

OREGON HEALTH AUTHORITY

2015–2018 BEHAVIORAL HEALTH STRATEGIC PLAN

Oregon
Health
Authority

ADDICTIONS AND MENTAL HEALTH DIVISION

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2015–2018 BEHAVIORAL HEALTH STRATEGIC PLAN

Forward

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This strategic plan represents a shared vision for building and expanding an integrated, coordinated and culturally competent behavioral health system that provides better health, better care and lower cost for all Oregonians. This plan grew out of a collaboration among the Oregon Health Authority, consumers and families, advocates, peer organizations, health providers, county and city governments, tribes, local law enforcement, community mental health programs, coordinated care organizations, and many other stakeholders. Through a series of town hall meetings, these interested parties discussed how to best align behavioral health services with Oregon's health system transformation efforts.

During these discussions, we heard some common themes. Our stakeholders told us that we must ensure that all Oregonians get:

- **The right care** – Behavioral health care should be culturally appropriate, person-centered and trauma-informed;
- **In the right place** – People should have access to behavioral health services regardless of where they live, and they should receive services in their community whenever possible, keeping people out of emergency departments and the state hospital who do not need to be there;
- **At the right time** – In addition to making sure that appropriate services are available when people need them, we must strive to catch illnesses early and prevent behavioral conditions from developing in the first place, through promotion and early intervention, especially with children, youth and families.

Based on these meetings, we developed this strategic plan that will guide our work for the next three years. It has a clear emphasis on health equity and access to care, behavioral health promotion and prevention, and supporting successful recovery in the community. Through the 2015–2018 Behavioral Health Strategic Plan, the Oregon Health Authority, specifically the Addictions and Mental Health Division (AMH), renews its commitment to improving the lives of some of Oregon's most vulnerable citizens and gives us the framework for how to achieve these goals.

Contributors

In 2014 the Oregon Health Authority hosted a series of events designed to solicit input from a wide range of behavioral health stakeholders. In six regional town hall meetings, stakeholders were asked to respond to four questions related to the challenges and strengths of the current behavioral health system, the role of the state in the delivery of behavioral health care, and the guiding principles and values underpinning services and supports. OHA also hosted a tribal consultation, a webinar and an AMH all-staff town hall meeting. OHA identified key themes emerging from all of the discussions to guide the development of the strategic initiatives and their underlying goals.

AMH is also guided by three formal advisory groups: The AMH Planning and Advisory Council (mandated by the federal block grants), the Oregon Consumer Advisory Council, and the Children’s System Advisory Committee. In addition, Oregon State Hospital has the Oregon State Hospital Advisory Board, whose members are appointed by the Governor. Links to the Web pages for each of these advisory groups are in Appendix A.

To finalize the plan and ensure it is aligned with the vision for health system transformation, OHA convened a work group of behavioral health stakeholders who met during September and October 2014.

Behavioral Health Strategic Plan Work Group

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Executive summary

This strategic plan reflects the voices of Oregonians from communities across the state who shared their top behavioral health care priorities. More than 500 people helped create a shared vision for building and expanding an integrated, coordinated and culturally competent behavioral health system. The Oregon Health Authority (OHA) and its Addictions and Mental Health Division (AMH) received input through a series of regional town hall meetings, advisory meetings, a tribal consultation, a webinar and written feedback. The information gathered demonstrates the need for strategic initiatives aimed at improving behavioral health care throughout Oregon.

The impact of addictions and mental illness in Oregon

Substance use disorders, gambling disorders and mental illness carry widespread physical, social and financial consequences for individuals, their families and communities. These problems result in billions of dollars each year spent on health care for preventable illnesses, the criminal justice and social welfare systems. There are the measureable costs, such as lost wages and homelessness, as well as the immeasurable human cost of lost potential and lost opportunity.

Behavioral health issues are a major public health concern nationally and in Oregon. It is estimated that in between 2011 and 2012, 21 percent of all adults (18 and older) dealt with mental illness, and 4.6 percent had a severe and persistent mental illness.¹ The estimated prevalence for children with serious emotional disorders is tied to a state's poverty rate; for Oregon, it was estimated that 6–12 percent of all kids ages 9–17 would experience serious emotional disorders in 2013.²

Substance use disorders remain a serious problem in Oregon. During any one-year period from 2008 to 2012, approximately 283,000 people aged 12 or older were dependent on or misused alcohol; 123,000 people aged 12 or older were dependent on or misused illicit drugs within the year prior to the survey.³ Oregon has made significant progress in reducing unintentional and undetermined drug overdose deaths; the rate declined from 11.4 per 100,000 people in 2007 to 8.9 per 100,000 people in 2012. However, the rate of overdose death in 2012 was four times higher than in 2000.⁴

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1. Center for Behavioral Health Statistics and Quality. (2013). Behavioral health, United States, 2012. Retrieved from www.samhsa.gov/data/sites/default/files/2012-BHUS.pdf.
 2. Substance Abuse and Mental Health Services Administration. HHS Publication No. SMA 13-4707. Rockville, MD: Retrieved from www.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf.
 3. Prepared by NRI/SDICC for CMHS: September 17, 2012.
 4. Substance Abuse and Mental Health Services Administration. (2013). Behavioral health barometer: Oregon, 2013. HHS Publication No. SMA-13-4796 OR. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Improving behavioral health care in Oregon

Oregon's health care transformation has changed how health care is conceptualized, managed, delivered and financed here. The number of people eligible for Medicaid-funded health services has significantly increased. Prevention, treatment and recovery services have a solid evidence base on which to build a system that promises better outcomes for people who have been diagnosed with or who are at risk for mental illness, substance use, gambling disorders and co-occurring disorders.

In order to align behavioral health care with the goals of health care transformation in Oregon (better health, better care and reduced cost), and to respond to the needs articulated by stakeholders in every community, the strategic plan will focus on these areas:

- ◇ Prevention and promotion;
- ◇ Early intervention services;
- ◇ Behavioral health crisis and treatment services;
- ◇ Recovery support and recovery-oriented systems of care;
- ◇ Trauma-informed care;
- ◇ Innovative and flexible services;
- ◇ Health equity and health disparities;
- ◇ AMH internal transformation to support the strategic plan.

Oregon's behavioral health system

Oregon's behavioral health system uses federal, state and local dollars to provide mental health and addiction services.

Medicaid/Oregon Health Plan – For people on the Oregon Health Plan, behavioral health services are covered by their coordinated care organizations if the services are covered by Medicaid. By integrating behavioral and physical health care for their members, coordinated care organizations are better able to treat the whole person, resulting in improved health outcomes. As the state continues to expand the coordinated care model, coordinated care organizations are assuming responsibility for more behavioral health services, such as treatment for substance use disorders and mental health residential treatment.

Local mental health authorities typically are composed of the local board of county commissioners that is responsible for the management and oversight of the community's public system of care for mental illness, intellectual and developmental disabilities, and substance use disorders. Local mental health authorities manage local funding and resources, and they plan, develop, implement and monitor services within their area to ensure consumers are experiencing the expected improvements in health outcomes.

Community mental health programs provide care coordination and treatment for people with mental illness, intellectual or developmental disabilities, and substance use disorders. Core services include screening, assessment and referral to providers and community organizations, as well as emergency or crisis services. All members of a community can access core services from community mental health programs, subject to the availability of funds. These safety net and crisis services play a key role in the overall behavioral health system.

The Addictions and Mental Health Division (AMH) is part of the Oregon Health Authority. AMH's mission is to help Oregonians achieve optimum physical, mental and social well-being by providing access to addiction and mental health services and supports to meet the needs of adults and children to live, learn, work and fully participate in their communities. This mission is accomplished by partnerships with service users and their families, cities, counties, other OHA divisions, state agencies, coordinated care organizations, providers, advocates and stakeholders. AMH is pursuing this mission at a time of significant transformation in Oregon's publicly funded health care system.

In the current biennium, AMH has a budget of \$980 million and employs approximately 2,200 people. More than 90 percent of its employees provide care and support services at Oregon State Hospital. The division makes services available through contracts with community providers and state-operated facilities, including:

- Thirty-six community mental health programs;
- Sixteen coordinated care organizations;
- Two Oregon State Hospital campuses; and
- One state-run secure residential treatment facility.

AMH is active in prevention. More than 275,000 Oregonians participated in community prevention or treatment services for behavioral health conditions in the 2011–2013 biennium. In addition, professionals work to prevent disorders in Oregon youth (ages 10 to 25). Prevention professionals work with community partners throughout the state to limit youth access to gambling, alcohol and other drugs. They also foster community environments that support behavioral health and individuals' ability to withstand challenges.

Oregon State Hospital provides an essential service to Oregonians who need long-term, hospital-level care that cannot be provided in the community. For adults needing intensive psychiatric treatment for severe and persistent mental illness, the hospital provides 24-hour on-site nursing and psychiatric care, credentialed professional and medical staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services. The hospital's role is to restore patients to a level of functioning that allows a successful transition back to the community.

The state hospital campuses are located in Salem and Portland. Their combined capacity is 659 adults. The hospital provides inpatient services to people who have been civilly committed or judged guilty except for insanity or who require assessment and treatment for their ability to assist in their own defense. In 2015, the hospital will open a new campus in Junction City and close the Portland facility.

New investments in 2013

In 2013, Governor Kitzhaber and the Legislature made an unprecedented investment in mental health services, with almost \$40 million going to the community mental health system. The budget identifies specific services and system expansions that focus on promoting community health and wellness, keeping children healthy and helping adults with mental illness live successfully in the community. During the September 2013 special session, the Legislature increased the cigarette tax to fund community mental health services by an additional \$20 million during the 2013–2015 biennium.

The new investments filled gaps and provided an opportunity for the Addictions and Mental Health Division to work with both established and new partners as the system adapts to the changing landscape of behavioral health and the implementation of coordinated care organizations.

Strategic initiatives

Six strategic initiatives will focus attention and resources in the areas of greatest need and opportunity in Oregon. These initiatives will guide behavioral health efforts from 2015 through 2018. The overarching goal of these initiatives is to improve the lives of all Oregonians, as well as those in need of behavioral health services and their families. These initiatives are designed to promote healthy communities using cost-effective and timely interventions.

The strategic initiatives are consistent with the triple aim of Oregon's health system transformation:

1. Better health – improve the lifelong health of all Oregonians;
2. Better care – increase the quality, reliability and availability of care for all Oregonians;
3. Lower cost – reduce or contain the cost of care so it is affordable for everyone.

Each goal has strategies and measures for success. The strategies will guide AMH in setting policy and budget priorities, collaborating with partners and measuring outcomes.

Strategic plan outline

- 1. Health equity exists for all Oregonians within the state's behavioral health system.**
 - 1.1. Promote health equity and eliminate avoidable health gaps and health disparities in Oregon's behavioral health care system.
 - 1.2. Target and treat common chronic health conditions faced by people with severe and persistent mental illness, substance use disorders and co-occurring disorders.
- 2. People in all regions of Oregon have access to a full continuum of behavioral health services.**
 - 2.1. Increase equitable access to culturally and linguistically appropriate prevention, treatment and recovery services and supports in underserved areas of the state.
 - 2.2. Expand access to crisis services in all areas of the state.
 - 2.3. Expand statewide access to Medication-Assisted Treatment.

3. The behavioral health system promotes healthy communities and prevents chronic illness.

- 3.1. Ensure all Oregonians have access to prevention and early intervention programs that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels.
- 3.2. Increase the availability of physical health care professionals in behavioral health care settings.
- 3.3. Develop and enhance programs that emphasize prevention, early identification and intervention for at-risk children and families.
- 3.4. Strengthen the prevention, screening and treatment of the psychological, physical and social impacts of early childhood and lifespan trauma.

4. The behavioral health system supports recovery and a life in the community.

- 4.1. Increase access to safe, affordable housing for people in recovery.
- 4.2. Provide supported employment services to people in recovery.
- 4.3. Reduce the stigma related to addictions and mental health through partnerships with people in recovery and their families.
- 4.4. Provide recovery support services, including those that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels, to people who are transitioning out of substance use disorder treatment and gambling disorder treatment as part of their continuing care plan to support ongoing recovery.
- 4.5. Improve the existing recovery-oriented system of care for people transitioning from residential to outpatient treatment for substance use disorders.

5. Only people who meet admission criteria are admitted to Oregon State Hospital, and admissions and discharges are performed in a timely manner.

- 5.1. Reduce or eliminate the waiting list for services at Oregon State Hospital.
- 5.2. Reduce the length of stay for patients who are civilly committed to Oregon State Hospital.
- 5.3. Discharge patients who are civilly committed within 30 days of being determined “ready to place” or “ready to transition” by their treatment teams.
- 5.4. Decrease the number of people who are admitted to Oregon State Hospital under ORS 161.370 for misdemeanors.

6. Addictions and Mental Health Division operations support the strategic plan.

- 6.1. Align AMH's structure to support the strategic plan, improve quality management and streamline the development of behavioral health policy.
- 6.2. Pursue an integrated approach to the collection, analysis and use of data.

The guiding principles reflected in the goals and strategies are:

- The full spectrum of behavioral health is applied – promotion, prevention, treatment and recovery.
- The recovery model is followed – “People get better. People recover.”
- Care is consistent with standards for culturally and linguistically appropriate services.
- Health care disparities are addressed.
- Behavioral health care is self-directed.
- Families are supported and involved.
- Diverse community outreach, engagement and collaboration are essential for success.
- Geography affects access and is a key factor in statewide planning.
- Care is based on evidence-based practices, promising practices and traditional culturally based practices.

Initiative 1

Health equity exists for all Oregonians within the state's behavioral health system.

Goal 1.1: Promote health equity and eliminate avoidable health gaps and health disparities in Oregon's behavioral health care system.

Background and importance

Health equity is the attainment of the highest level of health for all people. Many Oregonians are unable to attain their highest level of health because of cultural, language and other communication barriers. When the health care system is not responsive to the cultural needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes. In order to create a responsive, inclusive and equitable system of care, AMH will make investments in resources to reduce health disparities and pursue health equity in the behavioral health care system.

Cultural, linguistic and communication barriers can lead to increased health disparities. Research demonstrates that language barriers between patient and provider create problems such as delay or denial of services, issues with medication management, underuse of preventive services and increased use of emergency services. Racial and ethnic minorities have higher prevalence of chronic health conditions, higher mortality rates and less access to care than the general population.

Measures of success:

- Increased access and treatment completion among racial and ethnic behavioral health patient populations;
- Increased number of goals, policies and benchmarks integrated throughout the behavioral health systems that are directly linked to culturally and linguistically appropriate service standards;
- Increased knowledge and demonstration of cultural responsiveness among AMH staff;
- Increased racial and ethnic representation on AMH councils and committees.

Strategies:

1. AMH will gather feedback from communities and specific cultural populations to inform policy development to support health equity in the behavioral health care system.
2. AMH will collaborate with the Office of Equity and Inclusion on the implementation of a comprehensive civil rights policy and a procedure for taking reports of discrimination from service recipients, including tracking and monitoring for systemic issues.
3. AMH will revise contract language and Oregon Administrative Rules to institutionalize commitment to a behavioral health system that promotes equity and reflects current civil rights and protections.
4. AMH will conduct an Intercultural Effectiveness Scale Assessment with AMH staff.
5. AMH will use diversity development best practices in recruiting, hiring and retaining culturally diverse employees and in performance management, contracting and procurement.
6. AMH will develop and implement a health equity education and training plan for all AMH staff.

Over the next five years, AMH will partner with the OHA Office of Equity and Inclusion, Public Health Division, Division of Medical Assistance Programs, and both existing and new community partners and consumers to seek opportunities to support the health care needs of an increasingly diverse population. A key component to success in this area will be the development of a diverse work force. This strategy includes encouraging targeted programs at colleges and universities as well as the expanded use of traditional health workers in all health care settings.

Goal 1.2: Target and treat common chronic health conditions faced by people with severe and persistent mental illness, substance use disorders and co-occurring disorders.

Background and importance

People with severe and persistent mental illness die an average of 25 years earlier than the general population.⁵ This is a serious public health problem for the people served by our public mental health system. The increased mortality rates in this population are largely due to preventable conditions such as cardiovascular, respiratory and infectious diseases.

A number of factors place people with severe and persistent mental illness, substance use disorders and co-occurring disorders at higher risk of sickness or death, including higher rates of smoking, alcohol consumption, poor nutrition, obesity and lack of exercise. In addition, antipsychotic medications have become associated with weight gain, diabetes, high cholesterol, insulin resistance and metabolic syndrome.⁶ Lack of access to appropriate health care and lack of coordination among behavioral health and general health care providers compound these factors.

Measures of success:

- Establishment of a baseline indicating the difference in mortality rates between the general Medicaid population and people with severe and persistent mental illness, substance use disorders and co-occurring disorders;
- Decreased prevalence of risk factors and chronic health conditions in people with severe and persistent mental illness, substance use disorders and co-occurring disorders;
- Increased access to integrated physical and behavioral health care in patient-centered primary care homes;
- Increased availability of traditional health workers.

5. Oregon Health Authority, Public Health Division. (2014). Retrieved from <http://public.health.oregon.gov/PHD/ODPE/IPE/Pages/index.aspx>.

6. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2006). Morbidity and mortality in people with serious mental illness. Alexandria, VA: National Association of State Mental Health Program Directors.

Strategies:

1. AMH will collect, analyze and report on the mortality rates of people with severe and persistent mental illness compared to the general Medicaid population.
2. Under the guidance of the OHA chief medical officer, AMH will facilitate the development of certification standards for behavioral health homes and promote the integration of primary care services in behavioral health settings.
3. AMH will promote a culture of wellness by partnering with Public Health, residential and outpatient service providers, and consumers to actively address tobacco use, beginning with individuals living in residential settings.

Partnerships across systems are critical for reaching the goal of health equity for people with multiple health challenges. For example, AMH and Public Health have a number of joint initiatives focusing on tobacco prevention and cessation for youth, young adults aged 18–25 and individuals living in mental health residential settings. Information sharing and the enforcement of tobacco laws are coordinated across many agencies, including OHA, the Department of Justice and the Oregon Liquor Control Commission.

Initiative 2

People in all regions of Oregon have access to a full continuum of behavioral health services.

Goal 2.1: Increase equitable access to culturally and linguistically appropriate prevention, treatment and recovery services and supports in underserved areas of the state.

Background and importance

Oregon has experienced a significant increase in access to health care coverage through the expansion of Medicaid under the Affordable Health Care Act. In addition, the Legislature in 2013 made an unprecedented investment in the expansion of mental health services to provide increased availability of services for individuals without health care coverage and for services not covered by Medicaid. Both initiatives provide the opportunity for more Oregonians to access behavioral health services.

To take full advantage of these opportunities, we need to better define a structure for the behavioral health care delivery system that ensures access throughout Oregon, with particular attention to rural and frontier regions. These regions of Oregon struggle to find the human resources and infrastructure to support a basic array of behavioral health services. While recent investments in mental health services have improved the availability of behavioral health services for many, further funding of the non-Medicaid behavioral health system is necessary to reach all Oregonians.

Measures of success:

- Increased use of behavioral health services in all Oregon counties;
- Expanded service array due to 2013–2015 investments in behavioral health;
- Increased availability of tribal mental health services;
- Increased number of culturally and linguistically specific prevention, treatment and recovery services and supports.

Strategies:

1. AMH will collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.
2. AMH will work with coordinated care organizations, the OHA Transformation Center, community mental health programs, local mental health authorities and other partners to develop strategies to encourage and facilitate regionalization of behavioral health services in rural and frontier regions.
3. AMH will work the Oregon Health & Science University OPAL-K program, the OHA Transformation Center and others to identify strategies to develop the infrastructure and expand telehealth psychiatric services in rural and frontier regions of Oregon.
4. AMH will work with Public Health to develop more on-site behavioral health services in schools.
5. AMH will collaborate with tribes to revise the approval process for tribal behavioral health services to support them in providing culturally responsive services.

Several positive factors contributed to the coordination of behavioral health services in Oregon communities in 2014. Coordinated care organizations and community partners made strides in identifying community needs and coordinating services with a variety of partners from the counties, criminal justice system, judicial system, education and social services. The Legislature also made significant investments in behavioral health that have greatly increased capacity in many areas (see Appendix B).

Over the next several years, AMH will monitor the impact of the enhanced service array and use of services statewide. This will be accomplished through contractually required reporting by programs and monitoring the AMH data dashboard developed to track use and costs of both Medicaid and non-Medicaid services. A similar data dashboard was developed for Medical Assistance Programs.

Over the next several years, AMH will collaborate with internal and external partners to look for practical, long-term solutions to bring a set of basic services to all communities. Solutions are likely to include the use of traditional health workers, natural supports, telehealth, mobile units and schools. In all cases, engaging with both the private and public health systems will be imperative.

Goal 2.2: Expand access to crisis services in all areas of the state.

Background and importance

A responsive crisis system provides the necessary intervention and supports that reduce the likelihood of hospitalization or incarceration. Several of the recent investments in the behavioral health system are aimed at strengthening the crisis system. Recent investments in mobile crisis services and jail diversion programs provide timely behavioral health interventions in the community that decrease the need for hospitalization and avoid incarceration. The expansion of Assertive Community Treatment teams provides necessary supports for adults with severe and persistent mental illness, reducing the need for crisis interventions.

Emergency departments, medical units and correctional facilities are increasingly used to “board” Oregon youth who face primary mental health challenges. Adults, youth and children sometimes spend several days in an emergency department waiting for a psychiatric acute care bed to become available. This misuse of emergency care appears to relate to a range of issues including access and coordination of care challenges. Improving access to timely routine care and intensive outpatient care may prevent the need for higher levels of care.

Measures of success:

- Reduced number of emergency department visits for psychiatric services for individuals who are enrolled in the Oregon Health Plan;
- Decreased number of youth aged 0–17 seen in emergency departments for psychiatric reasons;
- Reduced lengths of stay in emergency departments for youth and adults with primary mental health diagnoses;
- Reduced criminal justice involvement for children engaged in fidelity-based Wraparound planning process.

Strategies:

1. AMH will lead a task force of key providers and make recommendations designed to prevent the use of emergency departments, pediatric units or correctional facilities for primary intervention in the absence of effective treatment services.
2. AMH will engage a consultant to assess and advise it on improvements in the statewide crisis system.
3. AMH will propose additional behavioral health crisis funding to support new and existing promising practices.
4. AMH will work with the OHA Health Information Team to develop a notification system so that coordinated care organizations know when their members are in emergency departments or pediatric units and are unable to return home due to safety concerns.
5. AMH will develop more diversion services that can respond to youth and families for more safe transitions to home.
6. AMH, the Department of Human Services and the Oregon Youth Authority will collaborate to increase the number of community justice and Oregon Youth Authority-involved youth participating in a fidelity-based wraparound planning process.

For children, youth and families, DHS Child Welfare and AMH will participate in a state-level steering committee to address regional barriers and to ensure that local systems of care can adequately plan for and serve children with significant and complex health care needs. For example, AMH is actively involved in developing the new family system navigators that will be part of the child welfare system. AMH, Medical Assistance Programs, Department of Human Services and Oregon Youth Authority are all participating in designing behavior rehabilitation services. AMH will continue to work closely with the coordinated care organizations, Department of Human Services, Oregon Youth Authority and others to increase the number of children and youth who have access to wraparound services.

Goal 2.3: Expand statewide access to Medication-Assisted Treatment.

Background and importance

Oregon ranks high among the states for the non-medical use of prescription opioid medications. Increasingly restrictive prescribing guidelines and increased access to heroin has resulted in a growing number of Oregonians becoming opioid-dependent. Addiction carries a high societal and medical cost, including increased criminal justice and Child Welfare involvement, overdoses, hospitalization and death. Intravenous drug use also increases the risk of the spread of infectious diseases. Medication-assisted treatment, combined with therapeutic services and psychosocial

supports, is an evidence-based practice considered the most effective for the treatment of opioid dependence.

Measures of success:

- Increased percentage of individuals with opioid dependence accessing medication-assisted treatment;
- Increased treatment retention among those individuals newly accessing medication-assisted treatment;
- Increased number of physicians providing medication-assisted treatment.

Strategies:

1. AMH will work directly with the Transformation Center and Public Health to create an opioid task force composed of stakeholders from a variety of OHA divisions, prescribers, treatment providers and other important parties.
2. AMH will provide education and resources to coordinated care organization representatives, community groups and health care providers on policies and best practices related to opioid dependence and treatment.
3. AMH will engage residential treatment providers to increase use of medication-assisted treatment in residential treatment.
4. AMH will collaborate with the OHA chief medical officer to increase the availability of physicians licensed to prescribe buprenorphine (an opioid used to treat addiction) and similar medications in all regions of Oregon.
5. AMH will provide education on best practices and integrating therapeutic services with medication-assisted treatment in physical health care settings.
6. AMH will collaborate with OHA Public Health and Pharmacy Services to increase availability of overdose-reversal medications such as Naloxone.

Opioid overdose affects Oregonians of all ages. AMH and Public Health will focus on work that will immediately increase the availability of medication-assisted treatment and promote the wide dissemination of medication that saves lives following overdose. At the same time, AMH will join with Public Health, the OHA Transformation Center, providers and communities to develop long-term prevention and treatment strategies to address this problem, which is statewide and national in scope.

Initiative 3

The behavioral health system promotes healthy communities and prevents chronic illness.

Goal 3.1: Ensure all Oregonians have access to prevention and early intervention programs that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels.

Background and importance

AMH provides prevention funding to all 36 counties and nine federally recognized tribes using Substance Abuse Prevention and Treatment Block Grant funds. The Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention requires that block grant funds be spent in each of the six strategy areas. Those requirements are passed along to the prevention providers.

Prevention – keeping youth from beginning to use alcohol and drugs – and early intervention in substance use disorders must be priorities if we are to curb the state’s lifespan rates of misuse and dependence. With Oregon’s eye on reducing the costs of health care, now is the time to invest in pre-treatment prevention and health promotion to achieve long-term reductions in misuse and dependence rates.

AMH provides leadership for the state in prevention messaging. AMH provides consistent, up-to-date information about emerging issues with timely and targeted messages about issues such as underage, high-risk and binge drinking, prescription drug misuse and social norming campaigns.

Measures of success:

- Increased number of biennial implementation plans that include strategies in all six Center for Substance Abuse Prevention areas;
- Increased accuracy in collecting and reporting prevention data using the prevention data collection system;
- Decreased use of alcohol, tobacco and other drugs as measured through existing statewide student and adult surveys.

Strategies:

1. AMH will revise implementation plan guidelines to include strategy requirements and communicate the requirements to prevention coordinators.
2. AMH will continue to develop and implement the “mORe” campaign, which offers resources to Oregon communities to support a statewide “positive community norms” effort to reduce teenage alcohol use.

Goal 3.2: Increase the availability of physical health care professionals in behavioral health care settings.

Background and importance

People with behavioral health conditions often do not receive adequate physical health care. The reasons for this include barriers such as difficulty navigating multiple systems, lack of transportation, lack of child care, and other factors. People facing any of these barriers may be more likely to access physical health care in an integrated setting. A behavioral health home offers the convenience and comfort of a trusted environment where services are coordinated and delivered in a single visit. Behavioral health homes are created when behavioral health facilities and agencies also provide primary care services.

Over the next two years, AMH will focus on tracking health status, promoting an optimal level of health care and creating the option of behavioral health homes for those people who will benefit from having their primary health care delivered where they receive behavioral health services. The work on behavioral health homes is going forward with a grant from the Centers for Medicare and Medicaid Services, OHA staff across divisions and a group of pioneering providers. At the same time, the OHA Transformation Center is working on a learning collaborative with providers and other projects to promote the integration of physical, behavioral and oral health care services. The Department of Human Services is participating on OHA’s task force to address access to physical and behavioral health care for children and youth receiving behavioral rehabilitation services. The goal for the entire system is to provide fully integrated care for all Oregonians.

Measures of success:

- Decreased chronic conditions and early death rates among people diagnosed with chronic behavioral health conditions;
- Increased percentage of people diagnosed with chronic behavioral health conditions who receive physical health care services in a behavioral health home or patient-centered primary care home;
- Decreased emergency department admissions related to physical conditions of those diagnosed with chronic behavioral health conditions.

Strategies:

1. AMH and OHA will sponsor and facilitate a behavioral health home learning collaborative. It will identify and reduce barriers to integration of physical health care providers in behavioral health homes and share best and promising practices.
2. AMH, under the guidance of the OHA chief medical officer, will standardize the certification requirements for behavioral health homes.

Goal 3.3: Develop and enhance programs that emphasize prevention, early identification and intervention for at-risk children and families.

Background and importance

New science is constantly emerging that reinforces the importance of early childhood development. According to the World Health Organization, early childhood is the most important time in overall development. Brain and biological development during the first years of life are highly influenced by an infant's environment. Early experiences determine health, education and economic participation for the rest of life.

Mental health promotion includes universal preventive interventions such as parenting education, support for growing families and creation of healthy communities and environments for children. Risk factors can be addressed before they become problematic and mitigate the need for early intervention or treatment. During the first years of a child's life, there are opportunities across systems (primary care, hospitals, early learning and behavioral health) for screening and early intervention. In a coordinated system of care, at-risk families with young children would be routinely identified and served by the appropriate entity. An effective early childhood system of care would identify, coordinate, serve and reduce risk factors for families with young children.

Measures of success:

- Increased provision of mental health services to children ages 0–5;
- Increased number of mental health professionals certified in an early childhood evidence-based or promising practice.

Strategies:

1. AMH will develop core competencies, including cultural competencies, for early childhood mental health service providers.
2. AMH will disseminate and fund mental health best practices for young children ages 0–5 in collaboration with Medical Assistance Programs and the Department of Human Services.
3. AMH will track consultation and treatment activities mandated by early and periodic screening, detection and treatment (EPSDT).
4. AMH will expand the use of prenatal maternal depression and substance use disorder screening and treatment.

Goal 3.4: Strengthen the prevention, screening and treatment of the psychological, physical and social impacts of early childhood and lifespan trauma.

Background and importance

In the Adverse Childhood Experiences study by Kaiser Permanente and the Centers for Disease Control and Prevention, researchers identified strong, graded relationships between exposure to childhood traumatic stressors and numerous negative health behaviors and outcomes, health care utilization and overall health status later in life among adult respondents. For example, people who had experienced four or more categories of childhood exposure had four to 12 times the health risks for alcoholism, drug misuse, depression, and suicide attempts compared to those who had experienced none.⁷

Most adverse experiences in the early years go unresolved. Unresolved traumatic experiences are highly correlated with the development of behavioral health conditions. The federal services reports that a significant number of people who receive mental health and addictions services have experienced traumatic events. Ninety percent of public mental health clients have been exposed to traumatic events.

Although some people develop mental illness in adulthood, more often the onset of severe emotional and behavioral disorders occurs in childhood and interferes with critical periods of development during childhood and adolescence. The onset of mental illness in adolescence often has a long-term impact on the individual's capacity to function as an adult. The presence of adverse childhood experiences greatly increases the likelihood of a mental illness or substance use disorder.

7. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences Study. *American Journal of Preventive Medicine*, 14 (4).

Measures of success:

- Increased number of behavioral health professionals trained to provide treatment to children ages 0–5;
- Increased trainings on adverse childhood experiences and trauma-informed care provided to physical health, behavioral health and helping professionals;
- Increased number of organizations that have a trauma-informed care policy that aligns with AMH’s trauma-informed care policy;
- A process developed to measure and implement screening, assessment and treatment services for depression in mothers of young children.

Strategies:

1. AMH will create professional development opportunities to increase proficiency in providing treatment services to families with children ages 0–5.
2. AMH will contract with Portland State University, in partnership with Oregon Health & Science University and the Department of Human Services, to form a collaborative called Trauma-Informed Oregon.
3. AMH will work with Public Health and coordinated care organizations to develop a screening and treatment protocol for mothers of young children in primary care settings.
4. AMH will disseminate the trauma-informed care policy to all community mental health programs and their service contractors.
5. OHA will provide more training in trauma-informed care to health care, behavioral health care and other helping professionals.
6. AMH will promote and provide training on the use of wellness recovery action plans for adults who receive and provide behavioral health services.

Initiative 4

The behavioral health system supports recovery and a life in the community.

Goal 4.1: Increase access to safe, affordable housing for people in recovery.

Background and importance

Safe and affordable housing is essential for the recovery process, but it is not always readily available. Individuals with severe and persistent mental illness often depend on Supplemental Security Income, which is not enough to cover rent and other living expenses.

Affordable apartments are in short supply statewide. People in recovery may have difficulty securing and maintaining housing if support services are not available. Landlords may be reluctant to rent to them despite fair housing laws. These factors can overwhelm people who end up cycling between jails, institutions and homelessness.

The Substance Abuse and Mental Health Services Administration defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. Its definition of recovery lists four dimensions that support life in recovery: health, home, purpose and community. The lack of a home and the stability it offers makes it difficult to address the other three dimensions.

According to the Bazelon Center for Mental Health Law, studies have consistently shown that people with mental illness overwhelmingly prefer living in their own homes rather than congregate settings with other people with mental illness. The benefits of supported housing include a reduction in the use of shelters for individuals who are homeless as well as reductions in hospital admissions and lengths of stay. According to the Center for Supportive Housing, a stable living situation improves a tenant's ability to participate in support services. Investments in housing and social services for individuals in recovery can significantly reduce public spending on medical and criminal justice services.

AMH funding aids the development of supported housing and rental assistance programs for people in recovery. Rental assistance programs serve individuals in recovery for mental illness and substance use disorders so that they can find and lease a rental unit with all the rights and responsibilities of any other resident. Affordable, community-based rental properties are funded with the stipulation that the units are integrated with non-disabled housing to ensure an individual's right to reside in the least restrictive environment possible, consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.*

Measures of success:

- Increased number of people in recovery who are enrolled in Supported Housing Rental Assistance;
- Increased number of individuals in supported housing.

Strategies:

1. AMH will implement rental assistance programs for individuals with mental illness and serve 576 tenants statewide.
2. AMH will fund rental assistance programs for individuals in recovery from substance use disorders and serve 628 people statewide.
3. AMH will continue the current practice of allocating General Fund, Community Mental Health Housing Trust Fund, and Alcohol and Drug-Free dollars to the development of supported housing for individuals in recovery.
4. AMH will expand partnerships with stakeholder groups, including those that represent racial and ethnic populations, to develop alternative and innovative ways to fund the development of supported housing for people in recovery.

AMH has a history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. In 2014, AMH partnered with the National Alliance for Mental Illness and the Oregon Residential Provider Association to develop proposals and identify community providers who will build affordable housing.

As a result of this partnership, 168 new units of affordable housing will be built in Oregon with tobacco tax funds. Over the next five years, AMH will work with the National Alliance for Mental Illness, Oregon Family and Community Services, providers, and other public and private partners to add affordable housing units for individuals and families and for people who are disabled due to mental illness, substance use disorders and co-occurring disorders.

Goal 4.2: Provide supported employment services to people in recovery.

Background and importance

Research consistently affirms that most people with severe and persistent mental illness want to work and think that it is an integral part of their recovery. Still, fewer than 15 percent of adults with severe and persistent mental illness are competitively employed.

Individual placement and support (IPS) is an evidence-based approach to supported employment for people who have a severe and persistent mental illness. Individual placement and support assists individuals in their efforts to achieve steady employment in mainstream competitive jobs, either part-time or full-time. Supported employment services include resumé-building and interviewing skills, assistance with job searches, and transportation to interviews. Staff members also work with clients on the job or debrief them after work to ensure a good transition. People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Individuals receiving supported employment services have been shown to reduce their use of hospitals and emergency departments.

Measure of success:

- Increased access to individual placement and support services for individuals diagnosed with severe and persistent mental illness.

Strategies:

1. AMH will ensure all community mental health programs have IPS programs in operation by June 2015.
2. AMH will increase staffing levels for Oregon Supported Employment Center for Excellence (OSECE) to provide more timely training and technical assistance to newly developing programs.

Goal 4.3: Reduce the stigma related to addictions and mental health through partnerships with people in recovery and their families.

Background and importance

The problems associated with behavioral health conditions are often mistaken for behavioral choices people make. This has created a negative association with behavioral health care and stigma toward those seeking it. Stigma can adversely shape how people who have behavioral health conditions view themselves. They often avoid treatment in an effort to keep from being labeled with a disorder that is viewed negatively by themselves, society or members of their community. The stigma related to addictions and mental health disorders results in limited resources for prevention, treatment and recovery. It also creates barriers to accessing services, gaining employment and maintaining recovery. Reducing stigma will strengthen people's ability to experience recovery and a life in the community.

Measures of success:

- Increased percentage of people accessing behavioral health services who gain employment;
- Increased percentage of people who receive peer-delivered services.

Strategies:

1. The AMH Office of Consumer Activities will conduct or support activities as part of its Stigma and Discrimination Reduction Initiative.
2. AMH Office of Consumer Activities will provide education, training and technical assistance to promote reduction of stigma and discrimination, recovery support partnerships and wraparound services.
3. AMH along with Medical Assistance Programs and other partners will develop plans for the expansion of peer-delivered services in Oregon.

Goal 4.4: Provide recovery support services to people who are transitioning out of substance use disorder treatment and gambling disorder treatment as part of their continuing care plan to support ongoing recovery. These services include those that are specifically responsive to diverse cultural health beliefs and practices, preferred languages, and literacy levels.

Background and Importance

Recovery from substance use disorders and gambling disorders is a lifelong experience. In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. The Substance Abuse and Mental Health Services Administration has allocated resources to promote recovery-oriented systems of care that employ person-centered planning to identify and meet individual needs across all life domains. These needs can be met by accessing recovery support services and non-traditional interventions that are usually not reimbursable as medically necessary services. Examples of recovery support services are traditional health workers, education and job training, housing barrier removal, transportation, and access to flexible funding to pay for miscellaneous items such as identification cards, interview clothing and bus passes.

Measures of success:

- Reduced substance use and problem gambling among individuals accessing behavioral health services;
- Increased percentage of people accessing behavioral health services who gain employment;
- Decreased arrests among people accessing behavioral health services who are referred by the criminal justice system;
- Increased number of people in recovery accessing supported drug-free housing.

Strategies:

1. AMH will identify aftercare recovery support services that are most needed by recovering individuals.
2. AMH will assess community capacity to provide aftercare recovery support services.
3. Identify programs, agencies and other stakeholders to collaborate on increasing access to aftercare recovery support services.
4. AMH will link providers and service systems across the continuum of care to ensure continuity of care, seamless transitions and capacity to provide ongoing care coordination and peer support.

Goal 4.5: Improve the existing recovery-oriented system of care for people transitioning from residential to outpatient treatment for substance use disorders.

Background and importance

A meaningful, transformed system of care that provides day treatment with supported housing, case management and peer-delivered services must be widely available. An enhanced recovery-oriented system of care will eliminate a gap in our continuum of care. If this transformation of our current system of care is not implemented, it will result in increased costs due to readmission to treatment, criminal justice and child welfare involvement, poor health outcomes, homelessness and premature death.

Day treatment with supported housing, case management, and addition or expansion of peer-delivered services is for people who are ready to be discharged from substance use disorders residential treatment, but do not have a supportive and stable living environment. Staying six to 12 months in day treatment with supported housing allows people to make strong connections in the community and identify local resources and supports for long-term competency in self-reliance. Peer-delivered services are effective in helping individuals build a foundation in the recovery community. This connection provides lifelong support to sustain long-term recovery.

Measures of success:

- Decreased readmission to high levels of care;
- Decreased number of children placed in foster care while family members receive substance use disorder treatment;
- Increased number of people in independent living.

Strategies:

1. AMH will support, sustain and enhance the current recovery-oriented system of care. This includes day treatment, supported housing, case management and peer-delivered services, and renter rehabilitation programs.
2. AMH will partner with existing “second chance” renter rehabilitation programs designed to help prospective renters overcome obstacles that prevent them from obtaining housing.

Initiative 5

Only people who meet admission criteria are admitted to Oregon State Hospital, and for those who need it, admissions and discharges are performed in a timely manner.

Goal 5.1: Reduce or eliminate the waiting list for services at Oregon State Hospital.

Background and importance

Someone experiencing a mental health crisis may be taken to a nearby emergency department for evaluation. A person needing admission to an inpatient psychiatric unit of a general hospital frequently waits under observation in emergency rooms; this is called “psychiatric boarding.” Psychiatric boarding is a problem for everyone involved. The child, adolescent or adult being boarded is not receiving the level of care needed and is often not in an environment conducive to recovery. The emergency department where the individual is being boarded is unequipped to meet the needs of the psychiatric boarder. People who are subsequently admitted to a psychiatric acute care service may be civilly committed and are then put on a waiting list for admission to Oregon State Hospital. Oregon State Hospital has approximately 200 beds for civilly committed adults and geriatric patients. One way to reduce psychiatric boarding in emergency departments is to reduce the wait time to be admitted to the state hospital. When acute psychiatric beds are open, individuals can be transferred more quickly from emergency departments.

Measure of success:

- Ninety percent of patients on the Oregon State Hospital waiting list are admitted within 14 days of placement on the list.

Strategies:

1. Oregon State Hospital will create a new process for determining that a person is appropriate for admission. In most cases, only those who have received treatment on an inpatient psychiatric unit for seven days will be considered.
2. Oregon State Hospital and AMH staff will develop a proposal to relocate the admission team currently housed at AMH to the Oregon State Hospital Salem campus in order to work more closely with the hospital’s program and discharge staff.
3. Oregon State Hospital will actively engage Oregon’s 62 acute care hospitals in finding solutions to psychiatric boarding through the Oregon Association of Hospitals and Health Systems (OAHHS).

Goal 5.2: Reduce the length of stay for patients who are civilly committed to Oregon State Hospital.

Background and importance

Patients who are civilly committed to Oregon State Hospital sometimes remain there after they have received the maximum benefit from hospitalization. The hospital has made a commitment to decrease the length of stay for these patients. The hospital will create a plan to address factors that unnecessarily extend the length of time between when a patient is declared ready to place or transition and when the transition back to that person's community takes place. Effective discharge planning that starts at the time of admission is a key factor in making this a success.

Measure of success:

- The average length of stay for patients who are civilly committed to Oregon State Hospital is reduced by 25 percent.

Strategies:

1. Oregon State Hospital will develop a plan to reduce the length of stay for civilly committed patients, including procedures for discharge planning.

Goal 5.3: Discharge patients who are civilly committed within 30 days of being determined ready to place or transition by their treatment teams.

Background and importance

Patients who are appropriate for community discharge sometimes remain at Oregon State Hospital after they have received the maximum benefit from hospitalization. Intensive discharge planning is the key to timely return to the community. Discharge planning starts at the time of admission and is patient-centered. Discharge planning includes not only the individual's behavioral health and overall health needs, but basic social needs including housing and employment. Oregon State Hospital has made a commitment to decrease the length of time between declaration of readiness and actual transition.

Measure of success:

- Ninety percent of patients who are ready to place or transition are discharged within 30 days of placement on that list.

Strategies:

1. Oregon State Hospital and AMH will collaborate with community stakeholders and patients to identify each patient's post-discharge needs and provide those programs and services within 30 days.

Goal 5.4: Decrease the number of people who are admitted to Oregon State Hospital under ORS 161.370 for misdemeanors.

Background and importance

When an individual is arrested, a court may order an evaluation if it appears the person may be unable to assist in his or her defense due to symptoms of mental illness. ORS 161.370 allows the court to order admission to Oregon State Hospital for evaluation and services necessary to restore a person's "fitness to proceed" with the legal process. The number of patients who are admitted to the state hospital under ORS 161.370 has increased significantly in the past two years, requiring the hospital to open additional units to serve them.

Approximately 20 percent of the patients at Oregon State Hospital are there under an ORS 161.370 court order. In 2013 the average length of stay was 108 days. A team that includes a psychiatrist, psychologist, social worker, registered nurse and peer recovery specialist works with each of these patients. They receive 20 hours per week of active treatment. In 2013, 44 percent of ORS 161.370 patients were charged with misdemeanors. Most of these individuals can be served in their communities. Reducing the ORS 161.370 population at Oregon State Hospital will free resources that can be used to reduce the hospital's waiting list and reduce the disruption in the lives of people charged with minor crimes by encouraging evaluation and treatment in their home community.

Measure of success:

- The percentage of patients who are admitted to Oregon State Hospital under ORS 161.370 for misdemeanor charges will decrease by at least 50 percent.

Strategies:

1. OHA will seek a change in ORS 161.370 so that no one can be admitted to the state hospital if only misdemeanor or felony Class C charges are in place.
2. Oregon State Hospital and AMH will collaborate with appropriate community stakeholders to develop programs and services to serve such patients in the community, ideally to prevent arrests.
3. AMH will seek opportunities to support communities in developing crisis and jail diversion services for people with behavioral health needs and crisis intervention training for law enforcement staff.

Reducing the number of people sent to Oregon State Hospital requires the collaboration of law enforcement, community behavioral health staff, the courts and jails. There is hopeful data from Marion County, where law enforcement and a new mobile crisis unit have teamed up with community leaders to address the number of misdemeanor-related admissions to the state hospital. Marion County has demonstrated a 50 percent decrease in the number of admissions during a three-month period compared the previous year. AMH, Oregon State Hospital and community partners will continue to work on putting community services in place and encourage the appropriate use of the limited number of state hospital beds.

Initiative 6

Addictions and Mental Health Division operations support the strategic plan.

Goal 6.1: Align AMH's structure to support the strategic plan, improve quality management and streamline the development of behavioral health policy.

Background and importance

Historically, AMH has been organized to reflect the two major sources of federal block grant funding, one for substance abuse prevention and treatment, and one for mental health promotion and the treatment of mental illnesses. Over the past decade or more, a greater understanding of the relationship between substance use disorders and mental illness has emerged, along with an emphasis on addressing substance use disorders and mental illness as co-occurring disorders for many people. The division's organization needs to reflect the integration of substance use disorders and mental health services into a "behavioral health" approach, which encompasses prevention, health promotion and treatment of all disorders defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This integration will facilitate efforts to integrate behavioral health services into physical health settings and vice versa.

In 2014 AMH engaged in facilitated conversations designed to map its fundamental daily work. At the same time, reports and data sets that are either sent into AMH by contractors or are generated by AMH were reviewed as a step toward creation of a standard set of reports, or "dashboard," that can be summarized and presented on a regular schedule. The quality assurance functions of AMH are robust, including the regulatory functions.

However, it became apparent that there is a gap in the quality improvement area. The introduction of a new data collection system, called the Measures and Outcomes Tracking System, and the finalization of the dashboards must be accompanied by a clearer path to using the data generated for behavioral health system improvement and development. The new Quality Management section will oversee quality assurance and data collection activities and will align with the OHA Quality Council to identify opportunities of quality improvement to promote Oregon's health system transformation.

Measures of success

- AMH addiction prevention and treatment programs, and mental health prevention, promotion and treatment programs are administratively combined under Behavioral Health.
- The Quality Management section conducts regular review of the AMH dashboard and the Measures and Outcomes Tracking System data.

Strategies

1. AMH will combine the substance use disorders, problem gambling and mental health programs under one administrative structure.
2. AMH will work with OHA Health Analytics to develop a set of measures (dashboard) regarding behavioral health services. It will include utilization, pharmacy claims, readmissions and costs at all levels of care, and will separate child and adult services data where relevant.
3. AMH will develop a Quality Management unit that will oversee quality assurance and data collection activities and promote transformation of the health care system from a behavioral health perspective.

Goal 6.2: Pursue an integrated approach to the collection, analysis and use of data.

Background and importance:

OHA implemented the coordinated care model to transform the state's health care system in 2012. The key components of the transformation included the integration of all publicly funded health care services, transparency and shared accountability. To align with health care transformation, AMH implemented a system change to create an outcomes-based, data-informed system of care. To ensure ongoing success of these transformation and system change efforts, AMH must collect, integrate, analyze and use data to drive and measure improvement across a diverse, publicly funded system of care.

Measures of success:

- Completion of the Measures and Outcomes Tracking System project by July 1, 2015.
- AMH performs quarterly quantitative and qualitative data analysis on key metrics resulting in actionable, targeted and aligned quality improvement initiatives.
- The review process includes increased collaboration with providers, coordinated care organizations and other stakeholders.

Strategies:

1. Establish the information technology infrastructure, resulting in meaningful, integrated business intelligence data sets. This will include developing health analytical capabilities necessary to mine and aggregate behavioral health system of care data across multiple data warehouses.
2. Expand the scope and competencies of the AMH quality improvement unit to include business intelligence data analysis, and collaboration and partnering with behavioral health system of care providers, coordinated care organizations and other stakeholders.
3. Develop and set performance standards, metrics, surveillance and data feedback processes and monitoring improvement initiatives. These will be carried out by the behavioral health system of care providers, ensuring strong collaborative partnerships and shared accountability for the delivery of high-quality integrated services.
4. Integrate Measures and Outcomes Tracking System data with the Medicaid administrative claims data.
5. Create a data workbook that defines metrics, the importance of each and how each one is measured. The data workbook will be used to build and customize behavioral health system of care performance dashboards.
6. Reallocate and invest additional resources to build the AMH quality improvement bench.
7. Build processes and workflows among Health Analytics and Business Solution Unit, AMH and Medical Assistance Programs quality improvement units and AMH program units in order to integrate business operations and increase their efficiency.
8. Coordinate all quality improvement work with OHA's Quality Council.

Summary

Behavioral health conditions have a negative impact on individuals, families and communities. Billions of dollars per year are spent on health care, criminal justice and social welfare systems as a result. Many of these widespread personal and financial consequences are avoidable. The Oregon Health Authority and its Addictions and Mental Health Division are committed to the strategic initiatives described in this plan. The six initiatives represent the beginning of an effort to build a behavioral health care system consistent with the vision described below.

A vision for the future

In the future, safe and compassionate mental health, substance use and gambling disorder treatment is available to Oregonians in urban, rural and frontier areas. There is increased use of technology, and many more trained traditional health workers to help people and providers monitor and manage health issues. Medication-assisted treatment is widely available to people coping with substance use disorders. Health disparities experienced by our most vulnerable citizens are eliminated so that everyone has equal access to health services and the opportunity for a full life in the community.

Resources have been added to prevention efforts so fewer young people start gambling or using tobacco, alcohol and drugs. There is routine screening for people of all ages for trauma, depression and substance use. Early detection and intervention for behavioral health issues leads to less psychological, physical and social impact for children and adults. Mental health first aid and crisis intervention training and similar training are widely available and routinely taught to health care providers, educators, law enforcement and corrections officers, health and welfare workers, and the general public, reducing stigma and increasing early intervention.

Crisis services are available as an alternative to incarceration and inpatient care; treatment is provided in the least restrictive environment and is centered on the service user and family choice. Every addition to the behavioral health system supports recovery, with an emphasis on affordable housing and employment. When hospital-level care is needed, people have access to the right level of care at the right time and only for as long as is necessary. As community programs grow, the need for psychiatric acute care is reduced, and savings can be used to enhance community supports.

Ongoing implementation of the strategic plan

This strategic plan is a living document that will be reviewed and revised annually. AMH will develop a detailed work plan for each goal with specific actions and timelines. Stakeholders and partners will continue to provide direction to AMH related to planning, measuring outcomes and revising goals as needed. Throughout the process, AMH will facilitate collaboration with the health care and social services systems so that resources are used efficiently and effectively to improve the overall health of all Oregonians.

Appendix

Addictions and Mental Health advisory groups

Addictions and Mental Health Planning and Advisory Council (AMHPAC)

Website: www.oregon.gov/oha/amh/amhpac/Pages/index.aspx

Oregon Consumer Advisory Council (OCAC)

Website: www.oregon.gov/oha/amh/Pages/ocac.aspx

Children's System Advisory Committee (CSAC)

Website: www.oregon.gov/oha/amh/pages/csac.aspx

Oregon State Hospital (OSH) Advisory Board

Website: www.oregon.gov/oha/amh/osh/pages/advisory-board.aspx

Glossary

Local mental health authorities (LMHAs) are responsible for the management and oversight of the public system of mental health, intellectual and developmental disabilities, and addiction services at the community level. They must plan, develop, implement and monitor services within the area they serve to ensure expected outcomes for consumers of services within available resources. This broad management and oversight responsibility includes the following primary functions:

- Management of children and adults at risk of entering Oregon State Hospital or residential care, or who are transitioning from the state hospital or residential care. This includes monitoring discharge and facilitating what is known as step-down housing;
- Care coordination of residential services and supports for adults and children;
- Management of the mental health crisis system;
- Management of community-based specialized services including, but not limited to, supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs, and home-based services for children; and
- Management of specialized services to reduce entry or recidivism in the criminal justice system by individuals with mental illness or co-occurring disorders.

Community mental health programs (CMHPs) provide treatment and coordinate care for people with mental illness, intellectual or developmental disabilities and substance use disorders. All members of a community are permitted access to core services, subject to availability of funds. Core services include screening, assessment and referral to providers and community organizations, and emergency or crisis services. The screening, assessment and referral process serves as a portal to services for people who are eligible for Medicaid or who meet the state's target population criteria. Core services also include managing the provision of services and conditions of release for individuals under the jurisdiction of the Psychiatric Security Review Board, pre-commitment investigation services for the civil commitment system, and universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, developmental disabilities, and addictive disorders. Core or safety net services are provided to all people who live in a community, regardless of where the money comes from.

Community mental health and developmental disabilities programs provide services as defined in Oregon law (ORS 430.630 [a] to [b]) to persons in the following order of priority:

1. Those at risk of immediate hospitalization for the treatment of mental or emotional illness or in need of continuing services to avoid hospitalization, those at risk of hurting themselves or others, and those under the age of 18 who are at risk of removal from their homes for treatment;
2. Those least able to obtain assistance due to the nature of their illness, geographical location or family income; and
3. Those who will not require hospitalization.

Coordinated care organizations are networks of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

Coordinated care organizations are responsible for coordinating all of the mental, physical and dental care for Oregon Health Plan members through collaborative community relationships. They have global budgets to pay for all types of care; this gives them the flexibility to manage their funding, so they can work to keep members healthier in the ways that best meet their members' and community's needs. Performance measurements for coordinated care organizations provide incentives for better care, and they are accountable for addressing avoidable population differences in health care outcomes.

Adverse childhood experiences (ACE): Adverse childhood experiences include verbal, physical or sexual abuse, emotional or physical neglect, or unfavorable family situations such as the presence of an incarcerated, mentally ill or substance-abusing family member; domestic violence in the home; or the separation or divorce of parents.

Affordable Health Care Act: The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965.

Americans with Disabilities Act (ADA): A civil rights law that prohibits discrimination based on disability. It affords similar protections to Americans with disabilities as the Civil Rights Acts did based on race, religion, sex, national origin and other characteristics. In addition, the ADA also requires covered employers to provide reasonable accommodations to employees with disabilities and imposes accessibility requirements on public accommodations.

AMH dashboard: A set of summary information useful in keeping track of key performance areas for AMH.

Assertive Community Teams (ACT): An evidence-based practice defined by a set of specifications designed to help keep the individual in the community and out of a structured service setting, such as residential or hospital care.

Behavioral health care: An umbrella term referring to a continuum of services for individuals at risk of or suffering from mental, behavioral or substance use disorders.

Behavioral Rehabilitation Services (BRS): A program that provides services and placement-related activities to address psychosocial, emotional and behavioral disorders in a community placement using either a residential care model or therapeutic foster care model.

Centers for Medicaid and Medicare Services (CMS): An agency within the U.S. Department of Health and Human Services responsible for administration of several key federal health care programs.

Civil commitment: A legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient) or in the community (outpatient).

Co-occurring disorders: The existence of a diagnosis of both a substance use disorder and a mental health disorder.

Culturally and linguistically appropriate services (CLAS): National standards issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

Culturally responsive: The use of the cultural knowledge, experiences, frames of reference and performance styles of diverse students to make learning more appropriate and effective for them.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A manual published by the American Psychiatric Association that covers all mental health disorders for children and adults. It also lists known causes of these disorders; statistics in terms of gender, age at onset and prognosis; and some research concerning the optimal treatment approaches.

Early and periodic screening, detection and treatment (EPSDT): A Medicaid benefit for children and adolescents that provides a comprehensive array of prevention, diagnostic and treatment services for low-income infants, children and adolescents under age 21.

Early intervention: The process of providing services, education and support to young children who are evaluated and deemed to have a diagnosed physical or mental condition or an existing delay, or a risk of developing a delay or special need that may affect their development or impede their education. The purpose of early intervention is to lessen the effects of the disability or delay.

Evidence-based practice (EBP): An interdisciplinary approach to clinical practice founded on the principle that all practical decisions should be based on research studies and that these research studies are selected and interpreted according to specific norms characteristic for evidence-based practice.

Family system navigators: Family members of children or youth in the mental health system who are trained to support or assist other family members, caregivers and guardians to access services.

Federal block grants: A block grant is a noncompetitive grant for prevention, treatment, recovery support and other services to supplement Medicaid, Medicare and private insurance. Recipients must demonstrate compliance with the terms of the grant annually in order to continue to receive the funds.

Fee-for-service: A Medicaid service paid for directly by the state. Some of these services are not covered by a coordinated care organization while others are for individuals who are not enrolled in a coordinated care organization but covered by Medicaid.

Gambling disorders: The range of pathological, problem and excessive gambling, also termed “pathological gambling.” They are characterized by a persistent and recurring failure to resist gambling behavior that is harmful to the individual and others.

Health disparities: A difference in health care opportunities that negatively affects groups of people who have systematically experienced greater social or economic obstacles to health, such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation or geographic location.

Health equity: A fair opportunity for everyone to live a long, healthy life that is not compromised or disadvantaged because of an individual or population’s race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition.

Intercultural Effectiveness Scale Assessment: An instrument developed specifically to evaluate one’s ability to interact effectively with people who are from other cultures.

Jail diversion programs: Services intended to keep people with mental illness from unnecessary incarceration.

Medication Assisted Treatment (MAT): The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of opioid dependence.

Mental health promotion: A universal prevention strategy to strengthen the determinants of mental wellness: healthy communities, individual skill development, social-emotional competence and strengthening an individual’s ability to cope with adversity.

Mental illness: A medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others and daily functioning. A mental illness often results in a diminished capacity for coping with the ordinary demands of life and can affect persons of any age, race, religion or income.

Mobile crisis services: A mental health service that includes immediate response emergency mental health evaluations. Evaluations are often requested by hospital emergency rooms or in the community. These services are often available on a 24-hour basis.

Office of Consumer Activities: An AMH office that works to ensure that people who have mental health and addiction histories have a strong voice in the state behavioral health system. The office is dedicated to serving as a conduit for peers to help shape behavioral health policy and service delivery.

Olmstead v. L.C.: In 1999, the United States Supreme Court affirmed that the 1990 Americans with Disabilities Act prohibits the segregation of people with any disability, including those with mental illness or intellectual disabilities. The court further found that states have an obligation to provide services and supports in the most independent and integrated settings possible.

Opioid dependence: Physical and psychological dependence on the opioid class of drugs (for example, heroin, morphine, codeine, oxycodone, hydrocodone) marked by an inability to stop use, including tolerance and physical withdrawal symptoms following an attempt to stop use.

Patient-centered primary care homes (PCPCHs): An integrated health care team or clinic, as defined in ORS 414.655, that has been recognized through the process established by OAR 409-055-0040.

Peer-delivered services (PDS): An array of agency- or community-based services and supports provided by peers and peer support specialists to individuals or family members with similar lived experience.

Prevention: Integrated strategies designed to prevent substance misuse and associated effects, regardless of the age of participants. They are designed to reduce risk factors and increase protective factors associated with substance misuse.

Psychiatric acute care services: A psychiatric service for adults age 18 and older with severe psychiatric disabilities in a designated region of the state. It includes 24-hour psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment.

Ready to place or ready to transition: A determination by an interdisciplinary team that an individual no longer requires hospital-level care and may be discharged to a community setting with appropriate supports.

Recovery-oriented system of care (ROSC): A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those at risk of alcohol and drug misuse.

Severe and persistent mental illness (SPMI): Adults with SPMI are defined as individuals age 18 or older, who have one or more mental illnesses recognized by the DSM IV, excluding substance use disorders and addiction disorders, and a score of 40 or less on the Global Assessment of Functioning (GAF) scale as a result of such illnesses. The illnesses include the following diagnoses:

Schizophrenia and Other Psychotic Disorders: 295.xx – 297.3 – 298.8 – 298.9

Major Depression and Bipolar Disorder: 296.xx

Anxiety Disorders: 300.3 – 309.81

Schizotypal Personality Disorder: 301.20 Borderline Personality Disorder: 301.83 OR

Substance Abuse Prevention and Treatment Block Grant: A program that provides funds and technical assistance to states to plan, implement and evaluate activities that prevent and treat substance use disorders and promote public health.

Substance use disorders: Disorders related to the taking of a “drug of abuse” including alcohol, as well as side effects of a medication or toxin exposure. The disorders include substance dependence and substance-induced disorders, including substance intoxication, withdrawal, delirium and dementia.

Trauma-informed care: An approach to care that evaluates and considers the role trauma plays in the lives of people seeking mental health and addiction services. The traumas it considers includes the effects of misdiagnosis and coercive treatment. Services are delivered in a way that recognizes trauma survivors’ vulnerabilities, avoids inadvertently re-traumatizing them and helps individuals take a hand in directing their own services.

Wellness Recovery Action Plan (WRAP): A recovery action plan that is developed by the person and cannot be mandated. The plan’s values include the belief that people do recover and there is hope, and are based on a person’s right to self-determination, personal responsibility and self-advocacy.

Wraparound services: A team-based planning process involving a youth and the youth’s family that results in a set of community services and supports individualized for that youth and family to achieve a set of positive outcomes.



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