AMH must take the lead in creating greater accountability and transparency within the mental health care delivery system.

There is a perception that there is an insufficient degree of accountability and transparency within Oregon's mental health care delivery system. This view is held by many stakeholders. Examples of concerns include:

- Inability to account for how state funds provided to the counties by AMH are being used and whether they are being used for their intended purpose;
- The variation in the availability of mental health services from one county to another;
- AMH not holding MHOs accountable for meeting terms of their contracts;
- Concerns expressed by community hospitals that they are not being paid by some county mental health programs for services provided in community hospital emergency rooms and psychiatric acute care units; and
- The financial difficulties experienced recently by Cascadia.

At the same time, there are systems in place that create accountability and transparency. Contracts between AMH and the MHOs are very detailed in establishing the accountability of the MHOs. The contract between AMH and the LMHA/CMHPs, while not as prescriptive as the contracts with the MHOs, does create accountability, including periodic quality reviews by AMH. While it has limitations, the data provided through CPMS does provide an accounting of how state funds are used.

AMH needs to take the lead in creating greater accountability and transparency within the community mental health service delivery system.

- Standard business practices should be defined by AMH and built into service contracts and should include:
    - Standard in-take and assessment forms;
    - Standardized performance outcome measures;
    - Standards for the development of quality assurance plans;
    - Standard record keeping forms; and
    - Uniform data reporting requirements.

- AMH needs to hold MHOs and LMHA/CMHPs accountable for meeting the terms of contracts;

- AMH needs to establish a consistent and transparent method of communicating policy decisions;

- The following information should be posted on the AMH web site:
  - Policy directives;
  - Field review results;
  - County contracts, allocations and expenditures; and
  - Utilization data.

- AMH should monitor the availability of services across the state and ensure consistency in availability; and

- The frequency of on-site reviews should be increased.

AMH needs additional funding in order to take the lead in creating greater accountability and transparency in the mental health system. Current resources are not sufficient to effectively accomplish the job.

AMH should look at the recent Children's Mental Health System Change Initiative as a model for how to move forward. Not all stakeholders were happy with all aspects of how the initiative was implemented. However, at the same time, there was agreement that the initiative was needed to improve the quality, consistency, and efficiency of service delivery and that it was an appropriate and necessary role for AMH to play in improving system performance.

11. DHS needs to develop a data management system that provides accurate, timely, and insightful information in order to make informed management decisions.

Data management systems are increasingly important in providing accurate, timely, and insightful information to policy makers, including the Legislature and DHS personnel. Challenging resource allocation decisions are more informed if good data is available. The ability to effectively plan and monitor mental health

services is tied to the abilities of the data management systems. The benefits of the integration of physical and behavioral health are enhanced through integrated data management systems.

The existing DHS data systems have limitations. In particular, CPMS has neither the data nor the capability to generate reports that would be helpful in making resources allocation decisions.

DHS/AMH need to:

- Design and develop a data system to replace the existing CPMS and redefine the characteristics of the data set that contractors need to provide;

- Complete the development of the Behavioral Health Improvement Project (B-HIP) for the state hospital facilities; and

- Develop an electronic medical record system that integrates physical and behavioral health and treatment data for planning, care management, and disease management purposes.

12. The program to promote evidence based practices in mental health services should be reviewed.

Oregon has made substantial progress in the adoption of evidence based practices as a means of improving the quality, consistency, and cost effectiveness of mental health services. Through the enactment of ORS 182.525 and its subsequent implementation, Oregon is a national leader in this area.

The progress that has been achieved to date reflects the cooperative efforts of AMH, service providers, consumers, researchers, and other stakeholders. In particular, it is important to note that the CMHPs have done a good job of working to meet the ambitious goals set out in the legislation without receiving any additional funding to cover the costs associated with implementation of the program.

In light of the progress that has been made, this is an appropriate time to review, reassess, and refine the evidence based practices program. Fidelity and workforce

development are two areas that deserve particular attention:

- How well has fidelity been defined and how well is it being monitored?
- Are staff involved in the delivery of mental health services getting the training needed to ensure fidelity to evidence based practices and is the funding available to cover the cost of the necessary training?

In addition, evidence based practices need to be identified for some service setting, such as state psychiatric hospitals.

The identification of and fidelity to evidence based practices is an important step in the evolution of the mental health system. At the same time, the ultimate measure of the effectiveness of mental health services is an examination of outcomes. Efforts are underway at the federal level through SAMHSA's National Outcomes Measures program and at the state level to develop meaningful outcomes measurement systems. This work should be encouraged and closely monitored

9 Appendix

The figures on the following pages were referenced in Section 5 - Investment Analysis.

County	Episode of Service	SE 20 Adult Non-Residential/ SE 31 Enhanced Care	SE 25 Crisis Services	SE 28 Residential Treatment Services/ SE 34 Adult Foster Care	SE 29 Pre-Commitment Services	SE 30 Psychiatric Security Review Board (PSRB)	SE 35 Older & Disabled Adult MH Services	SE 36 PASARR	SE 39 Community Support for the Homeless Mentally Ill	Total	% Non-Medicaid v. Medicaid Episodes
Baker	Not Medicaid	226	87		3					316	53%
Baker	Medicaid	223	50	6	2					281	47%
Benton	Not Medicaid	93	71		72	1		2		239	33%
Benton	Medicaid	368	45	16	37	4		9		479	67%
Clackamas	Not Medicaid	604	200	9	461	1		21		1,296	38%
Clackamas	Medicaid	1,666	80	117	214	11	8	27		2,123	62%
Clatsop	Not Medicaid	206	167		12		8	1		394	47%
Clatsop	Medicaid	274	140	6	5		25	2		452	53%
Columbia	Not Medicaid	104	67		24	4				199	33%
Columbia	Medicaid	311	48	24	16	1		2		402	67%
Coos	Not Medicaid	87	47	1	71	2	2			210	20%
Coos	Medicaid	696	28	27	49	3	22			825	80%
Crook	Not Medicaid	172	98		7		2	1		280	57%
Crook	Medicaid	158	41	2	5		3	3		212	43%
Curry	Not Medicaid	55	87		5					147	34%
Curry	Medicaid	152	111	12	6	1				282	66%
Deschutes	Not Medicaid	418	534		209	3	105	56	18	1,343	54%
Deschutes	Medicaid	686	200	28	67	5	88	56	25	1,155	46%
Douglas	Not Medicaid	232	30	2	184	3				451	28%
Douglas	Medicaid	1028	33	14	80	7		5		1167	72%
Gilliam	Not Medicaid	24	2							26	57%
Gilliam	Medicaid	18	2							20	43%
Grant	Not Medicaid	103	105		2	1		1		212	70%
Grant	Medicaid	59	32					1		92	30%
Harney	Not Medicaid	24	25		1					50	36%
Harney	Medicaid	63	8	14	2					87	64%
Hood River	Not Medicaid	76	29		5					110	45%
Hood River	Medicaid	107	19	1	5	1				133	55%
Jackson	Not Medicaid	230	441	8	307	2		1	13	1,002	33%
Jackson	Medicaid	1,373	345	130	181	25	1	1	12	2,068	67%

Jefferson	Not Medicaid	251	68		4					323	63%
Jefferson	Medicaid	155	29	2	3	1				190	37%
Josephine	Not Medicaid	45	313		38			13		409	30%
Josephine	Medicaid	642	260	22	20	1		25		970	70%
Klamath	Not Medicaid	346	310	1	34					691	42%
Klamath	Medicaid	625	251	34	29	4				943	58%
Lake	Not Medicaid	41	14		3					58	46%
Lake	Medicaid	62	4					1		67	54%
Lane	Not Medicaid	924	316	8	285	5			47	1585	25%
Lane	Medicaid	4212	260	133	226	16	1		12	4860	75%
Lincoln	Not Medicaid	279	161	1	7	1				449	42%
Lincoln	Medicaid	487	119	2	9	7				624	58%
Linn	Not Medicaid	371	604		43	1				1019	39%
Linn	Medicaid	1289	285	11	18	2		2		1607	61%
Malheur	Not Medicaid	84	68		3	3		1		159	31%
Malheur	Medicaid	270	48	14		16				348	69%
Marion	Not Medicaid	709	1551	9	324	20	1	81	42	2737	37%
Marion	Medicaid	2926	982	223	219	47		240	123	4760	63%
Morrow	Not Medicaid	23	8		2					33	29%
Morrow	Medicaid	56	6	17	1					80	71%
Multnomah	Not Medicaid	4273	4575	18	2414	20	109	115	36	11560	47%
Multnomah	Medicaid	8523	2088	397	1371	98	117	272	78	12944	53%
Polk	Not Medicaid	155	179		49	1		20	1	405	34%
Polk	Medicaid	597	105	36	21			27	2	788	66%
Sherman	Not Medicaid	6	2							8	44%
Sherman	Medicaid	9		1						10	56%
Tillamook	Not Medicaid	248	74	1	21			1		345	55%
Tillamook	Medicaid	236	37	2	7			3		285	45%
Umatilla	Not Medicaid	145	180	3	13	1	1	10		353	36%
Umatilla	Medicaid	440	111	29	12	2		36		630	64%
Union	Not Medicaid	99	36	1	2			15		153	32%
Union	Medicaid	264	19	7	3			37		330	68%
Wallowa	Not Medicaid	54	17		2					73	34%
Wallowa	Medicaid	87	38	12	3					140	66%
Wasco	Not Medicaid	116	40		1			1		158	37%

Wasco	Medicaid	228	28	5	6			4		271	63%
Washington	Not Medicaid	2162	556	16	572	8			49	3363	53%
Washington	Medicaid	2512	142	82	198	25		2	9	2970	47%
Wheeler	Not Medicaid	12	3							15	79%
Wheeler	Medicaid	3	0	1						4	21%
Yamhill	Not Medicaid	236	203	1	18	1		8		467	32%
Yamhill	Medicaid	735	172	19	10			34		970	67.50%
Total	**Not Medicaid**	**13,233**	**11,268**	**79**	**5,198**	**78**	**228**	**348**	**206**	**30,638**	**41%**
Total	**Medicaid**	**31,540**	**6,166**	**1,446**	**2,825**	**277**	**265**	**789**	**261**	**43,569**	**59%**
Grand Total		**44,773**	**17,434**	**1,525**	**8,023**	**355**	**493**	**1,137**	**467**	**74,207**	
% of Total		**60.34%**	**23.49%**	**2.06%**	**10.81%**	**0.48%**	**0.66%**	**1.53%**	**0.63%**	**100.00%**	

County	PRTS A/E	Assessment & Evaluation	Case Management	Community Support Services	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Total
Baker		$1,232					$319							$1,551
Benton							$1,027		$239	$2,815				$4,082
Clackamas	$494	$3,086	$893	$46,511		$1,985	$7,538	$692	$6,777	$6,151		$3,656	$18,579	$96,409
Clatsop						$0				$594				$594
Columbia		$1,063	$133			$1,465	$15,293		$6,551	$2,279		$46,137		$72,920
Coos		$476	$2,466		$137	$884	$1,325		$971		$193	$2,354	$12,100	$20,966
Crook			$71					$122						$192
Curry		$778	$86			$779	$3,949	$351	$1,629			$12,459		$20,031
Deschutes		$3,225	$8,121		$177	$1,621	$6,039		$3,729			$52,184		$75,096
Douglas		$415			$451		$132	$66	$154	$3,686		$369		$5,362
Gilliam									$36					$36
Grant						$88						$743		$830
Harney		$1,498	$1,672			$2,228	$2,461	$4,571	$65			$26,556		$39,051
Hood River		$84							$291		$74,063	$2,953	$9,575	$86,966
Jackson							$602		$2,362	$2,022	$121,360	$26,444	$26,307	$179,098
Jefferson														$0
Josephine		$86					$96		$6,991	$11,492		$19,040		$37,705
Klamath		$173					$60	$30	$1,040			$8,428	$7,162	$16,893
Lane		$4,030	$611		$173	$1,792	$6,738	$191	$6,103	$414	$84,346	$50,472		$154,871
Lincoln		$2,815					$15,935		$2,578	$1,201		$218		$22,747
Linn		$131				$113	$436	$193	$304	$10,054		$17		$11,249
Malheur													$15,673	$15,673
Marion		$9,840	$1,470	$7,221	$488	$2,368	$9,851	$8	$11,306	$97,532	$180,653	$10,707	$1,176	$332,691

County	PRTS A/E	Assessment & Evaluation	Case Management	Community Support Services	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Total
Morrow		$335	$2,859		$1,065	$13,980	$14,733	$258	$4,649			$1,011		$38,890
Multnomah	$4,160	$18,375	$17,392	$12,837	$1,759	$22,627	$93,047	$3,644	$35,361	$134,046	$159,090	$425,749	$36,682	$967,077
Polk		$3,405	$1,431				$3,190		$3,305	$14,618	$182,746	$10,284		$219,283
Tillamook		$175	$231			$162		$324	$323			$3,921	$168	$5,305
Umatilla		$357	$240			$790	$2,904	$864	$418	$15,885		$1,576	$2,486	$25,519
Union		$88							$326	$141	$2,470	$990		$4,015
Wallowa		$1,177	$2,715		$250	$391	$3,631	$360	$8,921			$11,303		$28,748
Wasco		$3,271	$2,201			$913	$5,142	$2,009	$7,101	$3,612		$3,185		$27,529
Washington		$5,829	$2,892		$432	$2,533	$8,022	$3,068	$15,955	$33,799	$3,874	$44,267	$70,513	$191,185
Yamhill		$2,210	$3,703		$312	$333	$9,848		$5,202	$19,789	$478,797	$35,813	$2,520	$558,528
Total	**$4,654**	**$64,156**	**$49,189**	**$66,569**	**$5,244**	**$55,051**	**$212,318**	**$16,751**	**$132,686**	**$360,131**	**$1,287,593**	**$800,835**	**$202,941**	**$3,261,091**
% of Total	0.14%	1.97%	1.51%	2.04%	0.16%	1.69%	6.51%	0.51%	4.07%	11.04%	39.48%	24.56%	6.22%	100.00%

Data Source: Addictions and Mental Health Division, Program Analysis & Evaluation Unit

County	Assertive Community Treatment	Assessment & Evaluation	Case Management	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Wraparound Services
Baker		6				2							
Benton		1	4	1		6		2	8				
Clackamas	2	26	13		23	36	4	63	10		16	6	
Clatsop			1		1			1	1		1		
Columbia	1	10	2	2	16	18		19	3		20		
Coos		5	11	3	4	6		12		1	7	1	
Crook			2			1	1	1			1		
Curry		9	1		6	11	3	11			13		
Deschutes		13	15	1	10	15		20			20		
Douglas		2	1	3	1	3	1	3	23		2		
Gilliam								1					
Grant			1	1	1						1		
Harney		13	17		14	15	16	1			22		11
Hood River		1		2				5		14	5	4	
Jackson		3	6	2	7	19		26	5	16	23	10	
Jefferson		1				1							
Josephine		3	1			1		15	16		12		
Klamath		3	3	1	1	2	1	16			15	3	
Lane	1	35	9	3	21	53	15	48	1	18	61		
Lincoln		15				66		15	2		1		
Linn		1	2	1	1	9	1	1	32		1		
Malheur					1	1					1	4	
Marion		70	21	11	35	60	3	79	139	25	63	7	8

County	Assertive Community Treatment	Assessment & Evaluation	Case Management	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Wraparound Services
Morrow		4	14	7	14	15	4	13			12		
Multnomah	14	171	136	23	151	251	15	249	229	20	239	15	1
Polk		27	15	5	2	15		26	20	24	28		
Tillamook		2	2		2		2	3			4	1	
Umatilla		6	4		7	11	10	5	31		10	1	
Union		1	5		1	4		7	1	14	8		
Wallowa	3	15	22	3	6	26	2	26			32		
Wasco	1	13	13		7	15	7	18	5		14		
Washington		36	31	8	23	46	28	49	58	16	53	8	
Yamhill	1	12	20	3	4	35		32	28	36	28	15	3
Total	**23**	**504**	**372**	**80**	**359**	**743**	**113**	**767**	**612**	**184**	**713**	**75**	**23**

County	Assertive Community Treatment	Assessment & Evaluation	Case Management	Community Support Services	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Interpretive Services	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Wraparound Services	Total
Baker		75					5									80
Benton		1	27		1		6			2	8					45
Clackamas	24	26	65	202		23	64	7		127	10		197	6		757
Clatsop			1			1				1	1		8			12
Columbia	3	10	2		2	16	549			109	3		2,981			3,681
Coos		5	24		3	8	10			57		1	139	87		356
Crook			3				1	1		4			2			11
Curry		9	1			18	34	3		34			344			443
Deschutes		13	56		1	14	207			46			1,383			1,720
Douglas		2	2		3	1	7	1		3	23		26			69
Gilliam										1						1
Grant			1		1	7							37			46
Harney		62	54			158	69	82		1			1,326		89	1,841
Hood River		1			2					5		572	360	4		944
Jackson		3	33		7	7	27			62	5	1,268	289	10		1,712
Jefferson		1					3									4
Josephine		3	7				1			145	16		432			605
Klamath		4	32		1	1	7	1		23			387	3		461
Lane	12	49	22		3	21	198	15		120	1	887	2,461			3,789
Lincoln		26					66			15	2		17			128
Linn		1	6		1	1	38	1		1	32		1			88
Malheur						1	1						1	4		8

County	Assertive Community Treatment	Assessment & Evaluation	Case Management	Community Support Services	Family Therapy	Group Therapy	Individual Therapy	Individual Therapy w/ Med Management	Interpretive Services	Medication Management	PASRR	Residential Rehabilitation	Skills Training	Treatment Foster Care	Wraparound Services	Total
Marion		84	50	36	11	41	82	3	9	210	139	1,282	371	7	26	2,365
Morrow		6	142		8	110	82	4		57			95			504
Multnomah	93	232	324	64	25	339	2,637	37	70	545	229	1,702	26,564	15	5	32,934
Polk		29	39		5	2	163		22	40	20	1,318	328			1,977
Tillamook		2	5			6		2		3			253	1		272
Umatilla		6	4			7	124	10		17	31		93	1		293
Union		1	10			1	4			7	1	14	83			121
Wallowa	32	37	22		6	6	129	8		215			657			1,112
Wasco	6	36	35			21	64	21		114	5		256			559
Washington		77	55		11	37	325	28		441	58	32	1,674	8		2,748
Yamhill	1	39	45		16	4	251			74	28	2,985	602	15	9	4,069
Total	**171**	**840**	**1,067**	**302**	**107**	**851**	**5,154**	**224**	**101**	**2,479**	**612**	**10,061**	**41,367**	**161**	**129**	**63,755**