

**BENTON COUNTY HEALTH DEPARTMENT
STRATEGIC PLANNING**

DIVISION: MENTAL HEALTH
DATE: January 4, 2006

Description of Health Initiative:

Increase service responsiveness through delivery of culturally appropriate education, prevention, and early intervention services.

Essential Public Health Service This (ES) Initiative Supports:

ES3. Inform, educate, and empower people about health issues

This Initiative Supports Benton County Strategic Plan Core Focus Areas:

Effective use of technology, Improve communications

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
1. Be sensitive to conflicts between standardization and uniformity with diversity and individuality.	A. Responsive, welcoming, and inclusive processes, procedures, and communication with the public.	A. Implement enhancements to sites to provide a more welcoming experience to customers.	A. MH Division Management Team	A. On-going
2. Implement culturally appropriate models of service delivery.	<ul style="list-style-type: none"> • Increase access to services for people of all cultural backgrounds. • Reduce stigma of disability as a barrier to service and community involvement. 	A. Expand Mental Health Promotora/Outreach program. B. Outreach to families, churches, schools, leaders, and cultural organizations/providers. Participation/representation with coalition efforts and events. C. Enhance capacity of staff to receive and respond with appropriate language and cultural understanding both for native culture and cultural perceptions of disability. D. Examine the needs of growing populations of people from Asia, Middle East, and Latin America. E. Increase diversity and customer voice in planning and program implementation activities.	A. MH Division Management Team B. MH Division Management Team C. MH Division Management Team D. Outreach Staff E. MH Division Management Team/Consumer Groups	A. 7-1-07 B. On-going C. On-going D. 7-1-08 E. 5-1-06 consumer panel and On-going

**BENTON COUNTY HEALTH DEPARTMENT
STRATEGIC PLANNING**

DIVISION: MENTAL HEALTH
DATE: January 4, 2006

Description of Health Initiative:

Fill gaps in children’s mental health services and assure maintenance of a system of care. This system should have service alternatives to meet individual needs. The service system and providers should assure that children, youth and their families are served within the local community whenever possible and using the least restrictive service options available.

Essential Public Health Service This (ES) Initiative Supports:

ES4. Mobilize community partnerships to identify and solve health problems

This Initiative Supports Benton County Strategic Plan Core Focus Areas:

Resource sufficiency and cost control, Data and value driven decision-making, Improve communications

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
1. Promote, coordinate, and develop community based youth and family mental health services.	<p>75% reduction in utilization of residential treatment and hospitalization for those youth engaged in community based mental health.</p> <ul style="list-style-type: none"> • Percent of youth with improved level of functioning. • Average length of time between acute care episodes. • Percent of youth readmitted into care at a more intensive level within six months. • Percent of youth readmitted into care at a more intense level within 30 days. • Percent of youth admitted to community-based services in a timely manner following discharge from more intense care. • Improved family/youth satisfaction 	<p>A. BCMH will develop, in conjunction with community partners, a menu of evidence-based wrap-around services for children and adolescents which will allow a greater number of children to remain in their own communities and near their support systems but will also allow for children who cannot be safely maintained in the community to experience shorter residential stays and more immediate returns to their homes.</p> <p>B. Develop and implement a means of tracking family satisfaction with services and systems that is tailored to the specific wishes of family members receiving services in the Benton County system of care for children.</p> <p>C. Decrease administrative barriers between agencies for serving youth.</p> <p>D. Establish a partnership, shared decision-making, and braided funding mechanisms between mental health service providers in Benton County, schools, juvenile services, parents, Child Welfare, and other stakeholders to ensure access to appropriate levels of service from crisis intervention to outpatient treatment and intensive intervention.</p> <p>E. Shift ACIST to operate as a model of wraparound service delivery.</p>	<p>A. Mitch A, Jim G, CFCC, CFPAC</p> <p>B. Mitch A</p> <p>C. Jim G</p> <p>D. Mitch A, CFPAC</p> <p>E. Jim G</p>	<p>A. July 08</p> <p>B. July 08</p> <p>C. July 09</p> <p>D. July 09</p> <p>E. On-going</p>

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
		<p>F. Provide outreach and education to referring parties i.e., school districts, juvenile department, court.</p> <p>G. Provide training/technical assistance for the provider system on systems of care values, evidence-based and promising practices, wraparound planning and concepts.</p> <p>H. Increase youth and family involvement in planning and implementing services.</p>	<p>F. Jim G.</p> <p>G. Mitch A, Jim G</p> <p>H. Mitch A, OFSN</p>	<p>F. On-going</p> <p>G. On-going</p> <p>H. On-going</p>
<p>2. Continuing to expand and enhance services to children and families with a focus on wraparound planning and service delivery.</p>	<ul style="list-style-type: none"> • Private agencies providing child and family mental health services will base 25% of services at minimum on evidence-based/promising practices. • Providers will meet certification standards for service delivery. • Customer satisfaction surveys and program quality improvement efforts will be monitored to show system improvement. • Percent of youth with improved level of functioning. • Average length of time between acute care episodes. • Percent of youth readmitted into care at a more intensive level within six months. • Percent of youth readmitted into care at a more intense level within 30 days. • Percent of youth admitted to 	<p>A. Develop a means of increasing utilization of personal care providers and skills trainers to provide individualized supports to youth and families.</p> <p>B. BCMH will establish a crisis respite program with local partners such as the Jackson Street Youth Shelter and the Children’s Farm Home.</p> <p>C. BCMH will seek funding to maintain and enhance mental health outreach for childcare programs to improve their ability to successfully work with emotionally/behaviorally troubled children and their parents.</p> <p>D. BCMH will serve as a resource and will facilitate the provision of countywide wraparound training and dissemination of information on evidence-based and promising practices.</p> <p>E. BCMH will secure funding to expand mental health services in rural health clinics</p> <p>F. BCMH will convene a focus group to review the availability of child psychiatry in Benton County and develop recommendations regarding expansion or more efficient use of this resource to improve access.</p> <p>G. BCMH will seek funding for services targeted to ethnic and sexual minority youth</p>	<p>A. ACIST</p> <p>B. Mitch A</p> <p>C. Mitch A, CFCC, Old Mill</p> <p>D. Jim G</p> <p>E. Mitch A</p> <p>F. Katy S</p> <p>G. Mitch A, Jim G</p>	<p>A. July 08</p> <p>B. July 08</p> <p>C. July 09</p> <p>D. On-going</p> <p>E. July 09</p> <p>F. July 08</p> <p>G. July 08</p>

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
	<p>community-based services in a timely manner following discharge from more intense care.</p> <ul style="list-style-type: none"> • Improved family/youth satisfaction 			
<p>3. Continue funding to operate A Community Integrated Service Team (ACIST) program of Benton County Mental Health.</p>	<p>Maintaining ACIST is a critical component of our children's system of care. Without local and state funds to support this access to service for children and families will worsen. Timely intervention and support to children and families in crisis will suffer without funding continuity. Early intervention produces better outcomes regarding overall functioning.</p> <ul style="list-style-type: none"> • Percent of consumers entering service at an appropriate level of care. • Percent of consumers with improved level of functioning. 	<p>A. Support a local levy to fund the ACIST program.</p> <p>B. Seek out the existing ACIST Program partners to pool funding or examine other creative ways to maintain the program.</p>		
<p>4. Provide comprehensive, coordinated care for clients.</p>	<ul style="list-style-type: none"> • Improvement in client outcomes • Increased timely access to services • Improved customer satisfaction 	<p>A. Institutionalize practice of designating a primary case manager who has the full array of cross-program services at their fingertips.</p> <p>B. Establish formal links and coordination opportunities between program staff.</p> <p>C. Define and configure mechanisms so case managers can access cross-program services</p> <p>D. Adjust record keeping and accountability to support and remove barriers to cross-program services</p>		
<p>5. To provide individualized alternative mental and behavioral health services to youth and</p>	<p>Maintain and increase by 5% ACIST referrals and ongoing cases.</p>	<p>A. Maintain school-based services, i.e., groups, assessment, individual sessions, and classroom presentations.</p> <p>B. Create a child/family specific crisis response service for the County.</p>		

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
families within the community.		C. Provide school presentations to educate referring parties regarding services available and how to access services		
6. Improving clinical efficiency and effectiveness of programs.	<ul style="list-style-type: none"> • Demonstrate program efficiency and effectiveness. • Meet productivity standards for clinical performance. • Meet required clinical documentation standards. • Utilize outcome measures to monitor performance of programs. • Demonstrate an active quality improvement program. • A minimum of 50% of services provided will meet criteria for evidence-based practices. 	<p>A. Provide staff training regarding efficient and accurate documentation and follow it up with supervisory monitoring and QI monitoring.</p> <p>B. Assess existing programs; provide staff training and incorporate evidence based and promising practices standards into service delivery models.</p> <p>C. Continue to refine and better understand productivity data, adjusting work assignments to improve staff productivity and reduce barriers (work that is not a priority).</p> <p>D. Maintain the OCI outcome measurement tool and monitor to ensure that all clinical staff are regularly utilizing the tool and are receiving feedback regarding client outcomes.</p>		
7. Increase the awareness of children's mental health services in the community.	<p>Collect a baseline number of youth and families receiving mental health services by both private and public sector.</p> <p>Increase access to care.</p>	<p>A. Maintain updates and distribute the parent handbook outlining how to navigate the children's system of care in the County</p> <p>B. Educate private and public medical and mental health providers regarding available mental health services in Benton County.</p> <p>C. Educate schools regarding available mental health services in Benton County</p> <p>D. Conduct a survey to all private and public medical and mental health providers to collect diagnostic and statistical information regarding mental Health services to all youth from 0 to 18 years of age.</p> <p>E. Establish a countywide training program with annual refreshers to inform all youth and family service providers of resources and the system of care.</p>		

**BENTON COUNTY HEALTH DEPARTMENT
STRATEGIC PLANNING**

DIVISION: MENTAL HEALTH
DATE: January 4, 2006

Description of Health Initiative:

Effective systems must ensure that an individual needing alcohol or other drug treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services. We will expand partnerships, referral relationships, and science-based programming to improve accessibility to services - greater numbers served, increase retention in treatment, and reduce recidivism.

Essential Public Health Service This (ES) Initiative Supports:

This Initiative Supports Benton County Strategic Plan Core Focus Areas:

ES4. Mobilize community partnerships to identify and solve health problems

Resource sufficiency and cost control, Data and value driven decision-making, Improve communications

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
1. To improve accessibility to services (treatment – both outpatient and residential, drug free housing, employment)	<p>75% of individuals who attend orientation will attend subsequent appointment</p> <p>Health Department orientation and enrollment data.</p> <p>Treatment Retention indicator</p> <p>Improved follow up services for BCC inmates as evidenced by report of corrections staff/jail/parole and probation</p> <p>Increase in numbers of individuals moving into recovery</p> <p>Treatment Completion and Reduced Substance Use indicators.</p>	<p>A. Create and maintain linkage/coordination agreements between outpatient and residential treatment providers, housing providers and employers/vocational programs.</p> <p>B. Maintain treatment of mental health and addictions for the Drug Treatment Court and Community Corrections programs.</p> <p>C. Maintain treatment services for the Juvenile Drug Treatment Court.</p> <p>D. Provide weekly orientation to services with assessment scheduled within fourteen days</p> <p>E. Offer AOD groups in middle and high schools</p> <p>F. Streamline AOD enrollment process for currently enrolled mental health clients</p> <p>G. Begin tracking follow-up for referred inmates</p> <p>H. Juvenile clients are contacted within two days of referral</p> <p>I. Establish a means of tracking retention in service correlated with successful termination</p> <p>J. DHS/CWP clients are contacted within two days of referral</p>	A-L. Jim Gouveia, Marie Laper	<p>A. On-going</p> <p>B. July 06</p> <p>C. July 07</p> <p>D. On-going</p> <p>E. On-going</p> <p>F. July 06</p> <p>G. July 07</p> <p>H. On-going</p> <p>I. July 07</p> <p>J. On-going</p>

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
		K. DHS/SSP on-site assessments L. Secured computer-generated referrals for corrections clients		K. On-going L. July 07
2. Reach ever-growing Hispanic/Latino and Asian/Pacific Islander populations within Benton County that have traditionally been underserved.	Increased knowledge about and access to AOD services for Hispanic/Latino and Asian/Pacific Islander populations in Benton County Access to Care indicator	A. Provide AOD training to the Health Department Promotoras, who are already engaging this population in providing education and referral about alcohol and other drug abuse problems and in assisting those that need it to enter the appropriate treatment services. B. Define need and create outreach strategies for Asian/Pacific Islander population	A. Jim G, Marie Laper B. Management Team	A. July 08 B. July 09
3. Provide comprehensive, coordinated care for clients.	<ul style="list-style-type: none"> • Improvement in client outcomes • Increased timely access to services • Improved customer satisfaction 	A. Adjust record keeping and accountability to support and remove barriers to cross-program services B. Establish formal links and coordination opportunities between program staff. C. Institutionalize practice of designating a primary case manager who has the full array of cross-program services at their fingertips. D. Define and configure mechanisms so case managers can access cross-program services.	A-D. Management Team	A-D. July 08
4. To incorporate science-based programming curriculum into treatment.	50% of state-funded service based on evidence based practices	A. Implement Matrix as an effective treatment intervention for methamphetamine B. Implement Matrix as a science-based curriculum		
5. Improving clinical efficiency and effectiveness of programs.	<ul style="list-style-type: none"> • Demonstrate program efficiency and effectiveness. • Meet productivity standards for clinical performance. • Meet required clinical documentation standards. 	A. Provide staff training regarding efficient and accurate documentation and follow it up with supervisory monitoring and QI monitoring B. Assess existing programs; provide staff training and incorporate evidence based and promising practices standards into service delivery models. C. Continue to refine and better understand productivity data, adjusting work assignments to improve staff productivity and reduce barriers (work that is not a		

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
	<ul style="list-style-type: none"> • Utilize outcome measures to monitor performance of programs. • Demonstrate an active quality improvement program. • A minimum of 50% of services provided will meet criteria for evidence-based practices. 	<p>priority).</p> <p>D. Maintain the OCI outcome measurement tool and monitor to ensure that all clinical staff are regularly utilizing the tool and are receiving feedback regarding client outcomes.</p>		
<p>6. To create and maintain a working relationship with OSU to prevent and intervene on AOD issues that impact our community.</p>	<p>Address community concerns about community norms related to AOD as it influences youth in the larger community.</p> <p>Enhance the ongoing work of the two institutions to better address the ongoing issue of AOD use.</p> <p>Decreased number of DUII and possession charges related to OSU students and adults who are involved in OSU activities.</p>	<p>A. Continue the ongoing work between Oregon State University (OSU) and BCHD</p> <p>B. Work with the fraternities and sororities to develop and promote a peer education model for Benton County High Schools.</p> <p>C. The AOD Prevention Program through the Health Department continues its work with community partners in relation to community education and policing.</p>		
<p>7. To provide better AOD services to the senior population in Benton County.</p>	<p>Increased outreach to the senior population as an effective means of intervention for AOD/Mental Health prevention, intervention, and treatment.</p> <p>Access to Care indicator Senior Peer Consultant program statistics and training records</p>	<p>A. Outreach to the faith community, training of local pastors, training to the medical community.</p> <p>B. Train Meals on Wheels, Visiting Home Nurses, and Senior Peer Counselors to identify AOD and other mental health issues and make the appropriate referrals</p> <p>C. Seek ways to involve the senior peer counselors in more screening and outreach.</p>		
<p>8. To increase and enhance gender-specific services</p>	<p>5% increase in retention rate</p> <p>Treatment Retention indicator</p>	<p>A. Establish women's group for the jail</p> <p>B. Notify referring agencies of availability of gender-specific services</p> <p>C. Create gender specific adolescent groups.</p>		
<p>9. To provide outreach</p>	<p>Reduce the incidence of alcohol and</p>	<p>A. Provide outreach and education to local gay, bisexual, lesbian, and transgender</p>		

Goals Identified In Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
to gay, lesbian, and transgender youth in our community.	<p>other drug abuse and addiction among this population.</p> <p>County data on incidence of suicide attempts and successful completion related to alcohol and other drug abuse and addiction.</p> <p>Records of programs to provide support and information to engage this group.</p>	<p>groups in Benton County.</p> <p>B. Create linkages with local high school alliances.</p>		

**BENTON COUNTY HEALTH DEPARTMENT
STRATEGIC PLANNING**

DIVISION: MENTAL HEALTH
DATE: January 4, 2006

Description of Health Initiative:

Persons with developmental disabilities should have equal access to services and services should be located and managed in their community of residence. The Mental Health Division of the Benton County Health Department is committed to locally planned and delivered services for persons with developmental disabilities. To this end our program will assure and integrate comprehensive support services and a safety net for persons with disabilities.

Essential Public Health Service This (ES) Initiative Supports:

ES5. Develop policies and plans that support individual and community health efforts

This Initiative Supports Benton County Strategic Plan Core Focus Areas:

Resource sufficiency and cost control, Data and value driven decision making, Improve communications

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
1. Provide comprehensive, coordinated care for clients.	<ul style="list-style-type: none"> • Improvement in client outcomes • Increased timely access to services • Improved customer satisfaction 	A. Institutionalize practice of designating a primary case manager who has the full array of cross-program services at their fingertips. B. Define and configure mechanisms so case managers can access cross-program services. C. Adjust record keeping and accountability to support and remove barriers to cross-program services D. Establish formal links and coordination opportunities between program staff.	A-D. Management Team	A-D. July 08
2. Meet the needs for mental health services for persons with developmental disabilities.	<ul style="list-style-type: none"> • Individuals with developmental disabilities receive mental health services as needed. • No children are left falling between the cracks of the mental health and developmental disability service systems. 	A. Maintain currently funded budget/staff providing mental health services. Expand services to children and families. B. Increase public education on mental health needs of persons with developmental disabilities and the mental health benefits of good physical health. Education needs to focus on spectrum of health and break down differences between physical and mental health in terms of funding, support, and public perception. <ul style="list-style-type: none"> • Family Support Network for peer support. • MARS-DD relationship and sexuality class. • Tobacco Cessation Class. • Meals Made Easy Diabetes and Nutrition Class. • Couples class • Conversation and communication skills class. 	A. Mitch A, Jasper S B. Jasper S	A. On-going B. July 09

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
		<ul style="list-style-type: none"> • Assertiveness class. • Training for residential and foster care providers. • Develop promotional/educational materials. • Forums to share information with and receive ideas from various constituencies. • Support for My Club socialization program, therapeutic gardening program, specialized exercise class, IMPACT program, Special Olympics and other program and community initiatives. <p>C. Create an understandable outline to parents and agencies on the range of mental health services available to persons with developmental disabilities across the lifespan. Coordination with children's mental health services to ensure children receive the most appropriate services to their needs.</p> <ul style="list-style-type: none"> • Outline of mental health services handout • Coordination with children's mental health <p>D. Utilize augmentative communication and assistive technologies to overcome barriers of communication in therapeutic relationships (ISP, counseling, medical appointments)</p>	<p>C. Jasper S, Mitch A, OFSN</p> <p>D. Jasper S</p>	<p>C. July 08</p> <p>D. On-going</p>
<p>3. Support independence and self-determination and ensure health and safety for individuals with developmental disabilities.</p>	<ul style="list-style-type: none"> • Healthy, safe, self-actualized individuals with developmental disabilities as active participants in community life. 	<p>A. Residential and vocational support programs.</p> <ul style="list-style-type: none"> • Develop and support adult foster care providers and residential programs as needed. • Develop children's foster/proctor care provider in conjunction with children's mental health program. • Develop and support vocational providers. • Access residential and vocational funding through diversion as needed. • Monthly monitoring of residential programs fully implemented. <p>B. Real jobs and independent housing.</p> <ul style="list-style-type: none"> • Housing support and assistance, coordination with LBHA and community partners. • Voluntary service transitional housing program. • Expand opportunities for community employment at Health Department and in wider community. • Service coordination and support. <p>C. Person-centered planning.</p>		

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
		<ul style="list-style-type: none"> • Implement person-centered planning at least annually for every individual enrolled in DD program. Individual Support Plans (residential and support services), Family Support Plans (children under age 18), Annual Plans (service coordination only), Mental Health Treatment Plans (MH services). <p>D. Assistance in accessing mental and physical health care.</p> <ul style="list-style-type: none"> • Service coordination and support – integration of mental health services with DD. • Ensure access to health insurance and services. <p>E. Coordination with adult support services.</p> <ul style="list-style-type: none"> • Monthly meetings. • Collaborate on quality assurance, including Title 19 waiver audit. • Coordinate in outreach to Spanish-speaking population - forum • Advocate for inclusion in planning processes. - Track plan dates. • Coordinate roles for individuals in crisis and private pay foster care. • Offer services through the Benton Supported Living Program. 		
<p>4. To understand and address the respite needs of local families. To maintain capacity for crisis residential placement. To increase the provider pool and family choice. To advocate for adequate funding for respite and crisis.</p>	<ul style="list-style-type: none"> • Increase number of respite options in the community • Improve proactive crisis response and resolution 	<p>A. Increase public awareness of respite needs for families, recognizing respite remains a primary service to the health of families.</p> <p>B. Increase the provider pool for individual respite and maintain capacity in foster homes for crisis needs.</p> <p>C. Full effective utilization of Family Support funds. Advocate for increase due to increased numbers served and full expenditure.</p> <p>D. Advocate for adequate funding for crisis services in the county and region.</p>		
<p>5. Ensure access to appropriate services. Serve all eligible individuals with no waitlists through full utilization of services available through the</p>	<ul style="list-style-type: none"> • High customer satisfaction and quality of life. • Safety net preserves health and well-being. 	<p>A. Implement planning and resource development.</p> <p>B. Support community providers.</p> <p>C. Provide crisis and diversion services.</p> <p>D. Provide protective services.</p>		

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
<p>local Brokerage (Integrated Services Network; 18 yrs. +), the Family Support services, (< 18 yrs.), Case Management (all ages), and subcontracts (vocational and residential services).</p> <p>Enhance and improve access to services.</p>		<p>E. Monthly monitoring of residential programs.</p> <p>F. BOC to advocate for stable Brokerage, Family Support, Case Management, and subcontract budgets. Advocate for crisis funding and non-crisis funding for expansion of comprehensive residential services. Advocate for changing criteria for accessing comprehensive funding under the Settlement.</p> <p>G. BOC to advocate for efficiencies, fairness, and consistency in administration and service delivery across the service elements. Specifically, consolidation of contracts at the County level with adequate funding for administration and service delivery.</p> <p>H. BOC to advocate for culturally appropriate service delivery models and outreach to underserved communities through community partners and system capacity building.</p>		
<p>6. Integration of services with families and community.</p>	<ul style="list-style-type: none"> • Inclusion and respect for role of families in decision-making. • Prevention of crisis. • Education and outreach. • Inter-agency understanding and cooperation. 	<p>A. Family Support Program.</p> <p>B. Crisis and diversion services.</p> <p>C. Public education initiatives (website, print materials, newsletter, parent groups, presentation)</p>		
<p>7. Needs assessment and planning for individuals with developmental disabilities.</p>	<ul style="list-style-type: none"> • Services responsive to individual and community needs. • Understand areas of individual and system need. 	<p>A. Implement support plans (Individual Support Plans, Family Support Plans, Annual Summaries).</p> <p>B. Update and maintain accurate waitlists.</p> <p>C. Receive community input through advisory committees and forums.</p>		

**BENTON COUNTY HEALTH DEPARTMENT
STRATEGIC PLANNING**

DIVISION: MENTAL HEALTH
DATE: January 4, 2006

Description of Health Initiative:

Our mental health programs must promote hope and recovery – a process in which people are able to live, work, learn, and participate fully in their communities – Our services should help overcome boundaries between health care, employment supports, housing, and criminal justice. To this end we will develop and expand community resources and supports for persons with mental illness including adequate and affordable housing, gainful employment opportunities, and strong peer and family support.

Essential Public Health Service This (ES) Initiative Supports:

This Initiative Supports Benton County Strategic Plan Core Focus Areas:

ES7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Resource sufficiency and cost control, Data and value driven decision-making, improve communications

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
1. Improve the continuum of services available to support individuals with chronic mental illness/disability in the community without fostering dependence on the treatment system.	Increase community based (non-office based) interventions and support – moving away from a psychotherapy model of treatment. Community-based case management, housing and employment are critical to consumer success in managing their mental health symptoms. <ul style="list-style-type: none"> • Percent of consumers with improved level of functioning. • Average length of time between acute care episodes. • Percent of consumers readmitted into care at a more intensive level within six months. • Percent of consumers readmitted into care at a more intense level 	A. Continue shifting the role of clinical staff to an evidence-based case management model building resources for recovery. B. Establish focus groups to explore and implement strategies to increase consumer participation in the design, development and operation of mental health services. C. Maintain and shift crisis staff to allow for outreach to areas besides the Emergency Room and educate partners on availability. D. Develop a means of increasing utilization of personal care providers to provide individualized support to consumers. E. Seek partnerships to expand Intensive Community Support services and enhance local respite options as hospital alternatives. F. Work with rural health clinics and identify funding to support mental health programming in these clinics. G. Improve access to and coordination of MH services to seniors starting with setting baseline as to who we are serving and identifying populations in need.	A. Management Team B. Mitch A, Marie L C. Marie L D. Marie L, Staff E. Mitch A, Marie L F. Mitch A G. Marie L	A. On-going B. July 08 C. On-going D. On-going E. On-going F. July 09 G. July 08

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
	<p>within 30 days.</p> <ul style="list-style-type: none"> Percent of consumers admitted to community-based services in a timely manner following discharge from more intense care. Percent of consumers entering service at an appropriate level of care. 	<p>H. Educate providers regarding best practices and recovery focus to improve treatment outcomes.</p> <p>I. Identify regional opportunities to establish programs and resources to meet the needs of State Hospital patients for which we do not currently have a local resource.</p> <p>J. Maintain the services of a Spanish speaking clinician within the clinic.</p>	<p>H. Marie L</p> <p>I. Marie L</p> <p>J. Mitch A, Marie L</p>	<p>H. On-going</p> <p>I. On-going</p> <p>J. On-going</p>
<p>2. Increase the number and types of housing opportunities for individuals diagnosed with a mental illness.</p>	<p>Community-based case management and housing are critical to consumer success in managing their mental health symptoms. Loss or lack of these resources will worsen this outcome.</p> <ul style="list-style-type: none"> Percent of consumers with improved level of functioning. Average length of time between acute care episodes. Percent of consumers readmitted into care at a more intensive level within six months. Percent of consumers readmitted into care at a more intense level within 30 days. Percent of consumers admitted to community-based services in a timely manner following discharge from more intense care. 	<p>A. Continued efforts to expand housing opportunities for the mentally ill, taking into consideration new funding opportunities, partnering with other agencies and service providers, etc.</p> <p>B. Utilize existing reserves along with grant funds to develop a continuum of appropriate permanent, transitional, and crisis housing for people with mental health needs.</p> <p>C. BCMH will seek funds to establish a Housing Coordinator position to focus on housing development, access, and support services and coordinate with local housing providers, Mid-Valley Housing Plus, and the Linn-Benton Housing Authority.</p>	<p>A-C. Mitch A, Marie L</p>	<p>A. On-going</p> <p>B-C. July 09</p>

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
<p>3. Expand vocational opportunities to individuals with a mental illness.</p>	<p>Community-based case management and employment are critical to consumer success in managing their mental health symptoms. Loss or lack of these resources will worsen this outcome.</p> <ul style="list-style-type: none"> • Percent of consumers with improved level of functioning. • Average length of time between acute care episodes. • Percent of consumers readmitted into care at a more intensive level within six months. • Percent of consumers readmitted into care at a more intense level within 30 days. • Percent of consumers admitted to community-based services in a timely manner following discharge from more intense care. 	<p>A. Re-focus efforts on evidence-based employment services and explore partnering with vocational rehabilitation to identify funding options and other employment service providers to increase the vocational opportunities for consumers.</p> <p>B. Set an expectation that clients work or are involved in education or other regular activity.</p> <p>C. Establish an internal champion for supported employment/job development.</p>	<p>A-C. Mitch A, Marie L</p>	<p>A-C. July 09</p>
<p>4. Continue to provide assessment, treatment, and wrap-around services for as many underinsured/ uninsured individuals as possible.</p>	<p>Maintain and if possible increase access to care numbers.</p>	<p>A. Support that County General Funds continue to be dedicated to provide assessment, treatment, and wrap-around services for as many underinsured/uninsured individuals as possible.</p> <p>B. Seek and continue to advocate for equitable distribution of state and county general funds to support basic mental health services at a level that allows access to service prior to the situation becoming a crisis.</p>		

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
<p>5. Promote and exchange information between mental health providers and physical health providers and promote the coordination of care between medical and psychiatric providers.</p>	<p>Provide up to date and accurate medication and healthy lifestyle education information to individuals, delivered in a way that each person can understand and be successful with.</p> <p>Increase in number of cases that document coordination of care between mental and physical health.</p> <p>Improved physical health of mental health consumers.</p>	<p>A. Continue efforts to improve the integration of physical and mental health services.</p> <p>B. Collaborate with BCMH Health Promotion to offer to people with a mental illness at least 2 sessions of specific health promotion education in the areas of smoking cessation, meal planning and diabetes, and/or exercise.</p> <p>C. Maintain and funding for psychiatrists to allow them to take timely referrals from primary care physicians and provide consultation to primary care physicians.</p> <p>D. Utilize the expertise of the Community Health Center, Health Promotions, consumers, family members and medical providers to discuss issues around diabetes and weight loss and work to establish effective and accessible programs.</p> <p>E. Work to improve client access to primary care – annual physicals etc. and create a tracking system to monitor this.</p>		
<p>6. Educate consumers, staff, community partners & stakeholders, and the general public about health issues and services available to adults with mental illness.</p>	<p>Sharing of information regarding what services are available to whom, increasing collaboration opportunities, problem solving around specific issues etc. so referrals can be made that best meet an individual's needs.</p> <p>Provide information and referral information to seniors that might otherwise not be engaged to get needs met.</p> <p>Increase the number of consumers entering service at an appropriate level of care.</p> <p>Maintain and improve the percent of consumers with improved level of functioning.</p>	<p>A. Organize, facilitate, and participate in 2 "Community Forums", which will bring together staff from BCMH, COI, Pastoral Counseling, GSH, Area Churches, RSVP, Senior and Disabled Services, NAMI, Consumer Drop In Center and others.</p> <p>B. Explore the use of a simple assessment tool that Jail staff could use to better determine the need for mental health or A&D intervention.</p>		

Goals Identified in Support of the Initiative	Anticipated Outcome(s) and Measurement	Projects/Tasks	Lead Responsibility	Target Completion Date
7. Provide comprehensive, coordinated care for clients.	<ul style="list-style-type: none"> • Improvement in client outcomes • Increased timely access to services • Improved customer satisfaction 	<ul style="list-style-type: none"> A. Establish formal links and coordination opportunities between program staff. B. Institutionalize practice of designating a primary case manager who has the full array of cross-program services at their fingertips. C. Adjust record keeping and accountability to support and remove barriers to cross-program services D. Define and configure mechanisms so case managers can access cross-program services. 		
8. Improving clinical efficiency and effectiveness of programs.	<ul style="list-style-type: none"> • Demonstrate program efficiency and effectiveness. • Meet productivity standards for clinical performance. • Meet required clinical documentation standards. • Utilize outcome measures to monitor performance of programs. • Demonstrate an active quality improvement program. • A minimum of 50% of services provided will meet criteria for evidence-based practices. 	<ul style="list-style-type: none"> A. Continue to refine and better understand productivity data, adjusting work assignments to improve staff productivity and reduce barriers (work that is not a priority). B. Assess existing programs; provide staff training and incorporate evidence based and promising practices standards into service delivery models. C. Maintain the OCI outcome measurement tool and monitor to ensure that all clinical staff are regularly utilizing the tool and are receiving feedback regarding client outcomes. D. Provide staff training regarding efficient and accurate documentation and follow it up with supervisory monitoring and QI monitoring. 		