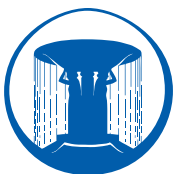


# IMPROVING THE DELIVERY OF MENTAL HEALTH SERVICES IN MULTNOMAH COUNTY



**City Club of Portland**  
Good citizens are the riches of a city

**City Club of Portland Bulletin, Vol. 93, No. 42, April 8, 2011**

City Club members will vote on this report on Friday, April 8, 2011. Until the membership votes, City Club of Portland does not have an official position on this report. The outcome of the vote will be reported in the City Club Bulletin dated April 22, 2010 and online at [www.pdxcityclub.org](http://www.pdxcityclub.org).

**The mission of City Club is to inform its members and the community in public matters and to arouse in them a realization of the obligations of citizenship.**

Copies of this report are available online at [www.pdxcityclub.org](http://www.pdxcityclub.org).

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# Table of Contents

<b>EXECUTIVE SUMMARY</b> .....	<b>1</b>
<b>BACKGROUND</b> .....	<b>3</b>
History of Turmoil .....	3
Delivery of Mental Health Services Today .....	4
<b>DISCUSSION AND ANALYSIS</b> .....	<b>7</b>
<b>CONTRACTS</b> .....	<b>7</b>
Contracting with Service Providers .....	7
Decision to Contract .....	7
Procurement Decision and Award .....	8
Contract Administration .....	9
<b>OUTCOMES</b> .....	<b>10</b>
Evidence-Based Practice and Assessing Program Outcomes .....	10
Mental Health Statistics Improvement Program (MHSIP) Measure of Patient Satisfaction .....	13
A Collaborative Outcomes Resource Network (ACORN) Measure of Patient Satisfaction .....	15
<b>BUDGETS</b> .....	<b>18</b>
<b>SYSTEMS</b> .....	<b>21</b>
Systemic Problems .....	21
Previous Assessments .....	22
Public Meetings and Advisory Input .....	23
The Imperative of Systemic Change .....	23
<b>CONCLUSIONS</b> .....	<b>25</b>
<b>RECOMMENDATIONS</b> .....	<b>26</b>
<b>APPENDICES</b> .....	<b>27</b>
Appendix 1: Organizations Providing Verity-Reimbursed Services .....	27
Appendix 2: Validated Outcome Measurement Resources .....	28
Appendix 3: Sampling Bias in the Mental Health Statistics Improvement Program (MHSIP) Measure of Patient Satisfaction .....	29
Appendix 4: Standards and Legal Guidelines.....	30
<b>GLOSSARY AND ACRONYMS</b> .....	<b>31</b>
<b>WITNESSES</b> .....	<b>34</b>
<b>CITATIONS</b> .....	<b>36</b>
<b>SELECT BIBLIOGRAPHY</b> .....	<b>38</b>

## Improving the Delivery of Mental Health Services in Multnomah County

*"Let us be clear: the present health care system is broken and in urgent need of change. It is too big for any individual interest group to fix. Changing it requires collaboration and leadership, with a shared goal. As taxpayers, we all pay the costs of a broken system. We must all come together to reshape this system."*

~ Oregon Health Fund Board, *Aim High: Building a Healthy Oregon Final Report* (2008)

# EXECUTIVE SUMMARY

"Blow up the system and start over!" More than one witness speculated that this might be the best way to improve mental health care in Multnomah County. Testimony from state administrators, patient advocates, and the providers of care produced overwhelming agreement that the system is in need of a dramatic and comprehensive overhaul. Several studies (David Lawrence's 1980 White Paper, the 1993 Multnomah County Commission's Task Force on Contracting, the 2000 Multnomah County Mental Health System Design) have concluded that Multnomah County's mental health system requires fundamental changes. It will be difficult to rebuild the system and keep patients safe while changes are made. Nonetheless, your committee is certain that bold initiatives are required.

The provision of care to the mentally ill is fractured both among the counties of the metropolitan area, among different health care providers, and among departments within Multnomah County. Needy individuals fall through the cracks, sometimes receiving no care or care at inappropriate levels and locales. Your committee heard reports that continuity of care frequently is lost as patients cross county boundaries in their (often unstable) residences and employment. These reports reinforce parallel continuity problems reported by law enforcement agencies that engage people with mental disturbances who commit crimes or disturb the peace.

Coordination among departments within Multnomah County that serve the mentally ill is poor. Financial resources (primarily Medicaid monies) flow through a multi-level system from the federal government, to the state, to the county, to those providing care in a system that is complex and opaque. It is impossible to distinguish direct costs for patient care from indirect costs for administration. Even worse, assessment of treatment outcomes is inadequate, so that the effectiveness of treatment cannot be ascertained.

Individuals with mental illness are among society's most vulnerable citizens. Providing for their needs represents a major cost to the community. Untreated or underserved

individuals with mental illness frequently become homeless, are arrested for engaging in unlawful or disruptive conduct, or become victims themselves of violence. The result is high service delivery costs, including emergency department care, incarceration, and sheltered housing. It is vital that those who pay for these services, namely government agencies and the taxpaying public, know that the money is being spent in the most effective manner possible and that bureaucratic and costly system inefficiencies do not impede access to care.

To address concerns about care for the mentally ill of Multnomah County, the City Club of Portland created a study committee and charged it to:

- Describe Multnomah County's process for managing its mental health services.
- Describe objective effectiveness standards for the management of public mental health services.
- Compare these objective effectiveness standards to current practices found in Multnomah County.
- Identify those areas that are working well.
- Make recommendations for improvement in areas that are not working well.

This research study evaluates the County's progress toward implementing the County Auditor's recommendations regarding contracting as well as the recommendations of prior studies on the management of mental health services. It assesses the County's progress in implementing and enforcing the state's approved evidence-based criteria as standards for practice.

Your committee interviewed administrators, providers of mental health services, patient advocates, and experts in the field of mental health delivery services and gathered material from journalistic sources and government documents.

Based on its findings, your committee proposes that the following improvements be made:

**BUDGETS: The County’s Mental Health and Addiction Services Division (MHASD) should develop a line-item budget that is accessible, transparent, and understandable to the citizens of Multnomah County.** At present, it is nearly impossible for citizens to determine costs of patient care, trace the origins and flow of money through the system, and assess the functioning of the system. MHASD should make a line-item budget that clearly identifies direct and indirect costs of care within each budget cycle available online to any concerned citizen.

**CONTRACTS: The Department of County Human Services (DCHS) should negotiate contracts with treatment providers that specify measurable terms of service, provide for monitoring of compliance independent of program administrators, and enforce compliance in accordance with stated County contracting standards.** At present the County identifies appropriate goals for service providers, but contracts do not specify the means by which compliance is measured. Current criteria used to identify inadequate performance are lower than those specified in the County purchasing manuals for other cooperating institutions. The Mental Health and Addiction Services Division should negotiate unambiguous performance standards, enforce compliance through independent oversight, and publicly report compliance and non-compliance. County contracts should be made available to the public online.

**OUTCOMES: DCHS should employ empirically validated systems of patient outcome assessment by each provider and allocate adequate resources to collect and analyze data collected.** At present, your committee found that treatment outcomes either go unmeasured or are measured in ways that your committee found inadequate. Data which are reported to the division go largely unanalyzed. The division should allocate increased money and resources to the assessment of patient outcomes.

**SYSTEMS: The Oregon Health Authority (OHA) should redesign the way it delegates responsibility for mental health care to counties, possibly taking back direct authority or creating regional agencies. DCHS should improve coordination among counties, hospitals, outpatient services, and county administrative divisions to ensure that patients receive appropriate care regardless of residency.** At

present, poor coordination results in patients losing continuity of appropriate care. In addition to intensifying existing efforts for coordination between county systems in the metropolitan area, the system needs to be reformed so that the individual is at the center of a system of care with a range of medical, mental health, and residential options suitable to his or her needs. In addition, the Mental Health and Addiction Services Division (MHASD) should dedicate resources to foster grass roots advocacy on mental health issues and reduce the persistent stigma of mental illness. With the urgency of health care reform at the top of many local, regional, state, national, and international agendas, some members of your committee believe OHA could, and should, accomplish this in a relatively quick time of six months.

Your committee concluded that the problems of Multnomah County cannot be solved simply by a dose of administrative efficiency or improved information technology. Your committee found many well-intentioned, hardworking employees and service providers who labor in a fractured system, often with poor communication between agencies and jurisdictions. Unless MHASD makes the quality of patient care central to its mission and rigorously monitors the outcomes of its efforts, it will not provide the mentally ill with the help they need or the community with the quality of service that it deserves.

# BACKGROUND

## History of Turmoil

Although the treatment of the mentally ill in Multnomah County dates to 1862, when the Oregon State Hospital was located on what was then Asylum Avenue—now Hawthorne Boulevard in honor of the Hospital's first director—the current system of care evolved in the second half of the twentieth century, as the institutionalization of the mentally ill fell increasingly out of favor.<sup>1</sup>

During the 1980s, mental health service needs were addressed through a range of direct and contracted services. Programs to treat or prevent substance abuse made up the majority of the mental health services offered, but the County also provided some services for “mentally retarded and/or developmentally disabled” (MR/DD) clients and clients with mental or emotional problems.<sup>2</sup> During that decade, the County began shifting the focus from directly providing mental health services to contracting out work for most services to small providers. By 1986, the County increased mental health services and shelter for homeless adults and shifted more to intervention services for MR/DD children age zero to six.<sup>3</sup>

In 1994, the Board of County Commissioners, as part of Resolution 94-28, identified 85 benchmarks, including 12 urgent benchmarks, one of which was to “increase mental health care services.” By 1997 the Behavioral Health Division had “the goal of promoting a more integrated, responsible, collaborative, and efficient system, as well as supporting the Department's managed care efforts. Ultimately, the new structure was intended to facilitate dual diagnosis treatment and pave the way for new forms of funding, contracting, and treatment.”<sup>4</sup>

The Oregon Health Plan, established in 1994, changed the way health and mental health services were provided. CareOregon, the County's capitated (population-based) health plan, allowed ongoing provision of services to traditional clients by providing a way to continue to receive Medicaid support.<sup>5</sup>

Since the mid-1990s, the County has alternated from relying on multiple smaller organizations to purchasing most of its services from a single large provider and back to contracting with a number of smaller providers. As former Multnomah County Chair Ted Wheeler stressed to your committee, mental health service provision is a politically

unappealing topic, and the system has not received the attention it should.<sup>6</sup> In 2008, when Cascadia Behavioral Healthcare, the largest single provider of services to the County, found itself insolvent, the state of the system became a matter of intense concern to County officials and the larger community.

Cascadia's dominance as a source of mental health services dated from 2001-02, when Peter Davidson, the County's mental health director, and Leslie Ford, who would become Cascadia's CEO, created Cascadia by merging the three largest mental health providers—Network, Mount Hood Community Mental Health Center, and Unity Inc. Within a year, Cascadia laid off 300 employees, as merging the units proved more difficult than anticipated. By 2005, Cascadia faced mounting debts, and the County auditor's review of contracts gave the organization a failing grade. This grade was later revised, allegedly in response to pressure from County commissioners.<sup>7</sup>

Beginning in 2000, the County auditor's office had expressed concerns about the management of contracts. The office identified three major areas of concern: lack of leadership, low priority placed on monitoring the quality of service, and problems with documentation of services rendered. County government largely failed to implement the auditor's recommendations. The auditor attributed this lack of implementation to a failure of support by leadership, a culture resistant to change, and multiple reorganizations and budget cuts that made dealing with systemic issues a low priority.<sup>8</sup>

In 2006, the County, responding to Medicaid procedural revisions, changed its billing model from one in which agencies were reimbursed on a per-capita or “capitation” basis to one in which payment was made for each unit of service rendered (known as “fee-for-service” or FFS). This change created problems for all agencies providing mental health services because payment was delayed while the costs of providing service were incurred at the time of service, creating a cash-flow problem. Cascadia, already in debt, was the least prepared to handle the transition. Cascadia's internal system of managing its finances was chaotic, with money being transferred from account to account to cover shortages.

Cascadia's leadership attempted to handle this crisis by requesting short-term loans from the County as a stopgap

## Improving the Delivery of Mental Health Services in Multnomah County

measure until reimbursement payments could catch up with costs. Despite repeated warnings from Patrick Payton, a Multnomah County employee, in a series of emails about the precarious state of Cascadia's finances, Cascadia repeatedly assured the County that the problem was a temporary one. In October 2007, Scott Dickison, Cascadia's newly hired chief financial officer, quit after less than a week because of the severity of the organization's problems. A request for an additional \$500,000 loan in January 2008 was accompanied by assurances that Cascadia was on the mend. In February, a new chief financial officer, Chip Burczak warned of continued financial problems. By April, Cascadia increased its request to four million dollars.<sup>9</sup> After a change in leadership at Cascadia, a \$2.5 million loan from the state and County, and a dramatic reduction in the size of Cascadia's operations, the County's system of delivering mental health care has stabilized financially.

In February 2008, Oregon's Addiction and Mental Health Division conducted a review, detailed three findings, and mandated two required actions of the Multnomah County Department of Human Services. One set of concerns dealt with monitoring the quality of services, the second centered on the ability of clients to get timely responses to calls to the system, and the third criticized the financial oversight of Cascadia. In response, the County has initiated a new system of quality oversight and has also revised call center procedures. The County vigorously contested the third finding, pointing to the role that Leslie Ford, as Cascadia's chief executive, had played in misleading the County as to the true state of Cascadia's financial affairs.

### Delivery of Mental Health Services Today

Beginning in 2008, the County shifted from contracting the majority of mental health services with one provider to using a number of providers, including Cascadia. The County is currently in the process of establishing systems to address the quality of mental health services and build cooperative relationships with its provider organizations. Your committee heard conflicting testimony regarding these efforts to date. While some expressed praise for these efforts, others described them as essentially "a train wreck in progress." To assess the current state of that process, it is necessary to understand the scope of the County's programs, the means currently in place to monitor programs, and the contractual relationships the County has with its mental health provider organizations.

In 2009, nearly 30,000 individuals received mental health treatment and support through the Mental Health and

Addiction Services Division of the Multnomah County Department of Human Services. The "MHASD Summary of Numbers Served in FY09" (see box below) indicates the scope of problems, ranging from addiction disorders to crisis calls to the evaluation of students in public schools.

#### **Mental Health and Addictions Services Division (MHASD) summary of numbers served in Fiscal Year 2009:**

- Involuntary Commitment Investigations of over 4,500 emergency psychiatric holds.
- The Mental Health Call Center responded to over 60,000 calls.
- Urgent Walk-in Clinic saw 5,200 residents.
- Mobile Crisis Outreach to 2,600 residents.
- Multnomah Treatment Fund (County General Fund program for individuals without insurance or resources who also meet certain risk criteria): 1,126 people accessed treatment.
- Prescription medication obtained for 319 people.
- Alcohol, Drug, and Gambling Prevention and Treatment Programs served approximately 22,000 people.
- Coordinated Diversion: 1,217 individuals diverted from hospitalization or incarceration into treatment.
- Bridgeview (transitional housing program) served 81 individual adults.
- 12,000 consultation contacts in the school-based mental health services.

Source: MHASD, DCHS.

Multnomah County addresses mental health needs with a complex system of funding from state, federal, county, and private sources and provides services largely by contracting with nonprofit providers, but it does continue to manage some services directly. Several factors, including cost and the ability of service providers to assume liability risk, provide the rationale for this mixed model of service delivery. The County directly administers programs such as Mental Health Commitment Services, Mental Health Residential Services, Mental Health Crisis Services, and some secure residential programs monitoring those found guilty except for insanity, or not criminally responsible. Third

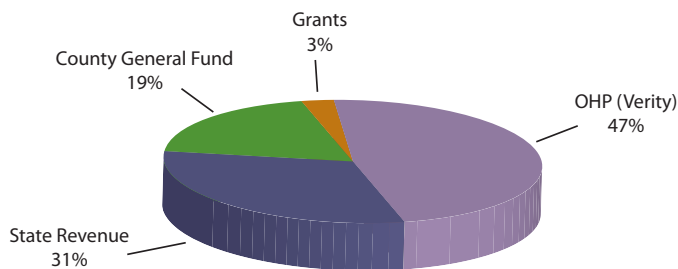
## Improving the Delivery of Mental Health Services in Multnomah County

parties such as Cascadia or Central City Concern provide programs offering other mental health services. Verity, the County's managed care organization for recipients of public benefits, reimburses the cost of this care.

Administrators point to several advantages in using nonprofit providers. Labor costs are lower in nonprofit organizations than those in a government agency. County administrators assert that the use of culturally specific mental health providers for populations such as Native Americans provides better support for clients. The County contracts with these providers on a fee-for-service basis through Verity and receives its money based on per-capita formulas from the Oregon Health Plan and the County's general fund. In essence, the County plays the role of a mental health HMO, reimbursing providers for services rendered to a population of eligible individuals.

Figure 1 (April 2010) illustrates the Oregon Health Plan's dominant role in funding mental health services, as it provides nearly half of all the monies spent.<sup>10</sup>

**Figure 1: 2010 funding sources for Multnomah County Mental Health and Addiction Services Division**



Source: MHASD.

Fee-for-service money flows to a variety of private providers through a two-stage contracting process that is increasingly being used for the procurement of services by governments. Periodically, potential providers are solicited through a Request for Provider Qualifications (RFPQ). Individual organizations respond to this request by providing a demonstration of their professional qualifications and capacity to deliver services. Successful responses to the RFPQ are placed on a short list for requests for proposals (RFPs) to contract for the delivery of services. The County can ask one or more of the qualified organizations to submit bids, and can award single or multiple contracts. These contracts specify the service, the qualifications of staff providing the service, the time involved, the program to which the service may be applied, the hourly rate that the

County will pay, whether the service occurs in or out of the facility, and work group guidelines. Contracted providers, with the exception of the four organizations starred in Appendix 1, diagnose and treat clients and bill for their services directly to Verity.

This two-stage contracting process has advantages for both the County and the providers. The County does not have to open all of its bids to any potential provider, and can thus perform the contracting process more efficiently. For their part, the qualified providers do not have to labor through all of the qualifications paperwork for each and every contract. There are, of course, disadvantages to this two-stage bidding process. One is that potentially qualified new entrants may experience a delay before they succeed in passing the first hurdle.

Channeling money from external sources constrains the way that mental health services are administered and delivered. The Oregon Health Plan pays for services provided in a clinical setting, for instance, but the same therapist's time cannot be billed for work done following up on a client's case to maintain contact or seek appropriate living arrangements. Some reimbursement may be available for therapies employing psychotropic medications but not other forms of therapy. Joanne Fuller, former Director of the County Department of Human Services, testified that these restrictions result in a greater reliance on the use of such medications than she would prefer.<sup>11</sup>

These limitations highlight the indirect nature of the control that the County can exert over the mental health care that patients receive. Because employees of nonprofit organizations and not County employees provide care, the primary means of influencing service delivery and assessing outcomes must be through the contractual relationship between the County and providers. The County can, and does, provide incentives for certain patterns of behavior by its service providers and can negotiate specific rates of reimbursement for particular therapeutic interventions, but the direct involvement of County personnel in monitoring the process is limited.

One way the County attempts to influence service delivery is through the payment of incentives for speed of delivery and willingness to handle patients with problematic dual coverage. If fewer than 60 percent of individuals receiving outpatient services are seen twice in the first 14 days after initial contact, the provider receives 75 dollars for each client seen twice in that time period. If more than 60 percent are seen twice in 14 days, then the provider receives 100 dollars for each client seen twice. A similar schedule ap-



## Improving the Delivery of Mental Health Services in Multnomah County

plies for clients seen four times in the first 45 days. The County compensates organizations for the difficulty and delay involved in Medicare and Medicaid billing by compensating services at a higher rate. The CEO of one large nonprofit provider, who enthusiastically supports the concept, testified that given the narrow margins that provider organizations work with, the incentives have been extremely powerful motivators.

It is not clear to what extent the payment of incentives has succeeded in affecting the quality of care. The same CEO who supported the concept reported that County administrators appeared disappointed with the initial results and expressed frustration with the pace of improvement in increasing the percentage of clients meeting the criteria for reward. This witness ascribed the apparent lack of progress to a failure to prepare providers for the advent of the incentive schedule. This CEO felt that, in time, providers would develop procedures more effective than simple scheduling and follow-up telephone reminders, but asserted that such changes in organizational behavior require time and experience to be implemented effectively.

The County also negotiates with service providers in an attempt to lower the ratio of patients to case managers. The County's current goal is a ratio of 50 to 1. Joan Rice, Director of Quality Management, described Cascadia as "quite close" to reaching a goal of 50 to 1, with both Central City Concern and LifeWorks characterized as "over [50 to 1]." Rice characterized "best practice" as a ratio of 35 to 1, indicating a major gap between the current state of care and the County's aspirations.<sup>12</sup>

In the spring of 2011, the County intends to open a 16-bed facility to provide an alternative to hospitalization for adults in crisis. Individuals will be in the facility on a short-term (typically seven- to 14-day) period, usually on an involuntary basis.

The County mental health system escaped having to introduce service cuts to its expanding population in 2010 because of the allocation of federal stimulus money. In a stressed fiscal and political environment, however, requests for additional expenditure seem unlikely to have much chance of success. Unless political leaders and the public believe that existing money is being spent in an ef-

**"The best way to ensure that mental health services can earn support is to provide credible evidence that existing support reaches clients with the most effective mental health care possible. This means monitoring the quality of service delivery, even though such monitoring has its own cost."**

fective way to provide needed services, they are unlikely to be willing to expand or maintain services. The best way to ensure that mental health services can earn support is to provide credible evidence that existing support reaches clients with the most effective mental health care possible. This means monitoring the quality of service delivery, even though such monitoring has its own cost.

The professionals of the Multnomah County mental health system and its provider organizations face extraordinary challenges as they perform their duties. The rate of provision of mental health services in the County is similar

to that in the state as a whole, but the proportion of clients diagnosed with the most severe problems is far higher in the County than in the rest of the state. The County's financial commitment to mental health is far larger than any other county in the state. In testimony, state officials especially praised the County's provision of mobile crisis services and housing support. In addition, your committee was impressed by the dedication and commitment of those who testified, including both service providers and County administrators.

In presenting its findings, your committee has isolated the following interrelated dimensions of the mental health system:

- contractual relationships
- assessment of the quality of service delivery
- budget
- role of the mental health division as part of the overall system of institutions supporting the mentally ill

In the next chapter we will discuss and analyze each of these dimensions. The *contracts* section deals with the process by which the County establishes contractual relationships with those who supply care to the mentally ill and defines the outcomes expected from care. The *outcomes* section deals with the means by which the County measures and verifies the quality of services being provided. The *budgets* section analyzes the flow of funds through the system. The *systems* section addresses how services are organized to deliver the needed continuum of care for patients.

## DISCUSSION AND ANALYSIS

### CONTRACTS

#### Contracting with Service Providers

Rigorous contracting and auditing systems are vital to the success of the mental health system. The County purchases therapeutic services, but it is not the direct recipient of those services that are, of course, delivered to those in need. Contracts do not simply specify reimbursement rates; they define programs available to the population,

and specify the terms by which the quality of service will be evaluated. Contracting is not simply an agreement to purchase; it is a process that begins with assessing community needs, procuring and evaluating bids, making appropriate award decisions, and administering the conduct of the contract through continual evaluation of the performance of vendors. The result will be decisions on renewal that shape the future of the mental health system.

**“Contracting is not simply an agreement to purchase; it is a process that begins with assessing community needs, procuring and evaluating bids, making appropriate award decisions, and administering the conduct of the contract through continual evaluation of the performance of vendors.”**

Because the vast majority of services in the Mental Health and Addiction Services Division are provided under contracts with nonprofit organizations, the process by which the terms of the relationship between the County and these providers is determined is vital to establishing and maintaining the level of care that individuals receive.

In 2009, the County Auditor’s office issued a scathing review of the process by which contracts for services are administered, identifying multiple divergences between best practices and the way the County does business. In response, the County established a Contract Action Team to implement 165 changes recommended in that report by 2011. As of November 2010, only 40 percent of the proposals were adopted toward a scheduled completion date. County administrators assert that the revised contracting procedures will involve technological changes including

a new ability to stop payment on unexecuted contract work. This system has the goal of supporting management of contracts and providing structure for site review reports. Training will be designed so that in six-to-nine months, the new system will be taught to County employees at all levels. Since many of these changes are not in place, it is not possible for your committee to say how they will improve management of contracts at this time.

#### *Decision to Contract*

Contracting is a continuous process that lays out the terms of a relationship, monitors results, and assesses outcomes. In contracting for personal services, it is crucial that expected outcomes be stated in clearly measurable terms and that the implementation be consistently evaluated. It is not as easy to evaluate mental health services as, for example, contracts to provide office furnishings. The County accordingly employs a separate purchasing manual to regulate personal service contracts. This purchasing manual, for instance, requires that, for partnering organizations, measurable goals be specified in the contract and that service providers whose performance is below 85 percent be subject to formal procedures.<sup>13</sup>

Karl Brimner, Director of the County’s Mental Health and Addiction Services Division, testified that “right now there isn’t a structure” for deciding whether to contract services or provide them directly, either in the Department of County Human Services, Mental Health and Addictions Services Division, or in the County as a whole. This lack of “clear standards” applies not only to decisions concerning newly created programs but also to the decision to renew contracts. MHASD is also required by the state mandate in 2009 Oregon House Bill 2867 (ORS 279B) to conduct feasibility and cost studies every time that a service provided in-house is converted to one that is contracted out. While the division administrators acknowledge that there are “waves” in which programs are either put out to bid or provided in-house, the County indicated a preference for contracting services, as when Brimner stated: “We’ve been very clear that Mental Health and Addiction Services is an administrative body—we’re an oversight, contracting, procuring, administering body, and we want to support the network of providers in the community.”<sup>14</sup>

# Improving the Delivery of Mental Health Services in Multnomah County

## Stages in the contracting process

### I. Decision to contract or provide services directly

County assesses whether it would be more effective to use its own employees to provide a service or to work through a contracted agency. By state law, decisions to contract out existing programs with budgets over \$250,000 must be preceded by a formal cost benefit analysis. *Auditor recommends that decisions to renew existing contracts be considered at this stage.*

### II. Procurement decision and development

County decides what sort of procurement is appropriate. Administrators set specifications of the contract and solicit bids.

### III. Award process

County sets criteria for the process and evaluation of bids. Bids are received and evaluated by the County. The viability of contractors to perform is assessed. Finally, the contract is awarded.

### IV. Contract approval and negotiation

Specific aspects of the contract are negotiated. The formal contract is written and subjected to legal review. The County Commission approves the contract.

### V. Contract administration

County establishes procedures for processing payments for contracted services and pays for services. Administrators monitor the performance, fiscal integrity, and compliance of contractors. Individuals with necessary skills, authority, and time assess whether outcomes meet those specified in the contract.

### VI. Renewal decision

Evaluation of program effectiveness precedes subsequent decision to buy.

Source: Adapted from LaVonne Griffin-Valade, et al., *Management of Large Contracts Audit Report* (2008).

MHASD has no established criteria or formal process for deciding whether to provide services by the County or contract with outside agencies. The director currently makes decisions in consultation with the individuals directly involved in administering the individual program. In one case, the director explained the decision to provide services directly as being due to the availability of money for a particular program from the state and in response to the belief expressed by members of the community that they had greater confidence in the County medical team.<sup>15</sup>

In the absence of clearly specified guidelines for deciding whether to contract services or provide them in-house, the County relies on the experience and judgment of individuals running the division. In a meeting with your committee, the director referred to issues such as “programs which are integrated into the community such as school based services,” and the “desires of consumer groups” as determining the outcome of these decisions.<sup>16</sup>

Your committee believes that the weakness of such an approach is that it depends on individual expertise and individual discretion to an extraordinary degree. An administrator may have individual biases that cause her or him to misjudge the effectiveness of a program or organization. Reliance on individual judgment makes the decision-making process difficult to review. The career paths of the individuals within the system can dramatically affect the process. Administrators may retire, choose other employment, or become ill, leaving the continuity of the County program at risk.

### *Procurement Decision and Award*

Both legal and practical circumstances guide the MHASD’s decision to award a contract. In contracts for general services (such as construction or office supplies), the County may attract seven or eight bidders. In contrast, because mental health providers must have state certification, the

## Improving the Delivery of Mental Health Services in Multnomah County

number of competing bids for mental health contracts may be only three or four or as few as one or none. Brimner indicated that the small number of competing bids is the result of County practice when he said, “We don’t, like commercial insurers, seek out small individual one person providers. Partly because the way we write out RFPs, you must have a large scope of service—you must have a bond, you have to be certified, you have clinicians, you have to have 24/7.”<sup>17</sup> These requirements limit the degree of competition in the procurement process.

Since Medicaid sets the reimbursement rates for specified services, vendors do not compete on the basis of price. Brimner stated, “We’re not making our decisions based on who’s the low cost vendor. We’re making our decisions based on who is the right vendor, who has the right capacity and the right ability to take the best care of our clients, so we’re offering RFPs which is a tool you use when you’re looking for that kind of solution to your problem.”<sup>18</sup>

County administrators found the state’s maximum five-year contract period and the complexities of a formal bid process laborious for both the County and service providers, so in the last two years they have developed a process of procurement that can be periodically reopened, usually every six months or one year. Administrators assert that this system is a response to the difficulty of predicting unstable state and federal funding. In the new system, organizations complete a Request for Programmatic Qualification (RFPQ). As funds become available they are put in pools of resources from which funds can be allocated to qualified organizations without going through the laborious bidding process. Not all organizations that have completed a RFPQ will be allocated funds for particular services. Administrators believe that this process gives the

system flexibility to respond to unanticipated changes in need for service and avoids a bidding process they regard as “cumbersome” and one that “everybody hates.” “RFPs will limit you to a winner. That doesn’t work for the people we serve,” said Brimner.<sup>19</sup>

Although the RFPQ process provides flexibility in contracting for services, it has the effect of making the process of

contracting less rigorous and more informal. The director’s comment noted above—that “we want to support a network of providers in the community”—suggests that

the focus of contract awards is less on the effectiveness of care and more on the organizational needs of nonprofit organizations in a symbiotic relationship with the County. The appropriate standard for the award of contracts is to maximize the quality of care given to those in need. Your committee believes that effective administration requires a systematic and rigorous assessment of the effectiveness of care given by providers, so that County administrators can allocate resources in the most effective manner possible.

### *Contract Administration*

In assessing the quality of service that individuals receive, administrators examine many indicators: complaints received from clients of provider institutions, hospitalization rates, critical incidents, reports to the County’s leadership team, a yearly satisfaction survey, and data obtained through fee-for-service billing. As the director noted: “there is not just one way” to evaluate the quality of service provided.<sup>20</sup>

In addition, the County’s Quality Management Unit reviews annual reports and is in charge of corrective action. Quality Management can issue a letter withholding payment if problems exist with the quality of care. The County also relies on the State of Oregon auditing process that includes interviews with stakeholders, providers, and case reviews. The County creates an annual quality report in which it may state that “corrective action” was required of a certain number of providers, but it does not release specific information. The certification teams can review selected cases in terms of the speed with which people are treated and whether they meet satisfaction standards.

In contract administration, as in the decision to contract and in the procurement process, the County relies on a system that is based on the judgments of key administrative personnel. Such a system contains several potential weaknesses, no matter how dedicated and skilled the individuals who make the decisions. Administrators who are engaged in long-term relationships with particular service providers may find it difficult to deliver negative assessments. Program administrators may become identified with the success of the programs and be less likely to perceive that performance is not meeting the standards of the contract. As suggested earlier, individual administrators may also choose to accept other employment or retire, leaving the system without the benefit of their expertise. Your committee believes that the best solution to these weaknesses is a system of outcome assessment that rigorously documents the success or failure of a program.

**“Although the RFPQ process provides flexibility in contracting for services, it has the effect of making the process of contracting less rigorous and more informal.”**

### OUTCOMES

#### Evidence-Based Practice and Assessing Program Outcomes

In a system that relies heavily on the judgment of individual administrators, information concerning the quality of assessment is crucial to program effectiveness. Without reliable information, administrators cannot assess the quality of service, compare the performance of different vendors, nor measure progress toward system improvements. In the absence of comprehensive data, administrators will make their decisions on an impressionistic basis in which a variety of factors are balanced to reach a conclusion.

The subjective judgment of individuals, no matter how dedicated or accomplished, cannot be the basis for an enduring and effective system of mental health care delivery in a community. Your committee believes that systems of assessment must be spelled out in the contracts with providers and that they should contain two elements. First, the contract must specify the tools by which outcomes are measured. These tools should be consistently applied to all contracting parties. Second, contracts must specify clear standards of acceptable performance. Without uniform data collection and clear standards of performance, objective judgments of the quality of performance are not possible.

The importance of measuring outcomes should be uncontroversial and is well supported by an extensive literature on health services research. Research literature also documents considerable reluctance to engage in the effort to measure outcomes. One frequently cited reason is the desire to avoid the expense of assessment. The literature is clear, however, that the up-front investment in measurement pays for itself many times over in providing information to improve effective and cost-effective care. Analysis of outcome results allows providers to compare alternative methods of providing patient care and so select therapeutic interventions that produce results at lower cost or choose treatments that produce improved outcomes at equivalent cost.<sup>21</sup>

For patients receiving evidence-based treatments, without an analysis of outcomes there is no way to determine the quality of care that a contractor is providing. Outcome assessment can improve both the cost effectiveness of care and provide assurance of the quality of the therapeutic effort. Evidence-based programs are defined and manda-

tory expenditures for such programs are codified at ORS 182.515-182.525. The state devotes an extensive section to evidence-based practices on the Department of Human Services, Mental Health and Addiction Services Division web page.<sup>22</sup> The increasing demand that care provision be “evidence-based” is laudable.

However, the scientific literature makes clear that there is no solid theoretical or empirical base for making the fine-grained decisions that are required for every individual mental health care case. There must be some local assessment of outcomes to know which of multiple evidence-based guidelines are the most appropriate for a local situation. Even if the evidence-based guidelines were clear, it is necessary to know whether providers fully follow the spirit as well as the letter of those guidelines in their daily practice.

In their testimony to your committee, County administrators stressed the difficulty of assessing outcomes in the mental health field. Among the problems they identified were psycho-social factors (e.g., whether the individual has adequate housing, employment, and/or personal supports) that influence outcomes. Nonetheless, the measurement of outcomes was acknowledged to be an important goal in spite of its inherent difficulty. Joan Rice, Quality Management Manager for MHASD, told your committee that one of four “major strategic goals” included identifying ways to improve systems of care to meet the clinical needs of consumers and their families with effective and evidence-based treatments.<sup>23</sup>

Your committee found that there are multiple ways to measure outcomes. The literature overwhelmingly supports the position that outcome assessments should be used as a tool for designing a system fitted to the needs of the population receiving treatment in the most effective way. Appendix 2 provides measures that would be useful for understanding outcomes of Multnomah County’s mental health care system. Better than any single type of measure is a mixture of measures, to provide confirmation and cross validation. Your committee, after surveying the literature on mental health outcomes measures, developed the following list, which sets out elements that should be present and what the County currently does.

**“Outcome assessment can improve both the cost effectiveness of care and provide assurance of the quality of the therapeutic effort.”**

## Improving the Delivery of Mental Health Services in Multnomah County

### Valid mental health outcomes measures and how the County measures up

- 1. Avoidance of hospitalization.** Not being in a hospital is a very good indicator, and one that is readily obtainable. It is not, however, an all-or-none measure; the County can obtain the number of separate admissions within a given time period, as well as the total number of days admitted within the period. These particular measures appear to be regularly collected.
- 2. Making and keeping appointments with care providers.** Reliably maintaining relationships with care providers is another good indicator, and one that appears to be regularly obtained by providers—possibly in part because the County provides incentives to care providers for keeping their clients.
- 3. Avoidance of dangerous behaviors.** Indicators here are often phrased in the negative, and include freedom from alcohol or substance abuse, freedom from self-harm, not engaging in criminal behaviors, and not being involved in violent situations. Generally, there are records for many of these behaviors, but your committee has not heard witnesses testify whether these records are being used to assess care recipient functioning.
- 4. Well-being as measured by case notes.** Case notes by providers—as inherently subjective as they can be—provide a legitimate measure of well-being and functioning. Such notes are required for all service provision. However, your committee has not heard of systematic analyses of these notes to assess improvement in recipient outcomes.
- 5. Well-being as measured by recipient questionnaires.** Recipient responses to questionnaires—again granting their subjectivity and the possible response biases that might be present—is a legitimate measure of well-being and functioning. Your committee has heard of increasing use of such questionnaires, using a system known as ACORN. These are often filled out by care recipients on a regular basis. *The County uses ACORN to measure outcome improvement and provider quality in ways that are not valid. Your committee discusses this in depth beginning on page 13.*
- 6. Patient satisfaction with provider.** Although client satisfaction with providers could be viewed as more of a process than an outcome measure, it does provide some indication of well-being and client motivation to improve. The County conducts periodic (12–18 month) surveys of patients using a Mental Health Statistics Improvement Program (MHISP) instrument, distributed at treatment sites, to determine such satisfaction. *These surveys, too, suffered from methodological inadequacies. Your committee discusses this in depth beginning on page 15.*
- 7. Well-being through steady employment.** Being able to hold down a job is a very good indicator. Jobs can be found independently, through a care provider agency, or for a care provider agency. In some sense, where the job comes from should be less significant than the ability of the person to establish a pattern of working and earning an income. These types of measures have been acknowledged as important by almost all interviewees who answered questions regarding outcomes; however, your committee has not learned of any consistent recording of these data for care recipients. *This is an area for improved data collection.*
- 8. Well-being through regular and consistent housing.** Not being homeless is of course a good indicator, as is being able to stay in the same living quarters for extended periods of time. Some providers supply housing; here, the question of continued residence is important. For recipients not in provider-supplied housing, knowing where and with whom they are staying, and for what periods of time, provides an assessment of functions. Data on provider-supplied housing are of course obtainable, but your committee has not heard witnesses citing such data for evidence of outcomes. *Your committee is not aware of any data gathering for housing that is not provider-supplied. This is an area for improved data collection.*
- 9. Well-being through healthy social interaction.** This indicator is the most difficult, yet could potentially be the most revealing. Mental health diagnoses often are based on such indicators as the ability to maintain friendships, to keep in contact with family members, to have an ongoing committed relationship, to have regular social interactions with peers. This indicator is in some senses the opposite of the “negative behaviors” one cited above. It is in part potentially detectable from case notes or recipient questionnaires. *Your committee is not aware of any department or agency that measures well-being or social interaction.*

## Improving the Delivery of Mental Health Services in Multnomah County

In assessing outcomes, your committee found that the County relies on the following factors: hospitalization rates, involvement in the criminal justice system, patient satisfaction surveys, and ACORN (A Collaborative Outcomes Resource Network)—a self-report measure of patient well being. The County's contract with LifeWorks Northwest, one of the providers of mental health services, specifies the outcomes that it expects the service provider to achieve:

“Reduction of inappropriate acute care admissions or other high utilization patterns;  
Stabilization of the acuity and severity of symptoms;  
Reduction of danger to self or others;  
Improvement in the level of function;  
Stabilization of behavior and conduct; and  
Strengthening of coordinated community-based services and supports.”

These are reasonable and appropriate outcomes to expect from a mental health service provider. *However, with respect to the outcomes outlined above, your committee found that measurement was inconsistent, inadequate, or absent.*

- *Reduction of inappropriate acute care admissions or other high utilization patterns.* The County tracks hospital discharges, which are readily available and useful data. However, your committee could not find analyses of which admissions are appropriate and which are inappropriate; instead there appears to be a substitute goal of reducing overall admissions. While this goal has its merits, it is not faithful to the contractual statement.
- *Stabilization of the acuity and severity of symptoms.* At present, this outcome (plus other items below as indicated) is measured through an annual survey using an instrument developed and validated by the Mental Health Statistics Improvement Program (MHSIP). There is a pilot program in place to add a further proprietary 14-item patient self-report instrument (ACORN). This is to be filled out at each clinical encounter or weekly, whichever is less. Your committee comments on the MHSIP and ACORN separately, below.
- *Reduction of danger to self or others.* Reduction of danger to self is measured by the MHSIP report via review of incident reports generated by providers. Your committee is not aware of measures of the reduction of danger to others.

- *Improvement in the level of function.* This outcome is measured through the MHSIP and ACORN self-reports. Although the Level of Care Utilization System (LOCUS)<sup>24</sup> is used as a proxy measure of level of function to determine what services are provided, changes in LOCUS scores are not used (nor do we claim that they should be used) as a measure of change in functioning due to care.
- *Stabilization of behavior and conduct.* This outcome is measured through the MHSIP and ACORN self-reports.
- *Strengthening of coordinated community-based services and supports.* Your committee requested but never received a report of how this is measured.

Although MHASD collects data on patient outcome, it analyzes the results in ways that are informal and lack systematic rigor. The enforcement level used by the division is far less strict than that the purchasing manual of the County requires for other organizations in partnership with the County. In testimony to committee members, Karl Brimner stated: “In terms of people passing their certification evaluations: we’re really looking at 70 percent. So we’re looking at people being competent in the activities they’re supposed to be competent. If you’re below 70 percent, you’re on corrective action.” This standard for vendors providing service to the County falls considerably below that which would be required if the County were in a partnership agreement with another organization such as the Loaves and Fishes program. In those cases, the County purchasing manual requires:

...measurable indicators that clearly show whether the goals of the partnership are being achieved, together with a process to periodically collect and share data that measures inputs, outputs, and outcomes of the services provided and the relationships between the use of those resources and those outputs and outcomes. Departments shall, in consultation with their Partner, set reasonable targets for each performance measurement. No less than once a year the department shall determine whether performance targets are being achieved. If actual performance for any of the performance measures is below the 85 percent level, a formal problem solving process shall begin

**“Although MHASD collects data on patient outcome, it analyzes the results in ways that are informal and lack systematic rigor.”**

## Improving the Delivery of Mental Health Services in Multnomah County

and be documented through meeting minutes. If performance is at or above the 85 percent level for all performance measurements, informal management procedures are sufficient and need not be documented with minutes.<sup>25</sup>

The division holds mental health service providers to a far more lenient standard than required by County administrative procedures in comparable situations. While the effort at using self-report forms to measure outcomes is important—and indeed could be considered necessary—this mode of measurement is not sufficient, even if the measurements met all scientific standards of reliability and validity.

The County monitors the provision of services employing LOCUS, a national system developed by the American Association of Community Psychiatrists to assess the appropriate level of care depending on the severity of an individual's symptoms. Patients are given a score of from 1 to 5 on the following six dimensions:

- Risk of harm
- Functional status (ability to fulfill social responsibilities to self and others)
- Medical, addictive and psychiatric co-morbidity
- Recovery environment (level of stress and level of support)
- Treatment and recovery history
- Engagement (subject's understanding of illness and treatment)

The resulting evaluations are run through a complex paradigm to determine the appropriate level of treatment. This process enables the County to assess whether individuals are receiving treatment commensurate with their degree of impairment. It also allows the County to determine whether it is financing a level of care appropriate to the individual need.

While LOCUS is a valuable tool for assigning individuals to appropriate treatment levels, it does not measure the quality of care received by the patient. The result of the LOCUS analysis is assignment to one of six levels of care. (See Table 1.)

**Table 1: Level of care utilization system (LOCUS)**

Level 1	Recovery Maintenance and Health Management
Level 2	Low-Intensity Community Based Services
Level 3	High-Intensity Community Based Services
Level 4	Medically Monitored Non-Residential Services
Level 5	Medically Monitored Residential Services
Level 6	Medically Managed Residential Services

Source: American Association of Community Psychiatrists, Level of Care Utilization System for Psychiatric and Addiction Services (Adult Version 2010).

The categories in which individuals are classified are extremely broad, so that an individual making progress and receiving excellent treatment could remain at a particular level for years without an apparent change in his status. LOCUS-based monitoring is considered an appropriate administrative tool for tracking service delivery within the system, but it is only an indirect and crude estimate of the effectiveness of intervention.

### *Mental Health Statistics Improvement Program (MHSIP) Measure of Patient Satisfaction*

Patient satisfaction has been related to the success of mental health interventions since satisfied patients are more likely to follow treatment plans. For a number of years, Verity has used the 28-item MHSIP Version 1.0, first issued in 2000, to measure patient satisfaction.\* In 2006 through 2009, the state contracted with Acumentra Health to survey clients from nine organizations around the state, including Verity. Acumentra also used MHSIP, but Version 1.2, first issued in 2006, adds eight questions to Version 1.0 to address functioning, social connectedness, and patient participation in treatment planning. All items in both versions of MHSIP are answered on a 1-to-5 scale, where both Verity and Acumentra used forms of the instrument that took 1 to mean dissatisfaction and 5 to mean satisfaction.

Your committee examined the Verity results and the Acumentra results for Verity patients for the years 2008 and 2009. The questionnaires in the statewide survey were mailed to samples of more than 12,000 clients with a response rate of 24 percent in 2008 and 23 percent in 2009. Of these totals, Verity clients were mailed 2491 surveys in 2008 and 2628 surveys in 2009, with response rates of 23 percent and 22 percent, respectively.<sup>26</sup> The Verity surveys were handed to patients at the time of their appointments

\* MHSIP provides free usage of its surveys; for information, go to <http://www.Mhsip.Org/surveylink.Htm#mhsipapprovedsurveys>. Accessed March 10, 2011.



## Improving the Delivery of Mental Health Services in Multnomah County

during three-week windows in May 2008 and 2009. The patients were asked to fill out the survey and deposit in a box before seeing their provider. Verity reports that approximately 27 percent of the patients seen in May provided surveys. Given the similarity of surveys and response rates, one would anticipate the two surveys to yield similar results.

Unfortunately, the results of these separate surveys reveal significant discrepancies in results across the board, as shown in Table 2. For all of the measures the two surveys had in common (four domains based on MHSIP Version 1.0), the Acumentra results showed considerably less satisfaction than Verity's internal results. In results not shown here, both Acumentra and Verity show that there is no remarkable change on any of the domains they measured for the time period 2006 through 2009.

**Table 2: Verity patient subjective satisfaction results in Verity and Acumentra Surveys, 2008 and 2009.**

Domain	Verity results		Acumentra results	
	2008	2009	2008	2009
General satisfaction	87%	90%	80%	78%
Access	81%	84%	71%	75%
Quality	90%	91%	76%	77%
Outcomes	71%	77%	53%	57%
Functioning	Not measured		53%	56%
Social connectedness	Not measured		53%	61%
Participation in treatment planning	Not measured		66%	70%

Note: Percentage is of respondents providing "satisfied" average response to items in the Domain. See below for discussion.

Sources: Acumentra Health, 2008 Oregon Mental Health Statistics Improvement Adult Consumer Survey Report. Salem: Oregon Department of Human Services, Addictions and Mental Health Division, AMH-EQR-OR-08-03, January 2009; Acumentra Health, 2009 Oregon Mental Health Statistics Improvement Project Survey for Adults. Salem: Oregon Department of Human Services, Addictions and Mental Health Division, Contract #109162,3, December 2009; MHASD, Verity Integrated Behavioral Healthcare Systems Adult Satisfaction Surveys May 2009, October 2009; MHASD, 2008 Verity Annual Quality Report, February 2009.

The disparity between these measures of subjective experience could be due to a number of factors. Your committee's first attempt at understanding the difference was to

look at the definition of "satisfaction" in the Acumentra and Verity analyses. Acumentra is explicit that for a patient to be "satisfied" on a domain, the *average* score of the items in the domain had to be over 3.5 on the five-point scale. Verity did not provide its definition of satisfaction in its report. However, we were informed that Verity required the average to be 3.6 or more to obtain a "satisfied" rating.<sup>26</sup> Hence, one would expect Acumentra to have *more* ratings of satisfied, not fewer, because their criterion was less stringent. Our second attempt was to examine the differences in survey administration to determine whether there were potential biases that could explain the differences. Our examination showed that the Verity method of administration was much more subject to biases favoring positive responses than the Acumentra methods. The full explanation of how these biases work takes us into technical areas, and is therefore presented in Appendix 3 to this report. The conclusion from this analysis is that the lower Acumentra numbers are the more credible.

Because your committee heard in some witness testimony that Oregon's satisfaction results, and especially those of Multnomah County, were better than national results, your committee looked at the most direct comparison it could find, in 2006.

**Table 3: 2006 Oregon and national patient satisfaction results**

Domain	Oregon	National
General Satisfaction	78%	88%
Access	70%	85%
Quality	75%	87%
Outcomes	65%	82%
Social Connectedness	59%	73%
Participation in Treatment Planning	65%	82%

Note: Percentage is of respondents providing "satisfied" average response of more than 3.5 on a 5-point scale to items in the Domain.

Source: Acumentra Health, 2008 Oregon Mental Health Statistics Improvement Adult Consumer Survey Report. Salem: Oregon Department of Human Services, Addictions and Mental Health Division, AMH-EQR-OR-08-03, January 2009.

In these results, which used MHSIP Version 1.2 administered by random sampling in a number of states, Oregon is significantly below the national average on all domains. While it could be claimed that the Verity survey figures for 2008 and 2009 (Table 2) approximate the national ones,

## Improving the Delivery of Mental Health Services in Multnomah County

the more appropriate comparison is to the Acumentra survey, because the same methods and instruments were used. Thus, Verity is below the national averages on all measures, but on a par with other Oregon providers for all domains except outcomes and social connectedness, where it is low.

### *A Collaborative Outcomes Resource Network (ACORN) Measure of Patient Satisfaction*

Your committee also had concerns regarding the use of the second measure of patient satisfaction known as the ACORN system. According to the Mental Health and Addiction Service Division 2009 Annual Verity Quality Work Plan Report, “MHASD took the lead in standardizing outcome data collection” beginning in 2009, with its selection of ACORN.<sup>27</sup> Briefly, patients complete a questionnaire prior to each treatment session or once weekly, whichever is less. The clinician reviews the questionnaire and guides the session based on the manner in which the items are endorsed by the patient. After the session, the completed questionnaire is faxed to the Center for Clinical Informatics (CCI) and entered into Verity’s database. The information can be viewed later and the patient’s status compared to previous entries and/or compared to a clinical sample. While it is widely acknowledged that subjective ratings of well-being may not always accurately reflect patient symptoms, they are, nonetheless, viewed as a valid outcome measure.

To better understand how the County came to select ACORN, we asked for and were provided with a spreadsheet of the 14 tools under consideration, along with the relative strengths and weaknesses of each measure’s ability to assess the six outcomes stipulated in provider contracts. Of the 14 tools reviewed, several appeared to be relatively equivalent with regard to the number of outcomes assessed and a few of the tools appeared superior to ACORN with regard to having a broader empirical base supporting them. Of the assessment tools reviewed, five were able to assess all six outcomes stipulated in the contracts. Of those five, three tools had no costs associated with their use. ACORN was not among the five that assessed all six outcome criteria. Furthermore, the County included the following “positives” in its review: “well liked and widely implemented by private insurance companies. Free. Minimal cost data analysis. Short and simple.” It was noted that ACORN is “highly endorsed by private mental health insurance companies and at least one mental health provider.”<sup>28</sup> While it is beyond the scope of this committee’s research to investigate alternatives to ACORN, the County’s choice

in piloting ACORN led us to questions about process and procurement.

In her testimony, Joan Rice, Quality Management Manager in the division, told your committee that Multnomah County serves a large population of individuals with mental illness, many with severe and persistent mental illness (SPMI). Reportedly, the County serves a higher proportion of clients with schizophrenia or other psychotic disorders than other counties across the state (21 percent of patients vs. state average of 17 percent). Additionally, she stated that the County serves a disproportionately large number of adults with SPMI who also require residential care.<sup>29</sup>

A review of the normative population to which Verity members are being compared revealed that fewer than one percent of the adults that comprised the ACORN clinical sample received treatment for psychotic disorders such as schizophrenia. Unlike the Verity membership, only 5 percent of the ACORN clinical sample was treated for bipolar disorders and 3 percent received treatment for post-traumatic stress disorder. According to the Center for Clinical Informatics, of the 4,000 adults that comprise the ACORN clinical sample, 28 percent sought treatment for depression, 26 percent for adjustment disorders, 13 percent presented without a diagnosable disorder, and 11 percent sought treatment for anxiety. In other words, less than 10 percent of the ACORN clinical sample resembles the actual Verity membership. Indeed, many of the items that describe common symptoms of those with psychotic disorders (e.g., “I heard voices when I was alone” or “I thought people could read my mind”) are excluded from the analysis of a patient’s “global distress”—the index used to assess improvement. Therefore, for agencies serving a majority of patients with severe and persistent mental illness, a reduction in psychotic symptoms would be undetected by this measure. Given that such a large proportion of individuals receiving mental health services in Multnomah County routinely face economic hardship or poverty, unstable hous-

**“Given that such a large proportion of individuals receiving mental health services in Multnomah County routinely face economic hardship or poverty, unstable housing and/or homelessness, co-morbid medical conditions, chemical dependency, and legal issues, it remains unclear why the County selected ACORN—an assessment tool better suited to the ‘worried-well.’”**

## Improving the Delivery of Mental Health Services in Multnomah County

ing and/or homelessness, co-morbid medical conditions, chemical dependency, and legal issues, it remains unclear why the County selected ACORN—an assessment tool better suited to the “worried-well.”

Once selected, the County initiated its pilot of ACORN across five volunteer agencies beginning in fiscal year 2009. Again, citing the Mental Health and Addiction Service Division 2009 Annual Verity Quality Report, “according to the ACORN data, Verity members assessed in pilot agencies received effective treatment.”<sup>30</sup> Based on information available on the CCI website, this conclusion can hardly be drawn from the data as we understand it.

The developers of ACORN promote an approach called “outcomes-informed care” that utilizes a “meta-method” for assessing patient outcomes. In contrast to current trends toward evidence-based practices, “outcomes-informed care” assesses patient self-report independent from the types of treatment interventions delivered, evidence-based or otherwise. The theoretical underpinning of “outcomes-informed care” is that the primary curative factors in mental health care are therapists themselves and the relationship between therapist and patient. In other words, “outcomes-informed care” uses subjective ratings of patients regarding various aspects of their functioning but makes no attempt to link these ratings with the potential causal factors associated with them, such as recent medication change or recent loss of housing. Therefore, while early data may suggest that patients are improving over time, their improvement cannot be attributed to the treatment they receive. In fact, research has long ago established that even patients in distress who receive no treatment at all get better over time. Furthermore, there are concerns about response-bias when completing ACORN just prior to entering a treatment session. The respondent is not afforded any anonymity and, consequently, may self-censor her or his responses, especially when answering questions about the therapist-patient relationship (e.g., “I felt that the therapist liked and understood me”).

Finally, as stated above, “outcomes-informed care” is predicated on the theory that the “individual therapist is the single most important ‘ingredient’ in the effects of treatment outcome.”<sup>31</sup> Your committee believes this is an overstatement and oversimplification of the literature on the range of factors associated with positive treatment

outcomes. Specifically, it minimizes the research showing that some therapeutic methods (e.g., pharmacology, cognitive-behavioral treatment) have better outcomes than others and that the therapist-patient relationship is only one of several variables contributing to patient improvement.<sup>32</sup> Furthermore, minimizing the role of the specific treatment method employed is inconsistent with the direction the state has taken in requiring state agencies to deliver 75 percent of their services from the approved list of evidence-based practices.<sup>33</sup> Therefore, while your committee agrees that the therapist-patient relationship is indeed very important, it contends that it is but one of several ingredients that facilitates improved mental health and functioning.

*The conclusions drawn from this inquiry troubled your committee. First, the County elected to pilot an assessment tool without having conducted a more thorough and objec-*

**“ [T]he County lacks a comprehensive and consistent system for assessing the outcomes of the services it funds.”**

*tive evaluation of its relative merits compared with other more established and validated measures of patient well-being. Second, County administrators, in selecting ACORN and inferring that it can measure treatment effectiveness, demonstrate that they do not understand the product they purchased (at last reporting, having spent \$150,000),*

*including its strengths and limitations. Third, and perhaps most troubling, is the distinct impression that neither the selection process nor the decision to “pilot” the tool appears to allow for the possibility that ACORN will not be selected as the de facto method by which all contracted providers will be required to measure their patient outcomes.*

*In summary, the County lacks a comprehensive and consistent system for assessing the outcomes of the services it funds. LOCUS, MHSIP, and ACORN—the measures that are applied across the system—are tools that provide only a limited perspective on the success of treatment. The data gathered are, by the County’s own testimony, largely unanalyzed. Given the fact that the contracting system relies so heavily on the judgment and intuitions of individual administrators, the lack of comprehensive information on the functioning of the system is extremely troubling.*

It is important to stress that this conclusion is not an indictment of the dedication or integrity of the individuals who are managing the County’s mental health system. After the collapse of Cascadia, they faced the task of reforming a bankrupt system at the same time that they continued

## **Improving the Delivery of Mental Health Services in Multnomah County**

to provide services to people whose needs were pressing and immediate. Your committee believes that many of the problems faced in the County stem from the system in which these individuals labor. In the following sections, your committee presents findings regarding the resources employed in providing mental health care and the system of delivery for mental and physical health in the County.

# Improving the Delivery of Mental Health Services in Multnomah County

## BUDGETS

In a time of fiscal stringency, the mental health system must compete with other state and municipal services for scarce resources. Taxpayers have every right to insist that the expenditure of monies is occurring in a way that maximizes the benefit both to recipients of care and the larger community. The flow of federal, state, county, and private dollars should be documented in a way that is clear and easily accessible to the public.

As taxpayers, committee members found it impossible to trace tax dollars through the budget process. The comment of State Auditor Gary Blackmer regarding state programs is duplicated on the county level. He said, “If you want to go in as an auditor and find out how much they got last year, how many were served, what kind of staff they had and what kind of results they got, it’s just not broken out that way. Instead, many state programs, especially in the vast Department of Human Services, are blended with others.”<sup>34</sup> Your committee believes that it should not require a staff of budget analysts and hours of testimony to understand a budget.

The common method of tracking expenses is a line-item budget expense report showing dollars spent on a regular basis (daily or month-by-month). Your committee finds it baffling that the County has been unwilling or unable to provide a complete line-item budget for MHASD, Verity, or other bodies. One public relations advisor from the County provided your committee a graph and stated: “We key it this way rather than having it in a line item because it is easier to track.” While colorful charts and graphs give an overview, they lack specific detail and do not promote budget accountability. Three requests for copies of the budget over a period of months have yet to produce a copy of the MHASD line-item budget—a public document that should be available to any concerned citizen.

Money for mental health care in Multnomah County comes from federal, state, and county sources. Because the funding from the federal government and the state is inadequate to provide services for the needy population of Multnomah County, the County supplements that funding from its own general revenues. This contribution appears greater than the sum of contributions from all other counties in Oregon.

Nevertheless, your committee found it impossible to determine exactly how much money is spent for men-

tal health services in the County. The Department of County Human Services (DCHS), the Multnomah County Sheriff’s Office (MCSO), the Department of Community Justice (DCJ), and the Health Department each have some responsibility for mental health services, yet Mental Health and Addiction Services (MHASD) is the division under DCHS primarily responsible for mental health care. It is difficult, if not impossible, to know how much each department spends on direct delivery of mental health services. Every time committee members interviewed division members attempting to track the flow of resources, they received roughly the same answer: “It’s complex.”<sup>35</sup>

According to the Budget Office web site, the 2010 Multnomah County budget was \$1,232,494,223.<sup>36</sup> Table 4 shows how a portion of that money is divided among various departments.

**“[Y]our committee found it impossible to determine exactly how much money is spent for mental health services in the County.”**

**Table 4: Multnomah County departmental total costs**

County Department	Total Costs
County Management	\$243,240,146
Non-Departmental	\$202,327,714
Health Department	\$137,155,977
Sheriff’s Office	\$113,513,025
Department of Human Services	\$193,404,640
Community Justice	\$82,336,088
Community Services	\$73,752,695
Library	\$63,677,957
District Attorney	\$24,367,388

Source: Adapted from Budget Director’s Message FY 2010 Adopted Budget.

According to Multnomah County’s Budget Director, “The Non-Departmental area in Table 4 consists of the Board of County Commissioners and its Chair; the Auditor; the County Attorney; the Public Affairs Office; non-County Agencies; independent County organizations; the County’s ITAX transfer to school districts; and Accounting Entities...”<sup>37</sup> When one combines these Non-Departmental costs with County Management costs and an undetermined amount from each department’s budget, it appears that a large proportion of the County’s budget is for administrative and overhead costs rather than direct services.

## Improving the Delivery of Mental Health Services in Multnomah County

About 30 percent of Multnomah County's revenue appears to come from federal and state sources; about 70 percent from taxes (including property, business-income, and motor-vehicle rental taxes), licenses/permits, service charges, beginning working capital, and interest (a minute fraction of one percent). Committee members asked: "Can you specifically track or break out the federal and state sources?" We did not receive a direct answer. Rather, your committee was told: "It's complex."

Multnomah County prepares budgets for 31 funds, including include the General Fund, Special Revenue Funds, Debt Service Funds, etc. Committee members asked how "Funds" relate to "Departments" or "programs?" The answer: "It's complex."

DCHS monies come from:

- Fund 1000 – General Fund
- Fund 1500 – Strategic Investment Program Fund
- Fund 1505 – Federal/State Fund
- Fund 3002 – Behavioral Health Managed Care Fund<sup>38</sup>

Mental health falls under the umbrella of the County Department of County Human Services and more specifically the DCHS Mental Health and Addiction Services Division. Mental health and addiction services are intertwined. DCHS "program offers" do not reflect or correlate to contracts with mental health service providers. A single contract with a mental health service provider may use funds from many different program offers.

Each department prepares program offers which make up that department's budget. There are "operating" programs and "administration and support" programs. For example, "Mental Health Crisis Services-Base" would be an operating program; "Medical Records for Mental Health & Addiction Services" would be an administration & support program. Most but not all program offers include an explanation of where the revenue for that program will come from. For example, program offer DHS 25067 lists:

- OHP Premium (OHP means Oregon Health Plan and in Multnomah County that means Verity. See the discussion of Verity above.)
- FQHC
- Title XIX/OMAP
- Head Start Contracts
- FFS Insurance Rcpts (FFS means fee-for-service.)

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\* The County defines "program offer" in the following way: "A proposal from a department that is submitted to the Board of County Commissioners. The program offer states the priority to be addressed, the services to be provided, the performance to be expected, and the cost."

- State Mental Health Grant Child & Adol MHS
- County General Fund

As the examples above show, one program offer may receive funding from numerous sources. Large service providers told your committee that their funding may come from as many as a hundred different sources.

The FY 2010 budget for MHASD according to the Board Briefing of April 2010 was \$77,831,455.<sup>39</sup> According to Brimner, the bulk of that money comes from the Oregon Health Plan, State General Funds, and County General Funds. Most, but not all mental health services, are contracted to non-profit providers. Contracts are not tied to program offers and may overlap budget years. Contracts may be funded from a variety of sources. All of this makes it difficult, if not impossible, to track the flow of dollars. County personnel provided much budget information but primarily in charts and graphs. Information was confusing and sometimes contradictory. Members of the County's Citizen Budget Advisory Committee for Human Services confirmed that they received many pie charts and graphs but not enough detail about the mental health budget.<sup>40</sup>

Your committee has not seen a list of contracts for mental health service providers in the budget; the budget does not reflect how many dollars go to mental health service providers via contracts. The DCHS Board Briefing from April 10, 2010 states that 93 percent of the \$77,831,455 goes to services as opposed to administrative costs,<sup>41</sup> however, your committee has not seen any documentation of this. Based on the FY 2010 Summary by Program Offer for DCHS, 93 percent seems high.

Our analysis of expenditures makes it difficult to accept the 93 percent figure of money devoted to patient care that was given in the briefing to your committee. While at any one level of the system, overhead may be no more than 7 percent, each level of the system requires expenditures for overhead. Since these levels include the state, the county, as well as the providers, the actual percentage of dollars spent in individual care diminishes at each level.

In attempting to assess the monies spent on mental health care by other County departments, your committee encountered similar problems. The goals of departments such as Community Justice and the Sheriff's Office are to promote public safety and provide quality, cost-effective prevention, intervention, and detention services to the communities of Multnomah County, and other programs. Mental health services may be a piece of the larger programs but mental health is not tracked as a discrete budget

## Improving the Delivery of Mental Health Services in Multnomah County

item in those departments. For example, 2010 MCSO program offer 60037A states, "Inmate Management: Counselors assess, evaluate and place offenders on the many work crews; provide orientation to help offenders navigate through the complex criminal justice system; diffuse escalating behavior; provide mental health services that link offender to services in the community; equip offenders with skills to manage behavior; offer group counseling to diminish criminal thinking errors." How much of the dollar value of that program goes towards mental health services? At this time it is impossible to determine. MSCO has no method to track the mental health services as separate from any other aspect of inmate management counseling.

The Department of Community Justice (DCJ) provides parole and probation services. DCJ program 50041, Adult Offender Mental Health Services, has a total program budget of \$1,314,651. This program funds parole and probation officers for over 200 adult mentally ill offenders, three contracted staff to work with 60 offenders preparing them for community treatment, mental health evaluations, and 15 residential beds of Dual Diagnosis treatment (the Residential Integrated Treatment Services) operated by Cascadia Behavioral Healthcare, for offenders who have not been successful in alternate treatment therapies. DCJ also spends about \$200,000 for juvenile mental health-related services.

If you combine the almost \$78 million MHASD budget plus the cost of jail beds for persons deemed to be suffering from mental illness plus related Corrections Health costs and Community Justice costs, it adds to approximately \$87 million. However, as one witness stated, "The primary (and really only legal) reason we see a person in a jail bed is due to either probable cause of a crime being committed, or sentencing of a person for a crime, so the bed cost associated with that person is criminal, rather than associated with mental health service delivery."<sup>42</sup> Thus, the 106 jail beds are a "criminal" cost rather than a "mental health" cost. However, many of those 106 jail beds are occupied by persons suffering a mental illness. If they were not mentally ill, they might well not have engaged in the behaviors that resulted in their incarceration. As Joan Rice pointed out in testimony to your committee, it is ironic that the individuals with the most systematic assessment of outcomes are among those in programs for the incarcerated.<sup>43</sup>

**"To be fair, your committee understands that budgeting is indeed a complex process. However, a few simple steps could make it somewhat less opaque."**

Your committee discovered that government budgets are unlike the average household, corporate, or business budget. When talking about "the budget" it is important to recognize that there is not a single document but rather numerous budget documents. Your committee searched in vain for a spreadsheet or the like listing income,

expenditures, and assets. It took some digging even to come up with the simple table of county departments and budget dollars as shown above. Within departments, your committee could not find in the budget, a listing of dollar amounts for individual divisions. At the division level your committee found it impossible to clearly trace budget dollars. Income, expenditures and programs appear tangled beyond the comprehension of the average citizen.

To be fair, your committee understands that budgeting is indeed a complex process. However, a few simple steps could make it somewhat less opaque. It would help the average citizen if in one place (the Chair's budget message, the Budget Director's message, or elsewhere), the Departments with their budgeted dollars were listed and totaled, followed by a listing of Divisions within each Department, with the Division-budgeted dollars. This would offer greater transparency. It would also help transparency if money were reported in a consistent manner.

In summary, the County's budget system fails to provide the public with the information it needs to assess the efficiency of its government. Your committee found that budget information is presented inconsistently — sometimes in charts and graphs, sometimes as specific dollars, and sometimes as rounded sums. This lack of transparency and the intermingling of funding revenues and expenditures have made it impossible for us to determine to what extent the limited resources are being used effectively in meeting the needs of individuals.

### SYSTEMS

#### Systemic Problems

Many of the problems relating to the delivery of mental health services stem not only from the system of health care as a whole, but also the relationship of the County's

mental health division to other governmental units. Your committee believes that for care to be effective, the individual must be at the center of an integrated system in which the organizations treating physical and mental health, arranging for special housing needs, and providing criminal justice to the community all communicate effectively with one another. This communication must extend to mental health systems in other counties of the metropolitan area.

**"Your committee believes that for care to be effective, the individual must be at the center of an integrated system in which the organizations treating physical and mental health, arranging for special housing needs, and providing criminal justice to the community all communicate effectively with one another."**

The system must be responsive to calls for changes that improve the delivery of care and encourage public participation in policy making.

As will be detailed in this section, communication between county mental health divisions is inadequate. Cooperation among departments within Multnomah County is ineffective. The system has failed to respond to earlier calls for its improvement and does not facilitate the involvement of outsiders in its functioning. Administrative improvements, such as changes in systems of contracting, budgeting, and assessment, while important, will not address these dysfunctional aspects of the system as a whole.

#### *Integration with the Systems of Other Counties and with Other Departments within the County*

The behavior of people suffering from mental illness frequently results in contact with police officers, many of whom have little expertise in assessing the appropriate action to take. Bruce Goldberg, Director of Oregon's Department of Health and Human Services, summarized the situation when he said that most parents of children with

mental illness tell him that at one time they have had to call the police to obtain mental health care for their child.<sup>44</sup> There is a tendency to take the mentally ill to emergency facilities in hospitals, which are legally obligated to provide care. Witnesses from Multnomah County hospitals testified that following the closure of a mental illness triage center at Providence Health Care Services in 2001, this pattern of hospital admissions has increased dramatically. Nursing personnel spend hours trying to obtain an appropriate placement for individuals who arrive in this way. Not only is such emergency care inappropriate for mentally ill individuals, it is also expensive and a burden on facilities established for other forms of care. Your committee considers this a system failure.

There is a human cost as well as a financial one. Mentally ill individuals who are released from the criminal justice system are forced to seek services in the already overtaxed public sector. Frequently, the Oregon Health Plan does not cover them and they must go through an elaborate bureaucratic process to demonstrate need. Continuity of care is fractured, forcing vulnerable individuals to navigate a frustrating and overly complex process.

Mentally ill individuals have distinct needs with respect to housing that are inadequately addressed in the current system of care. Administrators, when asked to define their goals for the individuals receiving treatment, repeatedly asserted that their idea of success was an individual with a stable job, decent housing, and no criminal activity. These three factors are interrelated since homeless individuals are far more likely than most to engage in actions regarded as a public nuisance. The mental health system's attempts to provide adequate residential facilities face financial hurdles. State law limits public contracts for the support of residential facilities to five-year terms, making lenders reluctant to finance projects for which funding is not secure. Your committee considers this a system failure.

As noted earlier, Portland hospitals experienced a dramatic overcrowding in their mental health wards and emergency rooms following the closure of the triage center at Providence. As reported to your committee, Providence was unable to continue subsidizing the one-million dollar deficit the center ran and the County was unwilling to increase its compensation. One result of this closure was to fill expensive hospital beds with patients who could be cared for in less expensive and less acute care settings. Beyond the financial consideration, some of the individuals admitted are in facilities inappropriate to their needs, while others may be turned away for lack of space. In the absence of



## Improving the Delivery of Mental Health Services in Multnomah County

triage by qualified specialists, non-mental health professionals must make the decision whether to take individuals to a detoxification facility, an emergency room, or jail.

Another system problem is the lack of integration in information technology systems. At present, each provider organization maintains its own system of recording patient care, making it difficult to communicate among individuals and organizations providing care. In times of crisis, such failures of communication exacerbate the problems in providing appropriate care. A therapist may be ignorant of the medications that an individual is receiving and unaware of the success or failure of previous therapeutic interventions. Your committee believes that the move toward a coherent system of information technology is a national priority in which Multnomah County should participate to as great an extent as possible.

A laudable desire to protect patient privacy may have made provider organizations reluctant to share patient data. According to the U.S. Department of Health and Human Services, "The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes."<sup>45</sup> The federal guidelines specifically state that a covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities. A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, so long as both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship. In short, facilitating information about patients to qualified applicants should pose no impediment to instituting a common information technology system.

Your committee also believes that the existing system needs to be reformed to allow specialists dealing with an individual's physical ailments to communicate more easily with those in the mental health delivery system. The symptoms patients describe, the medications they ingest, and the frustrations they encounter all involve behavioral and physical components. The health state of individuals should not be divided into physical and mental compo-

nents. These two types of complaint all too often can be deeply interrelated. Many individuals have both physical and mental ailments at the same time. Until individuals receive the coordinated expertise of all those who deal with them, they will not be able to benefit fully from the health care system. Unless this coordination is built into the system of care itself, the quality of service will be disjointed and suffer as a result.

### *Previous Assessments*

Your committee was distressed to find that previous studies have identified many of the problems outlined in this report, yet changes in the system have not been made. As the studies referenced in the box below make clear, there is a well-documented history of concern about the management of mental health services in Multnomah County:

#### **Previous Assessments of Mental Health Services in Multnomah County**

1980 David Lawrence White Paper:

"A sense of the Department of Human Services as a collection of fragments . . . prevails. Although the complexity of the Department has grown in terms of legal mandates, clients, service mix and delivery approaches, funding and reporting and oversight responsibility . . . [and] management capabilities . . . have not grown correspondingly . . . Information systems are spotty." "Not all problems can be addressed by the community, and even fewer by DHS."<sup>46</sup>

1993 Multnomah County Commission Task Force on Contracting:

"Too often, assessments of contractor performance have focused on contract compliance rather than program evaluation."<sup>47</sup>

2000 Multnomah County Mental Health System Design:

"The current system is overly fragmented and complex; The current system contains inherent basic design flaws; The services and system lack a best-practice family-centered systems [of care approach] for youth and a rehabilitation and recovery approach for adults; Care coordination and care management are only partially developed; Incentives and disincentives are not properly aligned to achieve system goals; and State and County roles and responsibilities are poorly defined."<sup>48</sup>

## Improving the Delivery of Mental Health Services in Multnomah County

### Public Meetings and Advisory Input

Although Multnomah County provides information online, your committee found County processes and information, at least in the mental health arena, opaque regarding budget matters, public meeting access, and public advisory input. Difficulties faced by our committee members in their attempts to read minutes or attend meetings of the Adult Mental Health Substance Abuse Advisory Council (AMHSAAC) illustrate the tendency of County activities in this area to be shielded from public view.

Having been told they were welcome to attend an AMHSAAC meeting, members of your study committee arrived to find the doors locked and were then escorted by staff to another room. Your committee had not seen any posted notice of this change. Other members of the public wishing to attend the meeting had to find someone with a key in a separate office because the meeting room had been changed at the last minute. While at the meeting, one AMHSAAC member informed your committee members that the meeting was in fact confidential and that your committee should consider the proceedings private. After objection, the Council chair affirmed that to the contrary, the meeting was a public meeting conforming to open meeting requirements, and not private or confidential. When your committee members reconfirmed that they were indeed scheduled to join the next meeting of the Council Executive Committee, they were later told that they should not attend because some Council members might feel uncomfortable with outside members of the public present. When your committee inquired about the public access guaranteed in the Council's bylaws (section V-3), they were told it came under an exception. Further, Council minutes should have been posted promptly, but our committee members had a difficult time finding such minutes. When asked, County staff stated they would have to look into the matter.

This apparent tendency for conducting business away from public view, whatever the legal implications, inevitably handicaps the ability of the mental health system to build a community of concern in the metropolitan area. Your committee believes that public access to the processes of government does not impede action, but rather builds support for public programs. If citizens are told that they cannot understand the budget because it is too com-

plex, they will be ignorant of the resources and constraints of the mental health system. If those who make extraordinary efforts to attend are told they are there as observers only, or that they are barred because some on the Council might feel uncomfortable, there is little incentive to attend. Treating mental health issues in this way may actually reinforce popular attitudes that stigmatize the mentally ill, while decreasing trust in government.

A system that actively shares information and solicits the perspectives of the general public will be rewarded for its efforts with a more knowledgeable and committed populace. Your committee was impressed by the example of the County's Schools Uniting Neighborhoods (SUN) Service System, which makes organizing grass-roots support and encouraging public engagement a priority as it works to foster educational reform. The SUN Service System promotes educational success and family self-sufficiency through an integrated network of social and support services for youth, families and community members. A nationally recognized system, it works to ensure that families are healthy so they can champion and support their children. Its staff members actively solicit participation by members of the affected community with the goal of improving the continuity of services. This degree of engagement is exemplary and pays ample dividends in terms of the public support necessary for continually improving the system. The mental health system, by contrast, functions in a way that is isolated from the larger community and is resistant to attempts to change its established patterns of behavior. Members of your committee commend the SUN Service System model, and believe that the County's mental health system would profit from emulating its example.

**"A system that actively shares information and solicits the perspectives of the general public will be rewarded for its efforts with a more knowledgeable and committed populace."**

### The Imperative of Systemic Change

In 2008, the Public Consulting Group conducted an evaluation of mental health care delivery systems in Oregon, concluding that "Oregon should establish a regional approach and contract with regional authorities for the delivery of mental health care services."<sup>49</sup> That same year, the Oregon Health Fund board made a similar suggestion in a report entitled *Aim High, Building a Healthy Oregon*.<sup>50</sup>

Mental health program leaders in Clackamas, Washington, and Multnomah counties responded to these proposals

## Improving the Delivery of Mental Health Services in Multnomah County

in a January 2010 report: “The Question of ‘Regionalization’ for the Portland Metro Area.” The response begins by citing a single source by a single author that describes regionalization as a “myth,” then presents a series of reasons for maintaining the existing structure in which each county has a separate mental health department. The response concludes that the benefits of regionalization will be better achieved simply by improving coordination between the various county mental health departments.<sup>51</sup>

In reviewing this report, your committee found many of the arguments to be unpersuasive. For instance, the response cites the ethnic heterogeneity of the metropolitan area as an impediment to care without explaining why care would be negatively impacted or acknowledging that care within both Washington and Multnomah counties already is delivered to a diverse population. The response argues that the transition would require the creation of “new layers of administration,” ignoring the fact that the goal of regionalization is to reduce the number of layers of administration. The response argues that local counties “might not continue” to support the delivery of services to their inhabitants, but provides no reason why counties would suddenly cease to support services. The authors assert that a “more complex decision making process” would result from regionalization. The report’s solution to regional problems—negotiation between three independent entities—is hardly a simple decision-making process.<sup>52</sup>

Oregon is among a minority of states authorizing counties to provide health care services. According to information provided by the National Association of State Mental Health Provision Directors Research Institute, 20 of the 50 states devolve mental health provision to counties. Most of those states are larger ones, such as California or Pennsylvania, and the inability to manage large populations is typically provided as the reason for this decision.<sup>53</sup> Oregon is, therefore, atypical in not having a large population but delegating care to the county level.

Your committee has received testimony indicating that individuals who move from one county to another within the metropolitan area may encounter difficulty in receiving care.<sup>54</sup> In other cases, hospitals providing care in one county may encounter resistance to reimbursement from the county in which the individual resides. The report acknowledges these difficulties, but they continue to exist.

Some states establish regional authorities, typically based on geographical or demographic boundaries rather than political ones. Oregon is currently experimenting with one such regional authority, in a geographically compact and

demographically homogenous three-county area surrounding Bend. The concept provides a promising alternative to the current system. Your committee encourages this experiment and sees it as having great potential.

Beyond the issue of regional integration, Multnomah County faces a problem of excessive systemic complexity—a bizarre web in which funds flow from half a dozen sources into a network of programs to reach the population served. The federal government, for instance, remits Medicaid dollars to the state, which transfers that money to the County, which in turn contracts with nonprofit providers of services. Each level of organization generates another layer of overhead that, inevitably, reduces the resources flowing to the direct care of the individuals who need it. Instead of a system where resources are allocated efficiently to effectively address community needs, the result is a patchwork of poorly coordinated programs.

In Multnomah County, the system of mental health care needs to be completely restructured. The outcome should be a system that integrates the provision of physical and mental health. It must coordinate with local systems of criminal justice and housing so that those in need do not have to navigate distinct departments and bureaucracies in search of help. The system must constantly monitor the outcomes for those it serves to ensure that care is available and effective. The result of such a patient-centered approach will be care that is more humane, more competent, and more cost-effective for all the citizens of Multnomah County.

**“...20 of the 50 states devolve mental health provision to counties. Most of those states are larger ones, such as California or Pennsylvania, and the inability to manage large populations is typically provided as the reason for this decision. Oregon is, therefore, atypical in not having a large population but delegating care to the county level.”**

## **CONCLUSIONS**

1. The procedures for negotiating and monitoring contracts between Multnomah County's Department of Human Services and its service providers are informal and rely on the expertise of individual administrators to an excessive degree. Independent assessment of compliance is absent.
2. The outcomes that are identified for providers are not stated in ways that can be measured effectively. Data that are collected are not adequately analyzed to provide information crucial to the evaluation and improvement of programs. As a result, it is impossible to assess objectively the effectiveness of therapeutic programs.
3. Crucial information on the budget is not available for citizen review. The direct and indirect costs of programs are not identified, making it impossible to determine how much of the resources are directly employed in individual care.
4. The administration of the County's Department of Human Services and its Mental Health and Addictions Services Division is resistant to outside input and review. Access to advisory boards is difficult. Questions about the suitability of assessment measures met with responses that failed to clarify the issues. As a result, there has been little effort to establish a community of care to support mentally ill individuals.
5. Communication between counties in the metropolitan area and departments within Multnomah County is poor. As a result, mentally ill individuals have difficulty navigating the system of care currently available.

# RECOMMENDATIONS

Your committee recommends that the following actions be taken to strengthen the delivery of mental health services in Multnomah County:

## Budgets

1. The County should make the Mental Health and Addiction Services Division (MHASD) budget more accessible and transparent. An online line-item budget that specifies what items are associated with direct costs of care and which are indirect costs related to the administration of care should be made available within the next budget cycle.

## Contracts

2. All County contracts with mental health service providers should be made available online.
3. The County should continue to expand the enforcement of existing contract standards including public reporting of compliance and non-compliance with mental health contracts.
4. The County should *change* the oversight of mental health contract procurement and enforcement so that the oversight is *completely* independent of those who manage the programs.

## Outcomes

5. The County should abandon ACORN as an outcome measurement tool and only use LOCUS as an acuity tool. The County should instead engage in a collaborative effort to define appropriate measures for each agency based on services delivered and client population.
6. The County should allocate resources to analyze the collected data to improve public mental health programs.

## Systems

7. The Oregon Health Authority should redesign, expeditiously, the structure of the provision of mental health services to achieve the following goals:
  - a. Remove jurisdictional barriers to mental health services.
  - b. Increase the proportion of resources devoted to direct care of recipients.
  - c. Reduce administrative layers relative to mental health services.
  - d. Reduce duplication of effort on the part of service providers.
  - e. Ensure uniform standards for measuring the quality of mental health care.
8. The County should formally disavow the internal recommendation that only counties provide mental health services. The County should adopt a formal resolution supporting the effort by the Oregon Health Authority, even if this means that a state or regional agency would replace the current County agency.
9. The County should improve and dedicate resources to encouraging public involvement on mental health issues. The County's Schools Uniting Neighborhoods (SUN) Service System provides an effective model that the Mental Health Division should consider for improving its own efforts.

Respectfully submitted,

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# APPENDICES

## Appendix 1: Organizations Providing Verity-Reimbursed Services

Albertina Kerr  
Cascadia Behavioral Healthcare  
Central City Concern  
Comprehensive Options for Drug Abusers  
LifeWorks Northwest  
DePaul Treatment Centers  
Volunteers of America/InAct  
Kinship Home  
Luke-Dorf  
Lutheran Community Services  
Morrison Child and Family Services  
Native American Rehabilitation Association of the Northwest  
Oregon Health and Science University  
Outside In  
Project Quest  
Trillium Family Services  
Western Psychological and Counseling Services  
Christie School\*  
Portland Dialectical Behavior Therapy Program\*  
Options\*  
Serendipity Therapeutic School\*

\*Clients must be referred by Verity for these agencies.

## Improving the Delivery of Mental Health Services in Multnomah County

### Appendix 2: Validated Outcome Measurement Resources

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices, <http://nrepp.samhsa.gov/>.

Agency for Health Research Quality (AHRQ) National Guideline Clearinghouse, <http://www.guidelines.gov/>.

The American Psychological Association Division 12 (Society of Clinical Psychology) list of evidence-based treatments, <http://www.div12.org/psychologicaltreatmentsorg/>.

The Cochrane Collaboration (international organization advocating evidence-based medicine that sponsors systematic reviews of the scientific literature), <http://www.cochrane.org/reviews/>.

The Campbell Collaboration (derived from the Cochrane Collaboration to focus on evidence-based interventions in the areas of education, crime and justice, and social welfare), <http://www.campbellcollaboration.org/>.

SUMSearch (a meta-search engine sponsored by the University of Texas Health Center at San Antonio for identifying evidence-based medical interventions), <http://sumsearch.uthscsa.edu/>.

### Appendix 3: Sampling Bias in the Mental Health Statistics Improvement Program (MHSIP) Measure of Patient Satisfaction

Your committee compared the administration of the MHSIP survey by Verity and Acumentra to better understand how the observed differences between the two surveys might be attributable to sampling bias. In our comparison, we found three biasing factors. The first one applies to both surveys and suggests that satisfaction ratings could be higher than actual patient satisfactions in both surveys. The second and third biasing factors are in the Verity administration but not Acumentra, and lead us to conclude that the Acumentra results are more accurate—with the caution provided by the first bias. The first biasing factor is one based on characteristics of the populations surveyed. The second biasing factor is entirely internal to the Verity survey, and concerns differential response rates across providers. The third biasing factor is again only for the Verity survey and involves the construction of the sampling frame—that is, the determination of who is asked to complete the survey.

**1. Patient characteristic response bias.** This bias emerges from the fact that for both Acumentra and Verity, responding to the survey is entirely voluntary among a population of people with mental illness problems. Many of these problems have a component of depression or other manifestations of not functioning well, and these manifestations are associated with not taking actions, including responding to a survey. It is fair to assume that individuals suffering from depression are not likely to report satisfaction with the world, and therefore—had they filled out the survey—would have reported low satisfaction scores. Because satisfaction is by definition subjective, it is not legitimate to dismiss these feelings, nor to say that the non-response “cancels out” an exaggerated feeling of dissatisfaction.

**2. Provider administration response bias.** Appendix A of the 2009 Verity Report provides the number of responses received from each of the 14 providers who fielded the survey, along with the response rate at each institution. Overall, 832 surveys were completed, representing 27 percent of patients seen in May, 2009. The range of response rate was from 9 percent to 100 percent of patients seen; this by itself indicates fairly strongly that different providers approached getting their patients to fill out the surveys differently. Moreover, the response rate differences observed were systematically different by the size of the patient population seen by the provider. The correlation between patient population size and response rate was  $r=-0.60$ , which is quite large. For example, Cascadia, with 38 percent of all Verity patients, had only a 9 percent response rate. This means that the more patients seen, the fewer patients filled out the survey, and this differential has the effect of magnifying the potential patient characteristic response bias. We have been informed<sup>55</sup> that a concerted effort was made in the October 2010 fielding of the survey to get improved provider response rates, and that moderate success was achieved.

**3. Administrative method bias.** The third biasing factor is in the nature of the yearly (or every 18 months) fielding by Verity. Patients in long-term care are likely to be asked to complete the questionnaire. But patients in short-term care, typically six weeks in duration, will miss the three-week window of opportunity. Up to 80 percent of short-term patients who are engaged in a full six-week program might never be asked to fill out the survey. Multiply this by the 27 percent response rate, and now the sample is down to a very small number. But a deeper bias is that patients who do not stay for the full planned duration of their treatment are even less likely to be solicited for responses. Consider two patients, A and B. Both start at the same time. A is satisfied with treatment and continues for the full six weeks. B, on the other hand, is dissatisfied, and drops out after two of the six weeks. In the administrative method of Verity, patient B is less likely to be asked to complete the survey than patient A. Thus, the survey administration method is biased towards longer-term patients who, by nature of the fact that they remain in treatment, are more likely to be satisfied with their treatment. This introduces a very strong potential for bias.

In conclusion, the first biasing factor indicates that MHSIP as a whole, whenever administered, may overstate patient satisfaction. This bias is almost inevitable and measuring its effect is well beyond the ability of the County or the State, much less your committee, to assess. The second biasing factor indicates that different providers within Verity approach the survey differently and systematically based on the size of the patient population, and this could lead to a greater reporting of satisfaction. This bias could be overcome by more uniform administration among Verity providers. The third biasing factor is an inherent weakness of limited-time distribution of surveys at the site of treatment and cannot be overcome. The second and third biases are not inherent in the Acumentra survey administration method. For this reason, we concluded, as stated in the body of the report, that the Acumentra satisfaction results are most likely more reflective of actual patient satisfaction than the Verity satisfaction results.



## Improving the Delivery of Mental Health Services in Multnomah County

### Appendix 4: Standards and Legal Guidelines

Multnomah County’s Department of Human Services operates under legal requirements that range from federal to state to local. Medicaid is a medical assistance program jointly financed by state and federal governments for low-income individuals and is embodied in 42 U.S.C. §1396 et seq. It was first enacted in 1965 as an amendment to the Social Security Act of 1935. Today, Medicaid is a major social welfare program and is administered by the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration.

The table below provides a listing of applicable governmental legal requirements.

42 U.S.C. §1396 et seq	<a href="http://www.law.cornell.edu/uscode/42/ch7schXIX.html">http://www.law.cornell.edu/uscode/42/ch7schXIX.html</a>
ORS 169.076-.077 Local Correctional and Juvenile Facilities	<a href="http://www.leg.state.or.us/ors/169.html">http://www.leg.state.or.us/ors/169.html</a>
ORS 279B Public Contracting	<a href="http://www.leg.state.or.us/ors/279b.html">http://www.leg.state.or.us/ors/279b.html</a>
ORS 294 Municipal Finance Administration	<a href="http://www.leg.state.or.us/ors/294.html">http://www.leg.state.or.us/ors/294.html</a>
ORS 297 Audits of Public Funds & Financial Records	<a href="http://www.leg.state.or.us/ors/297.html">http://www.leg.state.or.us/ors/297.html</a>  ORS 297 requires annual financial statement audit of all municipal corporations. Secretary of State Audits Division, with the Board of Accountancy, and in consultation with the Oregon Society of Certified Public Accountants, prescribes the minimum standards for the presentation of the report and the conduct of the audits.
ORS 414 Medical Assistance	<a href="http://www.leg.state.or.us/ors/414.html">http://www.leg.state.or.us/ors/414.html</a>
ORS 430 Mental Health; Developmental Disabilities	<a href="http://www.leg.state.or.us/ors/430.html">http://www.leg.state.or.us/ors/430.html</a>
OAR 309 Department of Human Services, Addictions and Mental Health Division: Mental Health Services	<a href="http://arcweb.sos.state.or.us/rules/OARs_300/OAR_309/309_tofc.html">http://arcweb.sos.state.or.us/rules/OARs_300/OAR_309/309_tofc.html</a>
OAR 415 Department of Human Services, Addictions and Mental Health Division: Addiction Services	<a href="http://arcweb.sos.state.or.us/rules/OARS_400/OAR_415/415_tofc.html">http://arcweb.sos.state.or.us/rules/OARS_400/OAR_415/415_tofc.html</a>
MCC 23 County Human Services	<a href="http://www2.co.multnomah.or.us/counsel/code/ch23.pdf">http://www2.co.multnomah.or.us/counsel/code/ch23.pdf</a>

## GLOSSARY AND ACRONYMS

Below is a list of terms and acronyms commonly used by your study committee in the report or by witnesses interviewed by your committee. Many terms are defined by statute or regulation.

**504:** Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 701. Oregon has “504 Coordinators” and “Facility 504 Coordinators.”

**ACORN:** A private nonprofit incorporated in Utah, see <https://psychoutcomes.org/bin/view/AcornOrg/WebHome>. Registered agent, G.S. (Jeb) Brown. ACORN stands for “A Collaborative Outcomes Resource Network.” The acronym also stands for questionnaires provided by the organization to be completed by clients/patients in behavioral health care and related fields.

**ACT:** Assertive Community Treatment (team), see <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>.

**ADA:** Americans with Disabilities Act, <http://www.ada.gov/>, 42 U.S.C. § 12101.

**AFSCME:** American Federation of State, County and Municipal Employees, <http://www.afscme.org/>.

**AMH:** Oregon Department of Human Services, Addictions and Mental Health Division, <http://www.oregon.gov/DHS/addiction/index.shtml>.

**Biennium:** Refers to the state’s two-year budget periods, beginning on July 1 of odd-numbered years and continuing through June 30 of the next odd-numbered year.

**Board:** Multnomah County Board of Commissioners, see <http://www.co.multnomah.or.us/cc/>.

**CAF:** Children, Adults and Families.

**Capitated:** Health care system in which a medical provider is given a set fee per patient (as by an HMO) regardless of treatment required.

**CATC:** Crisis Assessment Treatment Center (alternative to hospitalization).

**Categorically needy:** refers to families and children, aged, blind, or disabled individuals, and pregnant women who are eligible for Medicaid; 42 CFR 435.4.

**CER:** Comparative effectiveness research, see <http://www.hhs.gov/recovery/programs/cer/>.

**CFR:** Code of Federal Regulations.

**CGF:** County general fund; refers to funds that can be used for general purposes of county government.

**CIP:** Continuous Improvement Plan.

**CMH:** Community Mental Health.

**CMHP:** Community Mental Health Programs.

**CMS:** Centers for Medicare & Medicaid Services.

**Cost effect:** Cost savings realized over a reasonable period of time are greater than costs. (2009 SB 267; 2007 ORS 182.515(2)).

**CPCA:** Contract Procurement/Contract Administration, <http://www2.co.multnomah.or.us/Public/EntryPoint?ch=eb961c5808c57010VgnVCM1000003bc614acRCRD/>.

## Improving the Delivery of Mental Health Services in Multnomah County

**CPMS:** Client Process Management System, <http://egov.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/state-data.ppt>.

**DHS:** Oregon Department of Human Services, <http://www.oregon.gov/DHS/index.shtml>.

**DCHS:** Multnomah County Department of Human Services, also known as Department of County Human Services.

**DMAP:** Division of Medical Assistance Programs, <http://www.oregon.gov/DHS/aboutdhs/structure/dmap.shtml>.

**DSM-IV:** Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association. The manual was last revised in 2000; a new version, the DMS-V, is currently (March 2011) under review.

**EBP:** Evidence based practice. See <http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml>. Evaluated by well-designed research studies, published in peer-reviewed journals, and consistently found to be effective or efficacious upon consensus review.

**EBT:** Evidence-based treatments.

**EDI:** Electronic Data Interchange, <http://www.oregon.gov/DHS/edi/index.shtml>.

**Effective programs:** Well-researched programs without the needed generalizeability of model programs.

**Evidence-based program:** Incorporates significant and relevant practices based on scientifically based research and is cost effective. (2003 SB 267, ORS 182.515).

**FCHP:** Fully capitated health plans.

**FFS:** Fee-for-service; A type of health care plan under which health care providers are paid for individual medical services rendered, [http://www.oregon.gov/DHS/healthplan/data\\_pubs/feeschedule/main.shtml](http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml).

**Fidelity of practice:** Quality of being faithful and accurate in details in context of replicating the essential elements of the model defined in the research.

**FMAP:** Federal Medical Assistance Percentage, <http://aspe.hhs.gov/health/fmap.htm> and <http://edocket.access.gpo.gov/2009/pdf/E9-9095.pdf>.

**FQHC:** Federally qualified health center, <http://www.cms.hhs.gov/center/fqhc.asp>.

**GF:** General Fund refers to funds that can be used for general purposes of state government.

**ICTS:** Intensive Community-Based Treatment and Support Services, <http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/faqs-update.pdf>.

**LMHA:** Local Mental Health Authorities (ORS § 430.630 (2007)).

**LOC:** Levels of care.

**LOCUS:** County LOC diagnostic system.

**MHASD:** Mental Health and Addiction Services Division.

**MHSIP:** Mental Health Statistics Improvement Program. A national effort to develop and promulgate measures of patient satisfaction with mental health treatment. The acronym also applies to various instruments created by the program.

**MHO:** Mental health organization(s).

**Model programs:** Reliably validated and generalized across a large range of populations.

**MTF:** Multnomah (County) Treatment Fund, <http://www.co.multnomah.or.us/dchs/mhas/mcadmin.shtml>.

## Improving the Delivery of Mental Health Services in Multnomah County

**NAMI:** National Alliance on Mental Illness, <http://www.nami.org/>.

**OAR:** Oregon Administrative Rules, <http://arcweb.sos.state.or.us/banners/rules.htm>. (Rules for DHS, Addictions and Mental Health Division: Mental Health Services are found under OAR 309.)

**OHP:** Oregon Health Plan; see <http://www.oregon.gov/DHS/healthplan/>. Mission: To plan and implement medical programs assuring access to basic care for eligible clients. Goals: Increase access to health care for low-income Oregonians; improve the quality of health care and receipt of preventive services by low-income Oregonians, thereby improving their health; and contain health care costs.

**OMAP:** Oregon Medical Assistance Program (See OAR 410-127), [http://arcweb.sos.state.or.us/rules/OARS\\_400/OAR\\_410/410\\_tofc.html](http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_tofc.html).

**ORS:** Oregon Revised Statutes.

**OSH:** Oregon State Hospital, <http://www.oregon.gov/DHS/mentalhealth/osh/index.shtml>.

**Parity:** Oregon mental health parity requires group health insurance policies to cover treatment of chemical dependency and mental health or nervous conditions at the same level and with no more restrictions than those imposed for other medical conditions. [ORS 743A.168] (See [http://insurance.oregon.gov/FAQs/mental-health-parity\\_consumer-faqs.pdf](http://insurance.oregon.gov/FAQs/mental-health-parity_consumer-faqs.pdf) and <http://insurance.oregon.gov/consumer/mental-health/mental-health-parity-comparison.pdf>)

**Program Offer:** A proposal from a department that is submitted to the Board of County Commissioners. The program offer states the priority to be addressed, the services to be provided, the performance to be expected, and the cost, [http://web.multco.us/sites/default/files/budget/documents/tab\\_11\\_-\\_glossary\\_of\\_terms.pdf](http://web.multco.us/sites/default/files/budget/documents/tab_11_-_glossary_of_terms.pdf).

**PCG:** Public Consulting Group, Inc., <http://www.publicconsultinggroup.com/>.

**QA/PI:** Quality assessment/performance improvement program, 42 CFR 438.240.

**RFP:** Request for proposal.

**RFPQ:** Request for program qualification.

**SAMHSA:** United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; see Mental Health Dictionary, <http://mentalhealth.samhsa.gov/resources/dictionary.aspx>.

**Verity:** The mental health managed care organization responsible for assuring effective, managed mental health services for Oregon Health Plan members in Multnomah County. Services are contracted out to over 60 agencies and individual practitioners; see <http://www.co.multnomah.or.us/dchs/mhas/mcadmin.shtml>.

## **WITNESSES**

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## **Improving the Delivery of Mental Health Services in Multnomah County**

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Steve Weiss, Member, Human Services Citizen Budget Advisory Committee, Multnomah County

Ted Wheeler, former Chair, Multnomah County Commission

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