W. Bd of Health

Agenda Cover Memo

AGENDA DATE: May 5, 2004

TO: Board of County Commissioners

FROM: Rob Rockstroh, Director
Department of Health & Human Services

DEPARTMENT: Health & Human Services

DESCRIPTION: SEMI-ANNUAL BOARD OF HEALTH REPORT.

The following report to the Board of Health is a summary of recent or current health and human service highlights or possible future directions. It is designed to keep the Board advised of the status of health and human services in Lane County.

The report deals with each program area separately, although as a health & human service system, services are integrated to the greatest degree possible to ensure our support of Lane County citizens' health in an effective and efficient manner.

I. SPECIAL SERVICES / ADMINISTRATION

Family Mediation Program: (Barbara Lee, Program Manager)

For the six months between October 1, 2003 and March 31, 2004, the Family Mediation Program completed a total of 216 court-referred mediation cases. These cases involved open legal actions concerning child custody and/or parenting time disputes. The parents in these cases were parties to a Lane County dissolution, legal separation, modification, or (if unmarried) legal action to establish or modify child custody or parenting time.

A total of 520 parents attended the Family Mediation Program's "Focus on Children" class during the six-month period. The court requires that parents attend this, or a similar class, if they are involved in a current Lane County dissolution, legal separation, or legal action to establish child custody or parenting time. "Focus on Children" addresses the needs of children and parenting issues during, and following, parental divorce or separation. A Spanish language version of the class is provided for Spanish speaking parents.

Prevention Program (Karen Gaffney, Assistant Department Director)

The purpose of the prevention program is to promote and coordinate effective community-based prevention strategies toward creating healthier communities. Activities supported through the prevention program can be categorized within the six Center for Substance Abuse Prevention (CSAP) strategies for effective prevention

efforts: information dissemination, prevention education, environmental strategies, alternative activities, community-based processes, and identification and referral.

The prevention program provides system support through planning and coordination of prevention services, and by working with community partners to implement the 2003-2005 Biennial Alcohol and Drug Prevention Plan. A significant shift in allocation of prevention funds occurred this biennium with a mandate to fund more indicated or targeted prevention strategies. The Lane County plan allocates prevention dollars to enhance Lane County Family Resource Centers (FRC) in order to provide targeted services to families where substance abuse has been an issue. Prevention staff worked with staff from the Department of Children and Families and FRC coordinators to develop and implement targeted services. FRCs across the county are now offering evidence-based parenting education support and skill-building support for children referred to the center. Examples of services offered include Parenting Wisely, Make Parenting a Pleasure, and homework/mentoring clubs for youth. The first annual report on the outcomes of each program is due Summer 2004.

Another significant part of Lane County's prevention efforts is the Gambling Awareness & Prevention Program (GAPP). Since its inception, GAPP has reached thousands of Lane County citizens, including directly reaching over 700 middle school and at-risk youth since the year 2003 through school-based presentations, health workshops, and at-risk youth program presentations. Evaluations from youth exposed to school-based presentations have demonstrated that the average onset of gambling behaviors is nine years old. The post-test evaluations have also shown marked increases in awareness among middle and high school students exposed to GAPP youth presentations, in addition to youth reporting that they plan to reduce gambling behavior. In 2004, GAPP was advised that it received several nominations for a statewide award for excellence in problem gambling prevention; in March 2004, the program was honored in receiving Oregon's Outstanding Problem Gambling Prevention Program Award.

On Sunday January 25, 2004, the four local television stations that make up Media United Against Drugs simultaneously aired the fifth annual hour-long, commercial-free television town hall on substance abuse prevention. The show, developed with county prevention staff, showcased a forum of 150 Lane County middle and high school students responding candidly to local news anchors on what they need to make good healthy decisions. The town hall also featured vignettes about prevention programs, lack of alternative activities in Lane County for youth, and the consequences of bad choices. This show provided "21 tips and parenting skills to help you make a difference," as well as telephone and website contact for the viewing public if they needed additional resources. The overwhelming message from the youth and from national research states that positive, proactive parenting can be a strong deterrent to youth use of these drugs. Some of the results from the airing of the show follow:

- 41 telephone calls were received on Sunday evening.
- The mediaunited.org website received 185 hits.
- Eugene Area Radio Stations provided 20 promotional ads on its 20 stations, for a total of 400 ads.
- Many parents watched the show with their children and had an opportunity to talk with their children about alcohol and other drugs.

On October 1, 2003, the Prevention Team officially said goodbye to both the Lane County Prevention Coalition and the Heroin Task Force, due to duplication of services, meetings, and missions. In January 2004, the newly reformatted Lane County Coalition to Prevent Substance Abuse was formed to reduce substance abuse and its consequences in and throughout Lane County. There were 50 people in attendance for the first meeting and on average, 30 attendants since. Two committees have formed to address substance abuse on community-wide and individual levels, and are developing plans based on evidence-based practices.

Support for the ongoing development and sustainability of local community coalitions continues in the form of staff support and some project funding. Previously in 2003, OLCC conducted first time compliance checks in rural unincorporated Lane County where 42 retailers passed and 15 failed the compliance check. Through an incentive program managed by the prevention unit, all merchants that failed, had an incentive of $309 to purchase specific age verification equipment. At least eight of those merchants utilized the incentive. Earlier this year (January 2004), the 15 retailers that originally failed, were re-checked. Thirteen vendors (87 percent) passed the compliance check, two (13 percent) failed. According to OLCC, this re-check statistic is very good. Both of the vendors that failed actually had age verification equipment in their stores; they chose not to use the equipment.

The prevention program is involved with community partners in the initial stages of systematically bringing the 40 developmental assets into Lane County (see attached). These 40 assets are concrete, common sense, positive experiences and qualities essential to raising successful young people. Assets powerfully influence adolescent and adult behavior—both by protecting people from risky, problem behaviors and by promoting positive attitudes and choices. This power reaches across all cultural, socioeconomic, and age groups. Assets are divided into external and internal assets and when implemented help focus on what works and what is best for the community.

II. DEVELOPMENTAL DISABILITIES SERVICES (Lynn Greenwood, Program Manager)

Program Overview

Lane County Developmental Disabilities Services (DDS) provides an array of community-based services and supports for individuals with developmental disabilities

and their families. The program's professional staff directly provide lifespan case management for 1,390 Lane County residents who meet eligibility criteria. Other direct services offered by DDS include crisis resolution and family support. In addition, the program subcontracts with 17 local agencies to provide residential and employment services for adults. DDS authorizes funding and collects licensing information for 95 foster providers for adults and 29 foster providers for children. The program also serves as the lead agency in Lane County for providing protective services for adults with developmental disabilities.

Quality Assurance

A new state mandate, effective in Oregon Administrative Rule on January 1, 2004, requires Lane County DDS to more closely monitor services to individuals residing in group homes and foster homes. Monthly site visits to these 24-hour residential sites are an opportunity to review areas of service and support to individuals with specific focus on health, safety, behavior support, and financial services. Lane County has 152 sites that fall under this mandate. Staff have been in the process of developing and implementing a plan to meet these new guidelines. Information gathered and technical assistance provided during the monthly site visits will be used to improve the quality of services for residents in these long-term care settings.

The Serious Event Review Team continues to meet although some structural changes have been made to make the review process a responsibility of the DDS comprehensive team, instead of the Quality Assurance Committee (QA). This allows the QA Committee to focus on more global issues (such as the establishment of a public guardianship program). For the six-month period covered in this summary, the DDS SERT system received and reviewed six deaths, three cases of physical abuse, and three psychiatric hospitalizations.

Budget Issues

Oregon's economic downturn has impacted DD services in several ways. Although the bulk of the DD budget was not reduced by the state, the program did sustain a 50 percent reduction in family support services. This affects the approximately 75 families with children who receive financial support in order to meet the unique needs of providing care for their child with a disability. The cutback has resulted in some families going into crisis, which has put a greater demand on the funds available for resolving crisis situations.

In addition, caseload sizes continue to grow. Lane County DDS has an average caseload size of 112 families per case manager. In a recent statewide survey of caseload sizes, Lane County was one of four counties reporting caseload sizes over 100. DDS staff are working with the State Seniors and People with Disabilities Program to negotiate possible variances to the case management rule that will mitigate the effects of caseload driven workload.

A final budget related development in DD services is the continued instability of many of our subcontracted residential and employment providers. Since the last Board of Health Report in November of 2003, the City of Eugene has given notice on the contract for services to DD clients who reside in nursing homes. They had held this contract for 13 years. With no increase in revenue to offset the increases in personnel and related costs, the City could no longer manage this contract. The City's program was very highly regarded by participants, their families, and County staff. A Request for Proposal process is underway to develop a new provider for this service.

In addition to the City of Eugene program, another agency, Alvord Taylor, is struggling to continue services. The organization has an interim executive director who has been meeting with the Alvord Taylor Board of Directors and DDS to strategize plans for the future. At this time the agency is planning to give notice on residential services for five people. In addition, another two people will move into sites that are currently managed by Alvord Taylor. DDS staff are working with foster and other local providers to develop new homes for the five individuals. Alvord Taylor plans to sell two of their current properties when the projected moves are completed. These changes will hopefully bring about fiscal stability for the short term. However, the lack of COLAs and increases in insurance costs faced by all our service providers pose a potential crisis that continues to loom on the horizon. This situation is exacerbated by the planned reductions in the Oregon Health Plan which will have an impact on many of the families in our service delivery system.

III. HUMAN SERVICES COMMISSION (Steve Manela, Program Manager)

The Human Services Commission's (HSC's) coordinated care model finances and delivers an integrated community safety-net system of social services, supportive housing, and healthcare services for the low-income, uninsured, and under-insured. The HSC preventative services focus on strengthening the self-sufficiency, independence, well-being of people, and promotes the reduction of violence by providing protection from abuse and neglect. The HSC services target at-risk populations including: domestic violence, sexual assault victims, at-risk low-income and homeless people, teen parents, youth, farmworkers, ex-offenders, physically disabled, mentally ill, veterans, seniors, and those with a limited English language proficiency.

The HSC continues to play a catalytic role in the community, leveraging, focusing, and investing available local, state, private, and federal resources toward projects that assist the poor.

Accomplishments during this past six-months include:

- Establishing three Community Health Center clinics to provide preventive and primary health care, mental health, and dental services for low-income, uninsured, and underinsured school-aged children and their families, and homeless youth through the award of a three-year $1.87 million grant from the Federal Department of Health and Human Services.

- Establishing new supportive housing and services for chronically mentally ill homeless people and people with substance abuse problems maintaining services for homeless youth with serious emotional and/or substance abuse problems, and homeless families with children through a $1.7 million grant from the Federal Department of Housing and Urban Development.

- Expanded behavioral health and alcohol and drug services to homeless youth through the receipt of grants from private foundations and the City of Eugene.

- Maintained local governmental funding for basic needs human services for Lane County citizens.

Revenues from the federal Department of Health and Human Services, Medicaid, Medicare, clinic fees, and other local funds have increased with the implementation of the Community Health Centers. The staffing level of the division has increased by 23 FTE to provide for the implementation of the new primary health services.

With the backdrop of major local, state, and federal health and human services budget reductions, the HSC is forced to evaluate potential areas to streamline service delivery. At a time when major federal and state safety-net health and welfare programs are dropping services to a large proportion of low-income and at-risk Lane County residents, the HSC is also faced with having to make further agency payment reductions to non-profit health and human services agencies in the community. Last year, the HSC was able to avoid major changes in service funding levels by reducing most agency payments three percent, although some service funding levels were reduced by 25 percent. Parent education and homeownership services were eliminated in FY 2003-04. In FY 2004-05, some challenging decisions will be made which could include terminating some contracts with non-profit agencies and making some service delivery realignments. For the purpose of the budget process, we have reduced the future estimate of indicators across the board by a percentage that reflects the amount of the FY20 04-05 proposed agency payment reduction and an inflationary factor. Early intervention and preventive services are losing ground in this budget environment as we prioritize addressing emergency and basic needs.

The HSC staff has had the opportunity in the middle of financial difficulty to re-evaluate services and diversify financial support. The coordinated care model that the HSC adopted, which finances and delivers a more integrated model, has required some adjustments in budgeting and service delivery. The HSC pursued five basic strategies to move forward with the coordinated care model goals of increasing access to services, increasing coordination of services, and to net a larger return of federal funds on the investment of local and state funds during the past year. These strategies included:

- Obtaining a grant to become a Federally Qualified Health Center

- Leveraging and increasing access to mainstream federal entitlement funds, such as Medicaid, Medicare, and Veterans benefits for homeless persons, health care services, and veterans services

- Increasing revenues that support behavioral health services for at-risk and homeless children and youth

- Obtaining the investment of federal block grant funds for local self-sufficiency and emergency assistance efforts

- Obtaining the investment of additional local support for energy assistance and health care programs

State and federal rules have required the implementation of more sophisticated reporting and client/patient management information systems. While these systems foster further coordination of care and eliminate duplicate intakes and office visits, they will be challenging to implement, as such systems will increase the programs' complexity, as well as the cost of administration.

The HSC will be faced with reviewing and approving budget options for making reductions to agency payments for the second year in a row. Some retrenchment of services may be unavoidable.

Community Health Center

The opening of three new Community Health Center of Lane County (CHCLC) health care sites began on January 5, 2004 with the commencement of the health care services for homeless youth at the Safe and Sound Medical Clinic. Concurrently, on January 5, 2004 the health care services began for youth at the Springfield High School School-Based Health Clinic.

The health care services for all populations at the Metro Family Practice Clinic commenced on March 1, 2004. This Springfield location is in the heart of the targeted medically underserved census tracts, has 15 exam rooms with a layout conducive to efficient workflow, and will increase productivity for clinic encounters.

With the January 5, 2004 opening of the Springfield School Based Clinic and the Safe and Sound Homeless Youth Clinic, we began to provide services as a Community Health Center. At that time, we implemented the preventative dentistry program with the hiring of a Limited Access Permit (LAP) Dental Hygienist to perform dental hygiene service without the supervision of a dentist. The LAP Hygienist performs dental examinations, cleanings and fluoride varnishing for CHCLC children patients enrolled in nursery schools, day care programs, and primary and secondary schools in our service area.

The State of Oregon Office of Medical Assistance Program (OMAP) informed us that they would pay entirely for the costs of Outreach and Enrollment Workers (OEWs) employed by the CHCLC to assist uninsured patients of the Community Health Center (CHC) enroll in the Oregon Health Plan/CHIP. OEWs are to be advocates for patients, building trust, helping the uninsured understand the health care and Medicaid systems,

and assisting them in initiating and completing the process of applying for medical assistance and obtaining medical care. We added an additional Bilingual community service worker for this purpose. This position is being recruited and will be located at the Metro Clinic and outreach to other community sites as a resource for families in need.

Since September 2003, we have made substantial progress toward the implementation of the CHLC's business plan, particularly in the areas of personnel recruitment, financial administration, technology implementation, facility acquisition, and governance development. The plan assures that the CHCLC has the administrative and fiduciary capabilities, a management information system, and facilities to support competent clinical care.

On November 25, 2003, the Lane County Commissioners approved the Board Charter for the Community Health Centers Council. It is the preferred model for a single public entity, in full compliance with the federal program expectations and published policies, and has bylaws reflecting required functions and responsibilities. The Council will have 15 members, eight (8) of which will be consumer members who are served by CHC. The completion of seating the seven non-consumer Board positions occurred on February 25, 2004. Also, at that time, two of the eight consumer positions were filled. We expect to fill a majority of the Clinic Consumer positions by May 31, 2004. The Community Health Centers Council will guide CHCLC in promoting its mission to provide comprehensive health care that is quality-driven, affordable, and culturally competent to the people of Lane County. One goal of the Council is to review marketplace trends and to provide assistance and advice that reflects economic realities in the marketplace. The Council will work with the CHCLC's management and community leaders to actively engage in long-term strategic planning to position the CHCLC for the future. During the next year, Board members will participate in strategic planning for the CHCLC. Ongoing Board support will include technical assistance provided by a board development specialist and state and regional primary care associations.

The Finance and Audit Committee reviewed the proposed fee schedule on January 20, 2004 for services provided by CHCLC in compliance with federal statutes (Section 330 of the Public Health Service Act). On February 3, 2004, the Board approved the fee schedule for all billable services. Patients with restricted, limited, or no third-party insurance coverage will be expected to provide appropriate information for determination of eligibility in order to receive a sliding-fee discount. All patients are eligible to apply for the sliding-fee discount. Eligibility is based on total family size and family income using current Federal Poverty Guidelines. The minimum fee and discounted sliding-fee schedule is revised and approved on an annual basis by the Board.

CHCLC published a Notice of Intent to become a partner in the Oregon Community Health Information Network (OCHIN) as of February 25, 2004. A contract is to be put in place for installation of the electronic practice management system by May 30, 2004. OCHIN is a statewide collaborative network of FQHCs and CHCs that have joined

together to obtain and implement an integrated, consolidated Practice Management System. OCHIN is governed by the clinics that participate in the collaborative. In choosing Epic, OCHIN sought a system that supports the provision of culturally competent care, rather than merely standardizing operations. Epic designs and supports its software as a tool to improve patient care and clinic efficiency, rather than merely to register, schedule, and bill. OCHIN customized the software together with Epic programmers, thereby ensuring a robust system that fully serves the particular workflow and reporting needs of FQHCs and CHCs. Epic's Practice Management software is widely recognized as among the finest and highest-functioning health information software available on the American market. It has extensive workflow improvement, administrative efficiencies, and case management functions built into it.

CHCLC has developed a Health Care Plan for all life cycles. These plans include mental health, substance abuse, preventive oral health, and health education as well as primary care issues. Significant health disparities in the target population that are addressed include cancer, diabetes, teen suicide, and teen pregnancy rate. A plan for providing culturally and linguistically appropriate services and a pharmacy is also included. CHCLC is a freestanding, multi-site program with three strategic locations. This model is designed to provide easily accessed care in comfortable settings suitable for affirmatively serving the target populations. Particular focus on the health disparities and needs of the Latino population, the chronically homeless, and homeless youth populations will be provided through bi-cultural, bi-lingual staff (whenever possible) and easily accessible locations.

IV. MENTAL HEALTH SERVICES (Al Levine, Program Manager)

Outpatient Mental Health Clinic

The last fiscal year brought about a significant reduction in the clinic workforce due to the defeat of Measure 28 and the subsequent loss of most of the Crisis and Indigent Care funds that had supported the clinic and allowed it to provide services to those without the Oregon Health Plan or a mental health benefit. In addition, changes in OHP removed the mental health benefit from a large number of Lane County residents receiving services at the clinic. Although we did our best to try to transition as many of these individuals from services, this proved to be clinically difficult or ethically impossible. Many of these individuals had no service to transition them to, and we remained the "treater of last resort". This has always been the mission of community mental health, but became an extreme challenge to continue with the loss of staff and the loss of funding. Happily, the Legislature did end up restoring much of the previously reduced funding; since we hadn't budgeted for that, we may be able to carry forward some funds that will allow us to increase staffing to meet demand. We have already added a Child Mental Health Specialist, as caseload size was increasing to unmanageable levels and demand remained high (children did not lose their OHP mental health benefit), and will look to add additional positions as demand requires and funding allows. These funds now provide financial support for the services we had been providing "*pro bono*" to the clients we continued to serve even though they lost their mental health benefit.

In the last few months, we have taken steps to co-locate both family support services and consumer-operated services in our location. The Lane County chapter of the National Alliance for the Mentally Ill has leased office space and library space from us, and provides a wide array of complementary family support services, education, and system advocacy to our clients and their families. They are also in discussion with the Oregon Family Support Network (a similar family support program aimed at families of younger children) to allow them to use their space. On April 1, 2004, we also leased space in our building to SAFE, Inc., a consumer owned and operated entity that provides a wide range of activities, advocacy, support, and other services to mental health consumers. SAFE intends to use this space as a convenient location for LCMH clients to access information about consumer services and supports. These steps really help create the sense of the clinic site being a true community resource for our clients.

Acute Care Services

Concerns about the financial future of Lane County Psychiatric Hospital that were raised in the October 2003 Board of Health Report proved to be sadly prophetic. In October 2003, we were beginning to experience the negative financial fallout of the defeat of Measure 28, while at the same time seeing reasonable, but steady cost increases in running the facility. Due to the lag in fee collection, the full extent of the budgetary problem became evident in December 2003, at which time we initiated a meeting with both PeaceHealth and the State Office of Mental Health and Addiction Services (OMHAS) alerting them to a serious budgetary shortfall and enlisting their assistance in helping the County limit its financial exposure. The County was willing to keep the facility operational, but needed to limit its financial liability to no more than $500,000. This would require a significant increase in funding from OMHAS by an upward adjustment of the OMAP reimbursement rate, re-instituting payment for LaneCare patients awaiting state hospital beds, and increasing the State General Fund support for the facility. It also would require some commitment of funding or in-kind contribution by PeaceHealth to help close the budgetary gap. After careful analysis, all parties agreed that LCPH was not seen as being financially viable over the long run, and therefore, neither OMHAS nor PeaceHealth were prepared to provide the level of funding that would allow the program to continue. Facing the loss of over $70,000 per month, the County decided to close the facility on March 31, 2004 to limit its exposure, and that closure, has in fact, occurred on schedule. The last patient was discharged on March 26, 2004 and LCPH closed its doors on March 31, 2004 after over 16 years of outstanding clinical service to the community and over 7,000 admissions.

A committee including Lane County, PeaceHealth and OMHAS staff was formed to develop a program which would help reduce the negative impact of the closure of LCPH and to make optimal use of the remaining psychiatric inpatient beds in the County, located at Sacred Heart's Johnson Unit. Given the lack of clarity of what funds were available for such a project in the remainder of this fiscal year (it will be some months before we know with certainty how large the gap in the LCPH will be that we must fill), OMHAS agreed to provide $100,000 toward the development of a Transition Team, which will work closely with the Johnson Unit to provide an intensive level of

individualized mental health services and community supports that should allow some individuals to be discharged a number of days earlier than they might otherwise be, or to provide this intensive level of outpatient service to county residents as an alternative to an inpatient admission.

This team is modeled after a number of very successful such programs in other states and is considered an evidence based practice. It will provide for a better overall level of service to individuals either coming out of the hospital or being diverted from an admission. The team will work with these individuals for 4-8 weeks until they can be transitioned into whatever their ongoing care would need to be (back to primary care, less intensive services through another provider agency, or to Lane County Mental Health's outpatient clinic). The team is currently being formed (team members have been selected) and will consist of three QMHP level clinicians (Master's or above, contributed by PeaceHealth as in kind support to this program), a psychiatrist (Dr. Paul Helms, former Medical Director of LCPH), a business support staff and clinical supervision provided by the County, and contracts with three or four community providers to provide mobile crisis support, in home services, linkage to peer supports, etc. These providers will have funding added to their existing contracts, so they can have adequate capacity to serve Transition Team clients, who for the most part, will be indigent. The team will be housed at the LCMH Clinic and will operate seven (7) days per week.

With the closure of LCPH, the County again becomes financially responsible for the costs of indigent county residents placed on emergency psychiatric holds (this has always been the case, but Lane County had a gentleperson's agreement with PeaceHealth that the County would not be charged for such patients on the Johnson Unit as long as LCPH remained operational). We have negotiated what we believe to be a reasonable "cap" on such reimbursements with PeaceHealth that will allow Lane County to be able to budget funding for the Transition Team and other alternatives in the next fiscal year. Obviously, Lane County would continue to be financially responsible for any such costs incurred, in out-of-area hospitals, when the local beds are full, as well as transport costs. Clearly, it is critical that this team be successful in keeping local beds available and out-of-area admits to a minimum. Since the closure of LCPH, we have already seen a dramatic increase in out-of -area admissions. This creates not only potential financial concerns, but also adds to the already heavy burden of civil commitment investigations, which must occur within required timeframes with patients now in out-of-area hospitals and limited ability to bring them back. We have had to temporarily increase our FTE devoted to commitment to stay compliant with the statutory requirements. With the team about to begin operations, it is hoped we will soon see a reduction in inpatient utilization.

Mental Health Court

Lane County was awarded a two-year, $150,000 Federal Grant to establish a Mental Health Court for individuals charged with misdemeanor offenses or some non-person felony crimes whose criminal activity was largely a function of them having a mental disorder. Individuals can enter this "diversion" program voluntarily, participate in mental

health treatment for a year, and then get diverted from the criminal justice system. This new "court" is similar in many ways to Co-occurring Disorder Court (COD) and Drug Court, and will utilize Judge Carlson, as do the other courts mentioned previously. At present, referrals are limited to criminal cases filed in Circuit Court, not Municipal Courts. While getting this grant is certainly a feather in Lane County's cap, the timing of the grant happens to coincide with unfortunate budget realities in which most misdemeanor defendants are aware, or are informed that it is unlikely, they will spend any jail time if they simply plead guilty due to reductions in jail beds. We are also hearing that in high likelihood, the District Attorney's Office may stop prosecuting most misdemeanors. At this point, some nine months into the grant, we have only enrolled three clients, and we are expected to serve 35 per year.

We have discussed expanding the client base to include Municipal Court filings, and have discussed this with both Municipal Courts. They were quite enthusiastic about having access to the Mental Health Court, as they probably have many more appropriate cases filed there than in Circuit Court (nuisance type misdemeanors), but they lack the ability to maintain ongoing court supervision of such cases, which is a hallmark of the Mental Health Court model. They would therefore need to have the case transferred to Circuit Court and filed by the District Attorney's Office before they can close the Municipal Court case.

At this time, the District Attorney has indicated he will not accept any such transfers, due to pending budgetary concerns. A final attempt to make this Mental Health Court viable will be to see whether we can expand the base to include individuals on community supervision, who are at risk of being returned to jail due to their inability to follow their conditions of parole or probation because of mental health issues. We would need permission from the granting agency to go down this path, and it is not at all clear whether the District Attorney would be willing to consider this expansion, particularly if the original crime was a felony or a more serious misdemeanor. We will be meeting with the key participants in early May to see what we can work out. It is entirely possible that we may elect to return the grant funds as circumstances locally will not allow for us to meet the requirements of this grant. That would be an additional unfortunate fallout of the local fiscal realities.

V. LANECARE (Bruce Abel, Program Manager)

LaneCare is in the middle of its seventh year of operations. The past couple of years have been fraught with budget reductions and other destabilizing situations. Despite the unpredictability, the reduction packages, and the increasing service demands, LaneCare has managed to maintain the highest utilization rate in the state, preserving a vibrant continuum of services, and remaining fiscally sound. As we complete the financial analysis for last year, it is clear that LaneCare operated well in the black and will be able to use carry-forward funds for creative community mental health supports. This will be critical following the closure of Lane County Psychiatric Hospital.

LaneCare represents the County's effort at managing a capitated component of the Oregon Health Plan (OHP), the mental health "carve-out," while integrating community

mental health responsibilities in partnership with provider agencies. LaneCare continues to contract with a range of non-profit providers to offer a full continuum of services, to ensure access to services, and to maintain consumer choice.

LaneCare conducted a Request for Proposal (RFP) process and selected a panel of mental health agencies to provide services to LaneCare members. LaneCare maintains an incredible panel of nonprofit mental health organizations that partner with the County to ensure a high quality mental health system.

LaneCare is continuing our efforts to move the system toward evidence-based practices and is sponsoring several trainings to help providers develop new skills. We have initiated a series of trainings being provided by consumers from a consumer perspective.

LaneCare has worked in partnership with Lane County Mental Health (LCMH) and PeaceHealth in constructing a hospital transition team. Providers have been engaged and the services began in April. We are hopeful that this will provide a new type of community based support for individuals with a mental illness.

Effective October 1, 2003, LaneCare experienced an additional 14 percent capitation reduction. This was different from previous reductions in that we receive a smaller monthly payment with no reduction in membership or service expectations. This means that we provide 14 percent fewer services if we are to continue to serve the same number of individuals. LaneCare has remained stable throughout the series of state budget reductions. LaneCare has been involved in state discussions on regional risk adjusters and the provider tax; state changes that will affect LaneCare, but have yet to be implemented.

LaneCare has been actively involved with state stakeholders in discussing intensive treatment services and funds for youth. It is likely that in January 2005, these funds will be contracted by the state to LaneCare. LaneCare will then be responsible for managing these resources and subcontracting for services. This is a positive change and is in line with the pilot project proposals that we have presented to the state over the years.

LaneCare pays for a significant percentage of services provided by LCMH. LaneCare also has service contracts with 12 non-profit mental health agencies. A portion of clinical funds is contracted to consumer and parent-run organizations to provide activities to reduce social isolation and for peer and other support services. Another portion is dedicated to community-based prevention efforts. LaneCare continues to fund outreach to facility-bound seniors, coordination with developmental disabilities, parent training, and suicide prevention for teens, and crisis supports and response. In addition to these programs, LaneCare provides partial funding for outreach to homeless youth and an Internet site (TheLane) that provides community information, including mental health services information. LaneCare publishes two newsletters each month and a consumer newsletter quarterly.

In addition, LaneCare contracts with a number of hospitals including Sacred Heart's Johnson Unit and has a clinical exception procedure for paying for mental health services for professionals off panel. Flexible funds are committed to support clients in treatment alternatives in ways that could not be billed.

The quality-assurance process continues to help review policies, procedures, and practices of the LaneCare-funded mental health service system. As part of LaneCare's on-going quality improvement efforts, we:

- Have continued to provide trainings for our panel of participating practitioners
- Have updated the LaneCare Provider Manual
- Are identifying and funding quality improvement efforts
- Are identifying and funding prevention, education and outreach projects
- Have completed consumer satisfaction surveys
- Have collected data with the LaneCare clinical evaluation instrument

LaneCare has not been able to offer reimbursement rate increases to most providers for several years; this will be true again next year. Providers are experiencing increased costs without an increase in revenues. LaneCare has achieved a remarkable partnership with providers that has allowed for open communication and shared decision-making. As budgets become tighter, the tension between providers and LaneCare is likely to increase.

In April 2003, LaneCare and all contracted providers became fully compliant with the new Federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules. In October 2003, HIPAA began requiring the implementation of a standard transaction code set. This means that Oregon will shift from billing for services with its unique BA code system and will move to the standard service codes for claims payment. This has required a complete overhaul of the LaneCare system and the billing practices of each agency.

VI. PUBLIC HEALTH SERVICES (Karen Gillette, Program Manager)

Bioterrorism / Preparedness

During this reporting period, members of the Public Health management staff participated in an all day Incident Command System (ICS) training. As a follow-up, a subgroup completed an in-depth planning section training. A half day all public health staff training in this system occurred in December 2003.

In December 2003, Lane County Public Health preparedness staff joined with Health & Human Services management staff and representatives from Sacred Heart Medical

Center, McKenzie-Willamette Hospital, Lane Community College, and the University of Oregon to participate in a table top exercise around a SARS event. This was followed by an all Public Health staff meeting in January with a SARS response video from the Toronto outbreak in the year 2003.

Other staff trainings have included food-borne illness outbreak training. The objective of this series of trainings is to increase our capacity to respond to a large outbreak. As such, the trainings have included nurses, community service workers, and Public Health management team members from programs outside of communicable disease.

We conducted an off-hours call-up exercise to evaluate the availability of staff in an emergency. All staff members were called and 50 percent would have been able to report to work within an hour of the emergency call.

Preparedness staff continue to draft emergency plans for specific events, including those for SARS and pandemic flu. Staff have also met with Eugene airport personnel to draft an emergency plan in the case of a serious communicable disease event.

The multiple tasks required to meet the grant assurances are the ongoing work of the part-time preparedness coordinator. She and other preparedness staff continue to work with community groups including the Sheriff Office's Countywide Preparedness Committee, the Lane County Medical Society Disaster Task Force, the University Health Center at the University of Oregon, and the Red Cross.

Communicable Disease Service Unit

Beginning January of 2004, the Communicable Disease (CD) team began working with our recently purchased reportable disease computer database. The transition was remarkably smooth. It allows each of the CD nurses to enter data directly into the protected database as interviews are conducted. Each nurse can pull up on a computer screen up-to-the minute reports on the progress of ongoing investigations. Duplication of effort is minimized. Reports are completed and sent to the state more thoroughly and quickly. We expect that the improved efficiency will be reflected in our percentage of reports completed within the state required timeline. Monthly statistics are quickly tabulated. This significant improvement for both our daily work and for outbreak situations allows us greater flexibility to respond to emergent situations.

Lane County Public Health (LCPH) currently has nine (9) cases of active tuberculosis. The caseload of clients being treated for latent tuberculosis infection ranges between 62 and 80 cases per month. We continue to have a few new people testing positive for new tuberculosis infection at the homeless shelter. Though these numbers have decreased with the daily testing, screening, and medication management, our objective of eliminating new infection in that center has not been fully reached. The state obtained funding from the Centers for Disease Control (CDC) to install ultraviolet lights throughout the shelter. This project has been completed and LCPH staff will begin regular UV light checks to assure the success of this recent enhancement of prevention activity.

The state has extended the Hepatitis A and B Vaccine Program for high-risk adults to supply vaccine at no cost to the counties. This has allowed us to continue and expand this service to the community. We have continued to offer it within LCPH clinics and through a LCPH nurse at the Willamette Family Treatment Center. LCPH nurse staff and a volunteer have increased our ability to offer hepatitis A and B vaccination from monthly to weekly during HIV Alliance needle exchange hours. With these regular times, we are vaccinating more clients and are improving our rate of return for the second and third dose in the series. Our reminder call system from a LCPH nurse to a client overdue for their next shot has been appreciated by clients and we are beginning to see an improvement in completion rates. Vaccine series completion will significantly improve the rate of immunity and reduce disease transmission. Between April 2003 and April 2004, we have given over 800 doses of these hepatitis vaccines. In addition, we have added the University Health Service at the University of Oregon as a delegate site for this program.

In January, we filled the vacant HIV Outreach Worker position. We are updating and revising our HIV policies and procedures to reflect our planned work with targeted populations at high risk of HIV infection. Our effort brings the Lane County program into line with current CDC recommendations and state funding requirements to focus on work with HIV positive individuals and to direct more counseling and testing resources to high risk populations, including individuals in the injection drug use (IDU) and men who have sex with men (MSM) communities. Testing time continues to be available to the general public requesting this service. We completed the state sponsored Rapid HIV Test Pilot Project and are continuing to offer these rapid tests at the same venues as during the pilot including: the Community Corrections Center, Lane County Methadone Program, and the Willamette Valley Treatment Center. The state has continued to provide us with the kits at no charge for these groups.

Also beginning in January, we have dedicated some of the time of a communicable disease nurse who is experienced in HIV case management to HIV Alliance. He is providing the state mandated nurse assessments for HIV positive clients. LCPH has subcontracted with this organization to provide broad social and health related case management. By providing focused nurse time, we are making the most efficient use of these contracted funds.

Environmental Health Service Unit

The purpose of the Environmental Health Program is to protect the health of residents and visitors in Lane County as they use any of our 2,326 restaurants, hotels, public swimming pools, schools, and other public facilities throughout Lane County. Environmental Health (EH) employs 5.25 FTE sanitarians that are responsible for all food and facility inspections throughout the county. The following are the types and numbers of facilities licensed and regularly inspected by the EH staff: full service and limited service food facility (890), bed and breakfast (22), mobile units (131), commissaries (16), warehouses (15), vending (4), temporary restaurants (788), pools/spas (283), traveler's accommodations (104), RV parks (55), and organizational

camps (16). EH continues to work closely with the Communicable Disease (CD) teams as needed to ensure safe food and tourist accommodations for everyone in Lane County.

In the past year, EH received a grant to fund an additional sanitarian to work directly with the CD team to establish general preparedness procedures with a primary focus on bio-terrorism issues. This position has conducted several training sessions and presentations on preparedness and bio-terrorism for area health providers and agencies, Lane County Health & Human Services staff, and the Lane County Disaster Coalition.

During the first quarter of this year EH implemented an electronic field inspections and reporting system. Sanitarians are now able to produce and print concise inspection reports on site for restaurant owners. This new system also allows the sanitarians to upload the information to the state data collection system on the same day the inspection was performed. This has increased the efficiency of the field inspections as well as the data entry after the inspections are completed.

Testing and certification of food handlers in Lane County continues to be a priority, as a preventative measure against food-borne illnesses. EH issues approximately 7,000 Food Handler Cards annually. Working with Lane County's IS Department, EH is proposing to make this service more accessible through an on-line "e-commerce" function in the near future. EH staff is also pursuing a proposal to provide accredited Food Service Management training. This type of proactive education could have a considerable impact in limiting the number of food-borne illness outbreaks.

During the spring and summer months EH experiences a sharp increase in seasonal licensing and inspections for temporary facilities, festival events, bake sales and other outdoor food service activities. Maintaining the routine restaurant and facility inspections with the additional seasonal duties results in a particularly busy time of the year for the EH staff. Again, the EH team continues to work closely with the CD nurses to better coordinate investigations on food borne illness. EH and CD recognize the importance of having the two disciplines working together in the on-going effort to curb the number of food-borne illness outbreaks.

Teen Pregnancy Prevention / Family Planning Unit

The Family Planning and Teen Pregnancy Prevention Unit has continued to undergo staffing changes. Services in Florence have been particularly challenged with the retirement of a nurse. With scheduling changes, the core of professional staff has continued to address the Family Planning needs in the central office and in the branches.

Recent assessment of the past calendar year indicates that number of clients in the central office in Eugene that are non-English speaking approaches 40 percent. The increase in percentage of primarily Spanish speaking clients is due in part to the fact the LCPH remains the only Title X funded facility in the county, thereby serving a need that

is not otherwise met. Changes in bilingual staffing are in process. It has been critical to keep bilingual office staff in the reception area to schedule, answer questions, and triage clients. We are in the process of hiring a second bilingual office assistant 2 to fill this need.

With the proposed closing of the branch offices due to budget constraints for FY 2004-05, efforts are underway with community leaders to mitigate the negative effects on the three areas effected. To date, family planning and immunization management staff has met with Health Associates in Florence to discuss possible public/private partnerships in these areas. Such discussions will also be scheduled with Cottage Grove and Oakridge providers.

One successful long-term public/private partnership has been the LCPH/Sacred Heart Prenatal Clinic partnership. Young women who have positive pregnancy tests and will be seeking prenatal care, are triaged quickly to the LCPH Prenatal Program which helps eligible women sign-up for the Oregon Health Plan. Pregnant women are then given an appointment for prenatal care with a private provider or at the Prenatal Clinic depending on their insurance status. Following the delivery of the baby, Prenatal Clinic clients are then referred back to LCPH. This loop reduces pregnancy related complications secondary to late prenatal care, including pre-term delivery, as well as unintended pregnancies. In addition, these women receive timely referrals to the LCPH WIC program and maternity case management when indicated.

With the challenge of reduced funding, the Family Planning Program is working to identify and seek funds to continue program services. We are members of the Latino Medical Access Coalition which has identified access to family planning services as a critical health care need. We are working with the LCPH Breast and Cervical Cancer Screening Program to provide funded services such as pap smears and breast exams to eligible clients. We are working with leadership members of the newly established Community Health Centers on our joint family planning concerns. We continue to participate in the Family Planning Expansion Project.

Breast & Cervical Cancer Screening Unit

The purpose of the Breast and Cervical Cancer Screening Program (BCCP) is to decrease disability and death from breast and cervical cancer through early detection for the medically underserved population of women ages 40 to 64. In 1994, the Oregon Department of Human Services (DHS) received a grant from the National Centers for Disease Control and Prevention (CDC) to establish a Breast and Cervical Prevention Program in Oregon. The Lane County BCCP was established in 1997, and since that time has provided access to clinical breast exams, mammograms, Pap tests, pelvic exams and other diagnostic services for approximately 4,900 uninsured or underinsured women. Over the past six months, BCCP has screened approximately 400 clients, five of whom were diagnosed with breast cancer. The individuals who received a diagnosis were assisted in accessing treatment. Early detection and treatment of breast and cervical cancers increases the rate of survival.

Breast cancer is the most commonly occurring cancer and second leading cause of cancer death among Oregon women, as reported by the Oregon State Cancer Registry. Preliminary data for year 2003 indicates that 2,600 new cases of female breast cancer were diagnosed in Oregon and 500 women died of breast cancer. BCCP provides access to screening and treatment that would not otherwise be available to uninsured and under insured Lane County women.

Cervical cancer is a truly preventable disease. With early detection, precancerous cells can be detected and removed before they develop into cancer. The Papanicolaou (Pap) test has the potential to virtually eliminate invasive cervical cancer, and its use has significantly reduced the number of deaths from cervical cancer. However, deaths continue to occur—most often in women who are rarely or never screened. Routine screening remains less common among women who are uninsured, have less than a high school education, or live in poverty. BCCP provides access to Pap tests for Oregon women who would not otherwise be able to afford this important screening procedure.

Prenatal Unit

The purpose of the Prenatal Program is to optimize birth outcomes by helping low-income pregnant women access prenatal care as early as possible. Early and comprehensive prenatal care is vital to the health and well-being of both mother and infant. Early prenatal care helps prevent low-birth weight babies, a predictor of newborn health. Prenatal care identifies risk factors such as the use of alcohol, tobacco, or other drugs; domestic violence; diabetes; or heart conditions. Studies indicate that for every $1 spent on first trimester care, up to $3 is saved in preventable infant and child health problems.

The statewide benchmark goal for early prenatal care is 90 percent. Both state and county rates have remained well below that goal, and Lane County's rate has remained below that of the state as a whole. Preliminary data for year 2003 indicates that Lane County continues to lag behind the state in first trimester prenatal care. Data indicates that 76.1 percent of Lane County's pregnant women had first trimester prenatal care as compared to 81.3 percent for the state.

Improving access to care is the most effective means of increasing the percentage of women who receive first trimester prenatal care. Women who do not obtain early prenatal care often have no health insurance, do not know that low cost services are available, and find the system for accessing care both overwhelming and confusing. In the past six months, Lane County Public Health's Prenatal Program has assisted 322 low-income women access health coverage through Medicaid, and has helped assure the establishment of prenatal care for those women.

Maternal Child Health Unit

The purpose of the Maternal Child Health (MCH) program is to optimize pregnancy, birth, and childhood outcomes for at-risk families through education, support, and

referral to appropriate medical and developmental services. During the past six months, the MCH team has received 291 new referrals for nurse home visiting services, 221 referrals for Maternity Case Management, 22 referrals for Babies First!, 17 referrals for CaCoon, and 31 other referrals — a 54 percent increase over the previous six months. The CaCoon program is partially funded through grant funds from Oregon Health and Science University (OHSU), Child Development and Rehabilitation Center (CDRC). In addition, Willamette Family Treatment Center contracts with LCPH Health to provide MCH services at their facility. The referrals listed above do not include program services at Willamette Family Treatment.

The Maternity Case Management component of MCH provides ongoing nurse home visiting services for high-risk pregnant women and helps assure access to, and effective utilization of, appropriate health, social, nutritional, and other services during the perinatal period. Prenatal nurse home visiting has been shown to: increase the use of prenatal care, increase infant birth weight, decrease preterm labor and extend the length of gestation, increase use of health and other community resources, improve nutrition during pregnancy, and decrease maternal smoking — all of which increase positive birth and childhood outcomes.

The Babies First! component of MCH provides assessment and early identification of infants and young children at risk of developmental delays or other health related conditions. Screening for health or developmental problems helps identify children at risk of later problems. Early detection of special needs leads to successful interventions and the most positive outcomes. Nurse home visiting for high-risk families with young children allows early detection of potential delays, parental education regarding ways of overcoming early delays, ongoing assessment of development, and referral to early and appropriate interventions. Other benefits of nurse home visiting are: improved growth in low-birth weight infants, higher developmental quotient in infants visited, increased use of appropriate play materials at home, improved maternal-child interaction, improved maternal satisfaction with parenting, decreased physical punishment and restrictions of infants, increased use of appropriate discipline for toddlers, decreased abuse and neglect, fewer accidental injuries and poisoning, fewer emergency room visits, and fewer subsequent and increased spacing of pregnancies.

The CaCoon component of MCH provides services for infants and children who are medically fragile or who have special health or developmental needs by helping their families become as independent as possible in caring for the child, and by helping families access appropriate resources and services. CaCoon stands for Care Coordination and is an essential component of services for children with special needs. CaCoon provides the link between the family and multiple service systems and helps overcome barriers to integrated, comprehensive care. In addition to linkage to resources, nurse home visiting for young children with special needs provides the benefits listed above for Babies First!, family and child assessment, advocacy, and parental education and training.

Healthy Start Unit

Healthy Start offers support and education services for first-time parented families in Lane County through voluntary home visiting services. The program screens and assesses needs and strengths of families, and determines eligibility for participation; and, provides ongoing home visiting for families at risk of poor childhood outcomes, and one-time home visiting for those at lower risk.

The central administrative core of the program is part of Lane County Public Health, and the home visiting portion of the program is provided through seven contracting agencies throughout the county. Healthy Start is funded through state general funds dedicated to Oregon's Healthy Start program and through support of the local Commission on Children and Families.

Healthy Start is a research-based primary prevention program that has been proven to effect positive changes in the lives of families and children. Positive outcomes tracked in the yearly Oregon Healthy Start Status Report demonstrates a lower rate of child abuse and neglect, a higher rate of utilizing well-baby care by a primary care provider, decreased emergency room use, and an increased rate of childhood immunizations in Healthy Start families. Additionally, data indicates that families who participate in Healthy Start read to their children more than the general population and that they report that the program was helpful to them in their parenting.

Healthy Start actively promotes car seat safety by holding car seat classes and clinics, staffing the car seat information line, and playing a pivotal role in coordinating car seat services through the Lane County Car Seat Consortium. Oregon Department of Transportation and ACTS of Oregon, as well as United Way of Lane County, provide support for these activities.

Women, Infants and Children Unit

In March 2004, the WIC Program was serving 7,853 clients. The number of vouchered participants (the actual number of participants redeeming WIC vouchers for that month) was 7,682. The assigned target vouchered caseload level is 8,228 vouchered participants per month for this program year. The program is currently maintaining at 93.4 percent of this assigned caseload due to recent losses of trained staff. The reduction of clinic days in the branch offices of Cottage Grove, Florence, and Oakridge continues to have an effect on the program's ability to meet the assigned caseload as well. Although many clients from rural areas have been able to come to Eugene for appointments, some clients have no transportation and continue to request appointments in the branch offices.

Client requests for service have maintained a high level. It has been difficult to maintain an adequate number of appointment slots for the past four months, although there is currently no waiting list for services in the Eugene office. Clients have experienced short waiting periods for WIC appointments in the Cottage Grove and Oakridge offices, although they have generally been seen within two-to-three (2-3) weeks. There has

been a fairly consistent waiting list for WIC services in the Florence office, where clients often wait for four to eight (4-8) weeks for services. Extra clinic days have been added in Florence when possible.

As part of the new state WIC data system implementation plan, staff were trained on the use of laptops in December 2003 in order to provide services in the branch offices. Data from the main system is now downloaded into the laptops. Clients in the branch offices are served through use of the laptop computers and WIC vouchers are now printed on site at the branch offices. Eligible clients can receive WIC vouchers at the end of their appointments instead of waiting to receive vouchers in the mail. This has increased the efficiency of services provided our citizens.

WIC nutrition education class selections have continued to expand. Two new classes were added in English, including a children's dental health class and a menu planning class. The schedule now includes a fast meals class in the Spanish language as well.

VII. SUPERVISION AND TREATMENT SERVICES (Linda Eaton, Program Manager)

Methadone Treatment Program

As of March 31, 2004, the Lane County Methadone program had 114 active patients in treatment. With the closure of the CODA program in January of last year, the Lane County Methadone program has been the primary agency serving OHP Plus patients, under contract with LIPA. However, due to the loss of a counselor position in July, our waiting list had been closed for several months. We recently began taking new patients, including OHP Plus and self-pay patients, and are working with LIPA to transfer several OHP patients from Integrated Health Services to our program.

The State did not restore the chemical dependency benefit for OHP Standard members in January, as originally planned. It's also not certain whether OHP Plus members will continue to have a chemical dependency benefit. If OHP Plus members lose coverage, it will have considerable impact on the methadone patients in our program. The "Plus" population, as a whole, is less able to work and earn enough money to pay for their own treatment. Many of these patients have multiple disabilities or health problems. Thus, the impact is anticipated to be greater than on the "Standard" population, some of whom could afford to pay for treatment, at least for a time.

In October, the Methadone program participated in a CARF accreditation survey as part of a new federal regulation requiring accreditation of all methadone treatment programs in the country. The surveyors reviewed all aspects of our program, including fiscal, strategic planning, outcomes management, quality assurance, clinical and safety/emergency services. It was a much more rigorous review process than state site visits. In December, we were notified that the program had received the highest accreditation standard – a three year accreditation. In the award letter, CARF stated that "this achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served," and that "services,

personnel, and documentation clearly indicate an established pattern of practice excellence". The Methadone staff is very proud of the reflection this accreditation has on our program and the patients it serves.

As noted above, the Methadone Program lost one counselor position this fiscal year due to the end of a three-year federal grant. The program continues to look for ways to absorb higher costs and lower revenues. Recent measures include discontinuing a private security guard's presence during Saturday dispensing hours, and reducing the number of urine drug tests patients receive. In Fiscal Year 2005, the program will face a significant reduction in FTE for its only office assistant position.

DUII / Offender Evaluation Unit

The DUII/Offender Evaluation Unit served 968 new DUII cases and 132 other corrections cases between October 2003 and March 31, 2004, for a total of 1,110 cases. Although DUII cases remain fairly consistent, we have seen reduced referrals for offender evaluations compared to the same time period in the previous year. As reflected in the table below, this is especially true with referrals for domestic violence evaluations. The exact reason for the continued decline in these evaluations is still unknown. However, it is not limited to this program. Community batterer intervention programs are experiencing reduced referrals from other referral sources. Our office is working closely with the Lane County Domestic Violence Council to explore this issue in more depth.

October 1, 2002 – March 31, 2003		
Month	**Total Corrections Evaluations (excluding DUII)**	**Number of Corrections Evaluations Which Were Domestic Violence Cases**
October	43	17
November	27	11
December	42	17
January	20	10
February	28	20
March	33	20
TOTALS	**193**	**95**

October 1, 2003 – March 31, 2004		
Month	Total Corrections Evaluations (excluding DUII)	Number of Corrections Evaluations Which Were Domestic Violence Cases
October	21	13
November	22	10
December	23	14
January	20	10
February	20	8
March	26	3
TOTALS	132	58

We are working with the State Department of Human Services/Child Welfare Office on the possibility of providing domestic violence evaluations for Child Welfare clients. This would provide a needed service for that agency, as well as another source of funding for our agency.

The DUII unit will also be losing an office assistant FTE next fiscal year. A half-time position will be eliminated in order to balance next year's budget.

Sex Offender Treatment Program

Due to a series of cuts in community corrections funding in the previous and current fiscal year, the Sex Offender Treatment Program (SOTP) experienced significant reductions. Consequently, the number of indigent clients waiting to be served has increased. As of March 31, 2004, the program had 21 sex offenders on a waiting list. These offenders have been referred by their parole/probation officers and are awaiting a treatment slot. Of these 21 offenders, approximately 14 have been identified as indigent. Parole/probation officers have been encouraged to refer new clients to private treatment programs, if possible, but some offenders cannot afford private treatment.

Due to the staff reductions, the SOTP facility had vacant staff offices, as well as increased concerns about staff safety with fewer people in the office. As a result, two parole/probation officers (POs) volunteered to move their offices to this site. Both officers carry a full caseload of sex offenders, some of whom are also in our treatment program. Overall, this is working very well and serves a variety of purposes, including better use of space, better security, and closer coordination between PO and therapist on shared cases.

In October 2003, Lane County was awarded the Department of Justice's Comprehensive Approaches to Sex Offender Management (CASOM) grant. This two-year grant has provided funding for a .75 Mental Health Specialist (MHS) who is located at Parole and Probation. During the first four months of this grant, the MHS has established two pre-treatment groups (a service previously offered, but eliminated due to funding cuts), and began coordinating with treatment providers in the area. The MHS has also collected data on P&P-supervised sex offenders in Lane County, including offender and victim demographics, offender risk level, treatment status, release type, previous supervision for a sex offense, and other victim information. Most of this data has not been previously collected in a systematic manner. Project staff are working with the new research and evaluation analyst in H&HS to maintain that database and provide data analysis for planning purposes. The data has been analyzed using the Statistical Program for the Social Sciences (SPSS), an analystical tool commonly used in social sciences. In March, the CASOM team was presented with this analysis regarding the approximately 400 sex offenders on supervision. The SPSS analysis provides statistically valid information about patterns in the supervision and treatment of sex offenders, which will be very useful for management of this population.

Parole and Probation

As of March, Parole and Probation (P&P) supervised 3,412 individuals, 47 percent which are classified high or medium risk offenders. Since the last Board of Health report, Lane County had 1,224 new admissions and 1,005 case closures. Lane County parole/probation officers' caseload sizes continue to remain among the highest in the state at an average of 100 per officer.

P&P is working with the Sheriff's Department in a few specific areas. One is the Defendant/Offender Management Center (DOMC). A P&P supervisor was closely involved in the development of the DOMC over the past year, and the acting ADO supervisor is involved in on-going development of the Risk Assessment Tool and the Criminogenic Needs Assessment Tool. When the DOMC is in operation, one P&P staff person (a corrections services technician), will work 20 hours at the DOMC. It is anticipated the corrections tech will perform the following duties:

1. Liaison between the jail and P&P - keeping PPOs informed of which clients are in custody and which have been released.

2. Create release plan recommendations for 1145 local control offenders.

3. Maintain Parole/Probation 'silo' beds (see below) at the jail.

4. Administer risk tool to offenders in Phase One of DOMC; contribute recommendations to the plan on how a sentenced offender will serve sentence based on crimimogenic needs assessment and input from jail and PPOs.

P&P and jail management staff recently implemented three "matrix exempt" slots for P&P supervised offenders who are either high risk or there is an urgent need to keep

them in custody for a period of time. These slots are used by P&P in cases where an offender does not otherwise meet the jail's criteria for matrix exemption due to dangerousness. Placement of offenders in these slots is managed by the P&P supervisors. A typical use of the P&P slots would be for a chronic absconder, who is arrested and placed into custody, only to be released again before the PO can impose a sanction. Keeping an offender in one of these slots will at least ensure that he or she is available when the PO schedules a sanction hearing, if not for the entire length of the sanction imposed. Clearly, three slots does not approach meeting the need to contain offenders for a variety of purposes, but it does move us in a better direction. P&P is also working on a future P&P "silo" of beds, to be become operational with the DOMC. The plan is that a certain number of jail beds would be managed by P&P for supervised offenders held on detainers, warrants, and sanctions. According to "snapshot" data gathered by jail staff on December 8, 2003, 52 percent of the entire inmate population (including jail, Community Corrections Center, and Forest Work Camp) were under P&P supervision, either for probation, local control, parole, or post-prison supervision. The percentage of jail inmates on P&P supervision was 46 percent.

In February, P&P and Sheriff's department management staff participated in a National Institute of Corrections satellite broadcast on "Implementing Effective Correctional Management of Offenders in the Community". The three-hour broadcast reviewed principles and implementation strategies for evidence-based correctional practices. The information has relevance for the DOMC as well as other operational aspects of offender supervision.

Also in February, P&P held an all-staff meeting to discuss agency workload concerns, i.e., the unmanageable number of cases P&P supervises in relation to available staff resources. This has been an agency concern for years. The H&HS assistant director facilitated a brainstorming session on ideas for reducing the workload to a manageable level. The ideas identified had to meet the following criteria:

- Maintain community corrections funding levels (i.e., we can't decline to supervise felony cases without reducing future community corrections funding for the entire county)

- Be consistent with evidence-based practices

- Maintain supervision of person-to-person misdemeanors (a priority of the department director)

Several of the ideas involved ways of increasing the "casebanking" of lower-level offenders. A workgroup of five POs, one supervisor, and the program manager was assigned to further develop these ideas and make recommendations back to the full staff. This work, which is still in process, will generally involve a recommendation to casebank more low-risk offenders and reduce the contact standards for that group, to allow more time for supervising high and medium risk offenders. This focus on higher risk offenders is consistent with evidence-based practices.

In October 2003, Parole and Probation was awarded a two-year grant from the Federal Department of Justice (Office on Violence Against Women) for pre-trial monitoring of domestic violence offenders. Partners in the grant are Parole and Probation, Circuit Court of Lane County, and Womenspace. The project began accepting participants in February. Participants are identified by the custody referee's office, and offered pre-trial release from custody with participation in this project as a condition of release. As of the writing of this report, 28 defendants were in the program, seven of whom live in rural Lane County. New participants enter the program several times a week. The defendants are monitored by POs to increase victim safety and ensure that release conditions are being followed. Violations of conditions are reported to the Court. The pre-trial agreements usually include a condition for no contact with the victim, no possession of weapons, and requirements regarding future court appearances. Grant funding provides a .75 FTE victim advocate from Womenspace, who is working out of the District Attorney's Victim Services Office. This cooperative arrangement between a non- profit agency and a government agency is functioning very well.

Due to budget constraints and the importance of maintaining PO positions, one of three P&P supervisor positions has been left vacant and is currently unfunded. In the meantime, supervisor responsibilities have increased to a point which is untenable over the long term. The two supervisors currently supervise 40 staff, with an additional corrections technician in the recruitment process. The supervisors are also staffing a new after-hours, on-call system to improve our response to law enforcement agencies on evenings and week-ends. This involves a supervisor being on call at all times, including evenings and week-ends. Four new staff, in need of supervisory direction and training, have been hired in the last nine months due to grant projects and staff retirements. One of the supervisors functions as the P&P rangemaster, organizing several firearms trainings per year, as well as supervising the maintenance of related equipment. That same supervisor is the lead instructor for defensive tactics training, which is also conducted several times a year. The agency attempts to prioritize supervisor time for direct staff supervision. However, P&P is called upon to participate in many community and system projects, and due to an otherwise thin management structure, supervisors must participate on various committees and other aspects of program development and grant management.

VIII. ATTACHMENT

Health Communities Healthy Youth Pamphlet