

# Agenda Cover Memo

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AGENDA DATE: November 10, 2009

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

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The following report to the Board of Health is a summary of recent or current health and human service highlights and 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 and 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.

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## I. ADMINISTRATION (Karen Gaffney, Assistant Department Director)

### PREVENTION PROGRAM

The purpose of the prevention program is to promote and coordinate effective community-based prevention strategies aimed at creating healthier communities, particularly in the areas of substance abuse, problem gambling, and suicide prevention. The program supports multiple strategies, targeting efforts prenatally, in early childhood, in adolescence, and for the larger community. Highlights from the last six months include work in the following areas.

***Suicide Prevention:*** Funding from the Garrett Lee Smith Memorial Act was extended through May, 2010 to continue suicide prevention efforts in the county. Since its implementation in 2006, project outcomes have focused on: increased knowledge among clinicians, crisis response workers, school staff, youth, and lay persons. The countywide Suicide Prevention Steering Committee has met monthly and identified its primary goal: To facilitate community efforts to prevent youth suicide in Lane County. Focus is on identifying services, increasing coordination of resources and assisting schools in the county to increase their suicide prevention efforts.

Several trainings were offered to increase identification and intervention skills.

**Assessing & Managing Suicide Risk: Core Competencies for Mental Health Professionals** was held May 26 and Applied Suicide Intervention Skills Training (ASIST) was provided September 21-22. **RESPONSE**, school-based suicide prevention training was offered during the statewide school professional development day, October 9. Two surveys were created and distributed countywide: one, to identify potential referral resources and the second, to determine suicide prevention programs and needs in the schools. Two Question, Persuade, Refer (QPR), trainings will be delivered in November for City of Eugene staff.

Staff has met with personnel at Sacred Heart RiverBend to discuss ways to strengthen hospital follow-up reporting and coordination of referrals. Development is underway with other hospital Emergency Departments in the county.

***Healthy Babies, Healthy Communities Initiative:*** Prevention and Public Health staff continues to work on the Healthy Babies, Healthy Communities initiative (HBHC). The goal of HBHC is to reduce fetal-infant mortality and increase infant health in Lane County.

Work continues with the U of O Project FEAT to increase and enhance prenatal alcohol and drug screening. The pilot with the Oregon Medical Group (OMG) has continued. A meeting with the OMG nurses was held in September. This meeting provided feedback on the process and the experience was very informative to discover their reasons for not screening and documenting. Overall, the response has been positive and some have adapted the process to address confidentiality issues (i.e. when the patient's

family/partner is present during the exam). Another three months of data will be collected to determine how well the screening process is being implemented.

A Healthy Babies Award was created to recognize efforts in Lane County that help to reduce fetal-infant mortality and increase infant health in our community. Four recipients were selected and awards given at a reception held September 24<sup>th</sup>. This event provided an opportunity to honor the award winners as well as highlight what HBHC has accomplished over the last two years.

Staff worked with the Commission on Children & Families, United Way's Success by Six, and Health Policy Research Northwest to convene a Home Visiting Project Group to explore ways to enhance collaboration, expand capacity and increase quality of home visiting services in the county. Home visiting is known as an effective strategy for reducing substance abuse, child maltreatment and abuse.

**Supporting Parents:** Lane County Prevention Program continues to support parenting education efforts through partnerships with school districts and Family Resource Centers (FRCs), located across the county. Substance abuse prevention dollars fund various evidence-based parent education programs, including Strengthening Families for parents with children age 10-14. Although funding for the Strengthening Families Program from the State was cut, parent education remains one of our priorities and we continue to make efforts to fund parenting classes focusing especially on rural areas, as well as parenting classes with Latino families.

**Problem Gambling Prevention:** Lane County's problem gambling prevention program continues to be a leader in the field in its comprehensive prevention approach. Innovative youth presentations, media efforts, and other strategies have helped increase the awareness among youth and families about problem gambling as a public health issue. Middle school participants scored an average of 87 percent on awareness posttests during the 2008-09 school year, and high school/college participants scored an average of 90 percent (our performance measure goal is 80 percent or above).

The problem gambling prevention website, [www.lanecounty.org/prevention/gambling](http://www.lanecounty.org/prevention/gambling), received a total of 29,701 visits during the 2009 fiscal year (averaging 2,475 distinct visits per month). Our program continues to receive correspondences and requests from across the state and nation in response to the website. Most recently, Lane County's problem gambling prevention program has: 1) in conjunction with the University of Oregon, begun implementing a grant that is specific to on-campus problem gambling awareness & prevention, 2) made available resources and technical assistance for two best practice prevention programs (Reconnecting Youth and Strengthening Families), and 3) built Oregon's first problem gambling prevention & outreach website as a statewide resource for providers and prevention partners. These three efforts have come, in part or wholly, due to specific additional funding allocations from Oregon Problem Gambling Services to Lane County Health & Human Services.

**Community Engagement:** Prevention program staff currently work with four active community coalitions, McKenzie, South Lane, Oakridge and Siuslaw, each working with staff to develop work plans specific for their community. All community coalitions are examining ways to address underage drinking as this continues to be a concern in Lane County.

Siuslaw is in the beginning stages of 'Communities that Care', an evidence-based prevention community mobilization process. Additionally, members have focused their efforts on community education by providing presentations to existing community groups.

Oakridge, Cottage Grove and McKenzie communities are interested in environmental/policy changes to address underage drinking. McKenzie has been active in working with key leaders to support a Social Host Ordinance. Law enforcement in both Cottage Grove and Oakridge has expressed interest a similar city ordinance. Prevention staff has worked with county counsel and the Sheriff's Department to craft a county Social Host Ordinance and the draft is expected to go before the BCC this fall.

Monthly meetings of the developing South Lane Substance Abuse Coalition have been held in Cottage Grove during this period. Prevention staff is working with this community to reinvigorate its substance abuse prevention efforts, using the Communities That Care prevention-planning model.

**Prevention Outreach:** One primary tool for outreach is the development of the prevention website. During the period between April and October of 2009, there were 12,834 visits to the prevention website. In addition to ongoing partnerships and the prevention website, the program launched the 'Learning Institute' earlier this year. The Learning Institute is a new strategy designed to engage and offer community members prevention related information on a regular at very low cost. The Learning Institute has a monthly calendar with training and descriptions posted. Trainings are advertised through the county training & education newsletter as well as other statewide networks. Some of the offerings this year have included training to become a trainer for an evidence-based parenting education program, substance abuse prevention specialist, and evidence-based suicide prevention program.

## **II. ANIMAL SERVICES (Karen Gaffney, Assistant Director)**

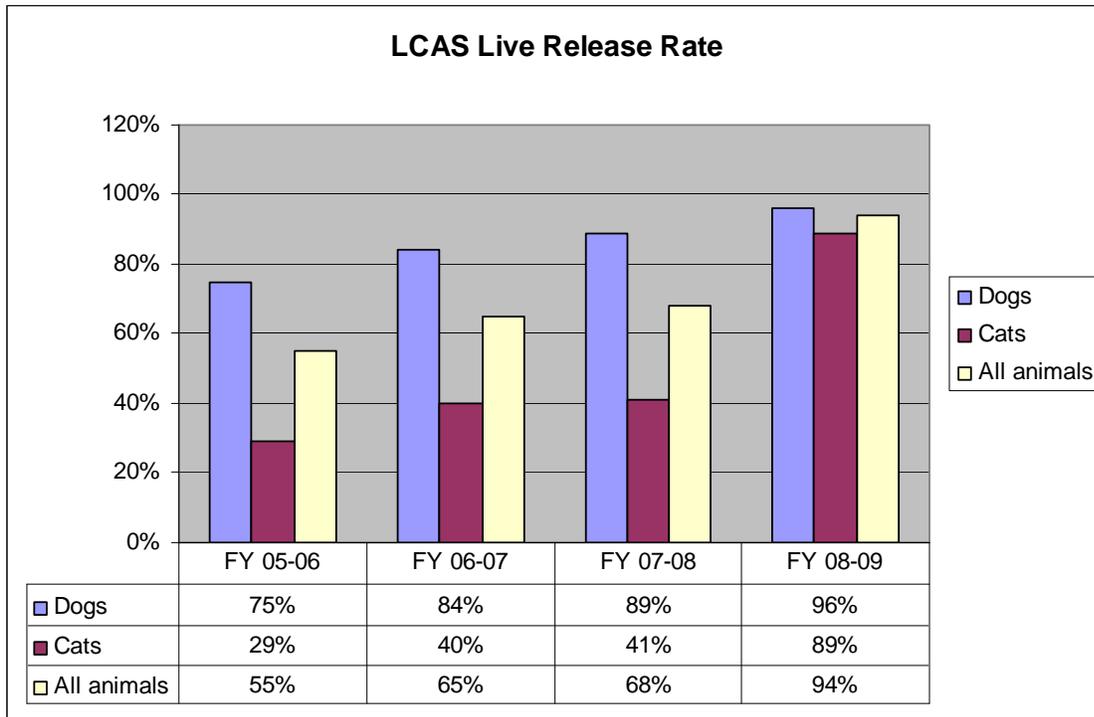
### **DIVISION OVERVIEW**

Lane County Animal Services (LCAS) works to fulfill its mission of ensuring public and animal health, safety, and quality of life; and bringing about and maintaining an environment in which people and animals can live harmoniously. This includes animal control and protection services to unincorporated Lane County, the City of Eugene, and by request to all other incorporated cities. LCAS provides progressive adoption, licensing, lost and found, and educational programs. Services include enforcement of state, county, and city ordinances regarding domestic animals and limited livestock

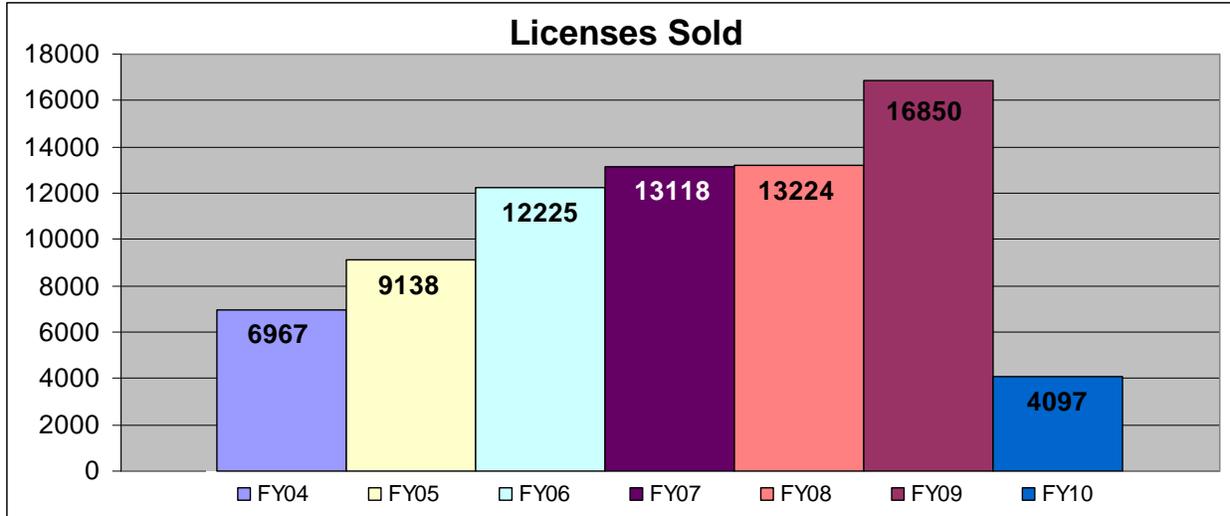
situations. LCAS investigates and prosecutes animal neglect, cruelty and abuse cases, and dangerous dog violations. Additionally, staff provides housing and basic medical services for lost, abused, and neglected animals; return animals to their owners; and transfer adoptable animals to local humane societies and rescue groups.

The outcomes at LCAS continue to trend positive on the primary indicators.

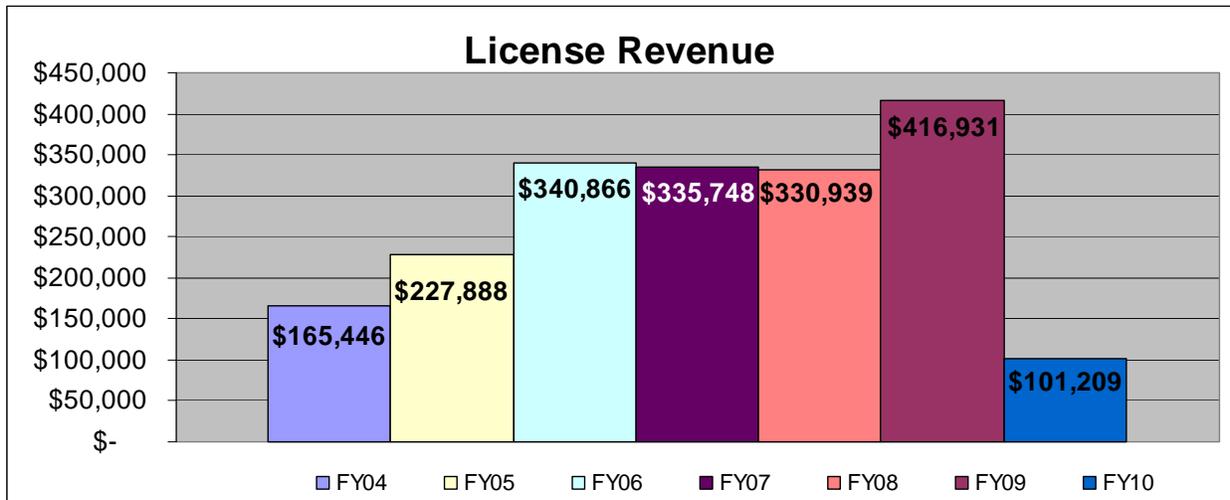
The changes at LCAS are most obvious in the changes in euthanasia numbers at the shelter. The standard measurement for shelters nationally is to calculate a Live Release Rate, which takes into account differences in raw numbers of animals impounded, those returned to owners, those adopted, and those who are euthanized. LCAS is an open door shelter, meaning that all stray, abused, and neglected dogs in our jurisdiction are impounded, regardless of whether they are adoptable based on medical and behavioral needs. Based on national data, LCAS has set a target that at least 90% of the animals that enter our shelter would leave the shelter alive, either returned home to their owners, or placed in new adoptive homes or otherwise rescued. LCAS exceeded that goal for the first time ever in FY 09 with an overall live release rate of 94%.



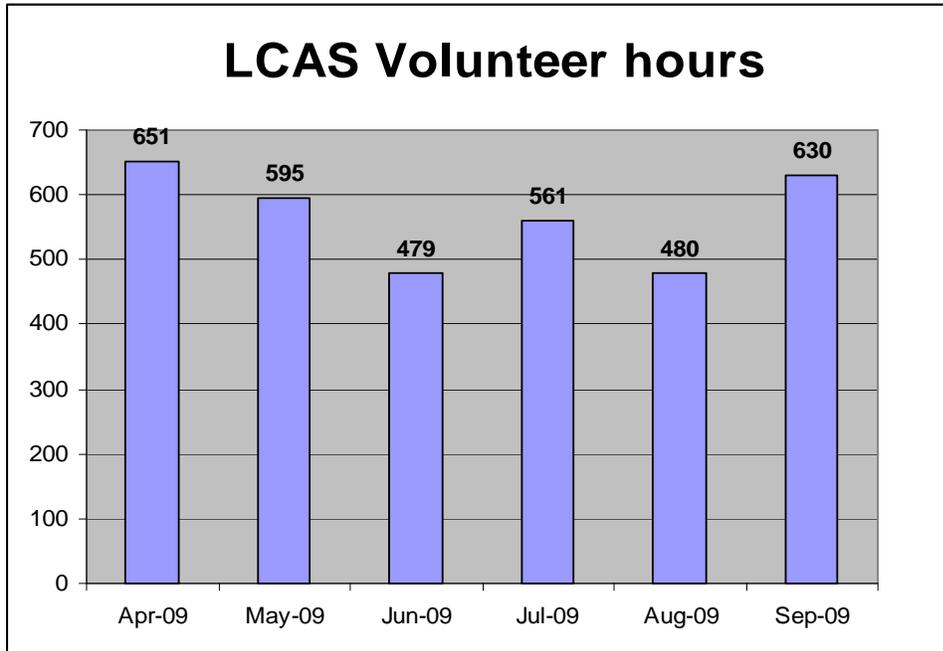
At year end, licenses sold were up significantly over prior year, and continue to be on track at the end of the first quarter of the current year. This is a key area not only because of revenue, but because any animal that is licensed can be returned home immediately without ever coming into the shelter. Increasing licensing compliance will allow us to decrease the number of dogs we impound in the future.



As would be expected, the increase in license sales has resulted in an increase in revenue from sales. This increased revenue has helped support the daily care of animals that have been in our care longer than in the past, and are part of supporting the addition of a full time Veterinary Technician for LCAS, and the ongoing support of a part time Veterinarian and a contracted Behavior and Training Coordinator. The plan for the current year is to increase that revenue even further to maintain these improvements, and sustain expanded spay/neuter efforts and other important programs for LCAS.



A key to implementing and sustaining new programs at LCAS has been through the effective use of volunteers. During the last six months, volunteers have logged a total of 3,396 hours at LCAS, in addition to the tremendous number of hours given by people in the community who provide foster homes for animals in our care. Boosting this cadre of volunteers continues to be a priority at LCAS.



Examples of specific new program efforts during the last 6 months include:

- Monthly licensing clinics with free rabies vaccinations, half of which were offered off-site in different parts of the County;
- Two-month door-to-door licensing canvass to increase dog licensing compliance;
- Launching a new cat program, to engage community members in providing two weeks of home care after an initial medical exam for found cats and kittens prior to impounding, resulting in less illness in the cattery and more adoptable cats;
- Launching follow-up with adopters at 3 days and 3 weeks to help reduce return adoptions and provide important information to help improve adoption service;
- Development of training standards for Animal Welfare Officers and a plan to ensure that sufficient training is provided for staff;
- Enhanced spay/neuter efforts including sponsoring a visit of the Neuter Scooter for cats, and free spay/neuter vouchers for “bully breed” dogs (pit bulls and pit mixes)

Despite these changes, there are still many challenges. Some of the most significant are:

- The focus on decreasing euthanasia of adoptable animals has resulted in more animals being housed than the shelter was designed to accommodate. This puts increased pressure on both the animals and the staff who care for them, highlighting the importance of more emphasis on adoptions and rescue work.
- In order to reach the Board’s goals regarding saving adoptable and treatable animals, the shelter staff needs to include permanent behavioral staff. These special needs animals require more staff time to care for them and to find them permanent homes, and the current staffing level is inadequate to meet those needs.

The reduction in Animal Welfare Officer time in the unincorporated area of Lane County to .5 FTE is having a significant impact in those areas. LCAS is triaging its response to calls, only able to respond to the most serious and dangerous situations. Reports of dog bites and other significant issues have to wait longer for an officer response, and concerns about animal abuse and neglect also have longer response times. The lack of officer time has limited staff ability to follow up on failure to comply with dog licensing.

### **III. CLINICAL FINANCIAL SERVICES (Ronald Hjelm, Clinical Financial Officer)**

Clinical Financial Services provides financial services support to the Community Health Centers (CHC) and Behavioral Health Services (BHS) operating units. These services include ensuring that the patient information is collected and maintained to ensure accurate and timely insurance billing, processing insurance billing, and posting of payments for services provided in the operating units.

The CFS unit is an active participant in preparing and submitting grant proposals to local, State, and Federal agencies. The unit is also responsible for monitoring financial transactions related to grant funding to ensure regulatory compliance, and is responsible for compiling many of the required grant reports.

#### **Grants Filing**

The CFS program participated in the following grant submissions during the past six months:

- American Reinvestment and Recovery Act – Capital Improvement Program (CIP) Grant. Received award for \$716,480 over two years. This grant will provide the CHC and BHS programs with funding of \$272,000 for the expansion of an electronic health record that is being implemented for Behavioral Health Services. Additionally the grant will provide \$444,480 for renovation of the CHC's new primary care site in the Charnelton Building.
- American Reinvestment and Recovery Act – Facility Improvement Program Grant. Requested funding of \$4,920,024 to assist with the renovation and equipment purchases of the CHC's facility to replace the RiverStone Clinic location in Springfield. Grant submissions will be evaluated in a competitive process, with awards to be announced in late October or early November.

#### **Regulatory Reporting**

CFS staff is responsible for preparing and filing reports to State and Federal agencies to ensure the County remains in regulatory compliance for the receipt of these grant awards. The CHC has received four major grant awards totaling \$2,333,155 during this year. Each of these awards requires extensive quarterly and/or annual reports on financial and operational performance. During the past six months, the CFS program compiled the following grant reports:

- Federal Health & Human Services Annual Financial Status (FSR) report filing completed for the CHC's main grant for \$1,228,037.

- Quarterly ARRA Grant Reports filed for the Capital Improvement Grant (\$716,480) and the Increased Demand for Services (\$294,588) Grant. To date the ARRA funding has enabled the CHC to retain/hire 3.4 FTEs. Staff has enabled the CHC to provide 1,516 patient visits to 368 new patients.
- Final Report – Health & Human Services Grant for \$73,812 to fund architectural and engineering costs related to renovating the Charnelton Building to enable Public Health and other County H&HS programs to move to this new location.
- State of Oregon – Annual Outstate Outreach Worker Submission Report to substantiate the CHC's costs related to the provision of support services to assist low income Lane County residents with the completion and filing of applications for Medicaid and other support programs. The State provided approximately \$250,000 for these costs of providing these services during the past year.

### **Claims Processing:**

CFS uses two distinct practice management/claims processing systems. We have one system for the CHC and a different system for BHS. We are evaluating options to integrate these two systems in the future.

The Behavioral Health Services program implemented a new electronic health record/practice management system in December, 2008. CFS staff played an integral role in the design and implementation of this new system. We have experienced some minor delays in claims processing as a result of implanting this new system. Unfortunately, we have experienced delays in claims payments from Medicare and Medicaid. The Medicare delays resulted from issues related to the change in mental health's licensure to be included under the CHC's federally qualified health center license. The issues have now been resolved, but we are still working with Medicare to complete the processing and payment of all past-due claims. The Medicaid delays related to the State's implementation of a new claims processing system in December, 2008. Most of the State problems have been resolved and they are now promptly paying the majority of claims. We also experienced administrative processing issues with LaneCare related to some mental health claims. These issues have been resolved and LaneCare is now reprocessing many denied claims for payment.

### **Days in Accounts Receivable (A/R)**

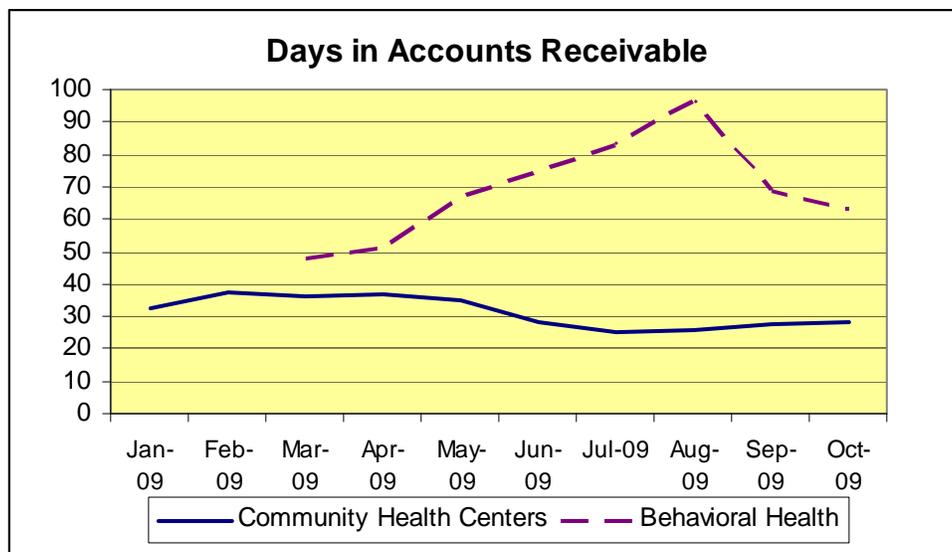
Days in A/R is derived by dividing the total dollar value in accounts receivable by the organization's average charges per day. Many organizations only look at the total dollar amount in accounts receivable, or in the accounts receivable aging. (That is, the total dollar amount of A/R that is 30 days past due, 60 days past due, etc.)

Days in A/R is a single measure that combines all of these other measures into a single indicator. For example, an organization with 45 days in A/R would take 45 days, on average, to collect payment for services from the day those services were provided. This measure reflects many aspects of how well the organization is functioning including:

- How accurately front office staff collect and enter payor information, and collect patient payments,
- How quickly and accurately medical and administrative staff collect and enter encounter data,
- How quickly and accurately the billing staff send out claims,
- How quickly payors process and pay claims,
- How quickly and accurately the billing staff post remits and,
- How accurately the billing staff “work” denials, and send out corrected claims.

Health care industry standards for days in A/R vary greatly depending on payor mix – for example, Medicare routinely takes 60 – 90 days to process claims. Trillium pays claims in about 20 days. Oregon Medicaid pays claims in about two weeks. An organization with a high Medicare payor mix would be expected to have more days in A/R than an organization with no Medicare.

A solid industry benchmark for days in A/R would be less than 45 days. The CHC has always out-performed the industry standard, and have been below 30 days for the past 4 months. With the new system, we are better able to measure accounts receivable. The mental health program has experienced delays, as noted above, with Medicare and Medicaid claims. We are now well on the way to having the mental health days in A/R meet or exceed our 45 day target. Through mid-October, our MH days in A/R is now down to 55 days.



#### **IV. COMMUNITY HEALTH CENTERS OF LANE COUNTY (Jeri Weeks, Program Manager)**

Community Health Centers (CHC) has been awarded \$716,480 in stimulus funds. These funds will be used for the following projects:

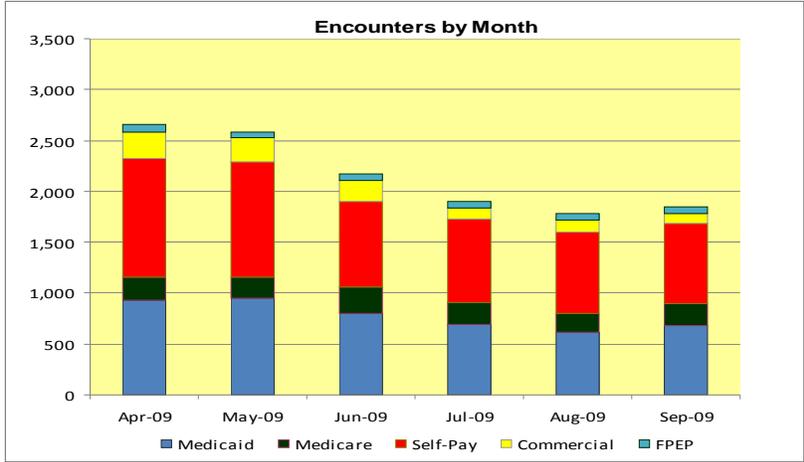
- Charnelton Clinic renovation project: \$444,480
- Electronic medical records project for mental health: \$258,610
- Voice recognition software for mental health and CHC staff: \$13,390

We also submitted a grant proposal for funds to help pay for the RiverStone replacement on Olympic Street. The final grant request was for \$4,920,024. These grants are based on competitive reviews of proposals. Health Resources and Services Administration will award 100 grants out of the 600 applications. Grant awards will be made in early November.

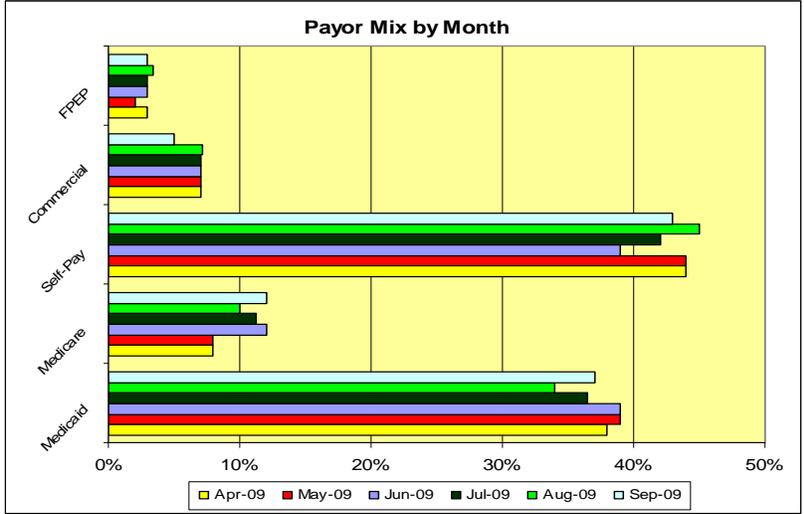
##### State Assessment – Dual Eligible Patients

The State legislature mandated a reduction in Medicaid payments to FQHCs of \$1.1MM over the current biennium. The State's proposed method to reduce payments was to tie Medicaid payments for patients who have Medicaid and Medicare coverage to the lower of the Medicaid or Medicare rate. The FQHCs in Oregon, along with the Oregon Primary Care Assoc. (OPCA) determined that the expected financial impact of this payment methodology would far exceed the legislature's \$1.1MM target. As such, the public FQHCs proposed to the State that we agree to a one-time assessment equivalent to the \$1.1MM, and retain the current Medicare/Medicaid payment methodology. The State has agreed to this proposal. The OPCA and the FQHCs are negotiating the total amount to be reimbursed to the State, as well as the pro-rata share for each health center. We expect that our maximum payment will be approximately \$275,000, paid over two years. The majority of this assessment would come out of the mental health program budget because that program has the larger percentage of dual eligible patients.

We continue to monitor CHC encounters and payor mix very closely. Encounters typically decline during the summer months. September proved to be a particularly challenging month as we had three nurse practitioners leave the CHC. We have replaced two of the three and should see encounters increase in October.



Our payor mix improved slightly in September, but still fell short of our 40/40 target.



Recruiting efforts to fill new provider positions for the Charnelton Community Health Center and the new RiverStone facility are underway. Two physicians have been hired, Christine Jensen Fox, MD and Beth Blumenstein, MD. A third candidate is very interested in the final position. We have six new nurse practitioner positions to fill in order to be fully staffed. Cynthia Voegeli, FNP has accepted one of our regular positions and Julie Penton, PNP, accepted another of our regular position.

We continue to make progress in developing quality assurance measures. We are looking at software that assists providers with medication management. The software helps to verify dosage, quantity and drug interactions as well as submits prescriptions electronically to local pharmacies. This is a high volume, high risk activity that needs an electronic management system to reduce risk and increase efficiency.

We are also looking at software that tracks outside diagnostic tests. This system tracks tests ordered, results received, flags abnormal results, etc. This system will bring us one step closer to electronic medical records.

## **V. DEVELOPMENTAL DISABILITIES SERVICES (Karuna Neustadt, Program Manager)**

Lane County Developmental Disabilities Services (LCLCDDS) provides an array of community-based services and supports for individuals with developmental disabilities and their families. The program currently offers lifespan case management for 1714 individuals who meet state-mandated eligibility criteria. In addition to case management, LCDDS directly provides crisis services for children and adults and family support services. LCDDS also subcontracts with eighteen local agencies to provide residential, transportation and employment services for adults. LCDDS authorizes funding and collects licensing information for 112 foster homes for adults and 16 foster homes for children, as well as placements in 48 Child Welfare foster homes. LCDDS also serves as the lead agency in Lane County for providing protective services for adults with developmental disabilities.

### **PROGRAM SERVICES**

Services provided by LCDDS are grouped into three areas: services for children, services for adults living in group homes or foster homes, and services for adults who live independently or with families. Historically, LCDDS staff and programming have been organized in three teams to meet these specialized needs: the children's services team, the comprehensive team and the support services team. In addition to these three teams, LCDDS has a family support program, a crisis program and a quality assurance program. LCDDS also works in conjunction with Cascade Region, which provides rate-setting, assessment, and technical assistance to a four-county region. The following narrative highlights significant activities and issues in each of these areas during the past six-months.

#### **Services for Children**

The amount of children (from birth to 17 years old) receiving case management with developmental and intellectual disabilities, continues to grow in numbers and complexity. We receive referrals for children from many sources in Lane County including early childhood special education, primary care physicians, school districts, DHS – Child Welfare, Department of Youth services, mental health agencies, and residential treatment programs. Due to the wide-ranging referral sources, the children's service coordinators are working with a wide array of children and their families. These children are eligible for DD Services due to being born with Down syndrome, cerebral palsy, autism spectrum disorders, chronic seizure disorders, complex genetic syndromes, fetal alcohol or drug effects, as well as intellectual impairments or mental retardation. Due to the children's team's positive efforts working with community partners in Lane County, the numbers of children referred to DD Services for case management services continues to grow. This has also been impacted by a positive change in case management services, as Family Support funding is now connected to children's case management as an entitlement support. As the Lane County community is more aware of this funding availability, more families are contacting Lane County DD

Services for case management/family support funding for their children with developmental disabilities.

A significant change for Children's Services has been the addition of our first bilingual Spanish language DD Service Coordinator. Outreach to the Latino community has been a growing need in our community over the past 10 years and we are now able to offer culturally competent access to the Spanish speaking children and families in Lane County. Twenty-five initial families were transferred to this service coordinator's caseload, who will be working with children in all areas of the DD children's system: intake, eligibility, in home support, family support, foster care, and residential programs. This is a great development for the children's team and the community we serve, and will allow LCLCDDS to more effectively service this community.

Our partnership with DHS Child Welfare and residential mental health programs in Lane County and the I-5 corridor has increased the number of children receiving services through LCLCDDS who have complex behavioral and mental health disorders that are challenging for our system serve. These children are diagnosed with disorders such as: reactive-attachment, post-traumatic stress, bi-polar disorder, and sexual offending, among others that complicate the support services LCDDS can provide to them and their families. It also has increased our need for a larger pool of foster care providers and respite care providers who have the skills to work with these challenging children and adolescents, both in and out of the family home.

With the support of the Cascade Regional Team and Lane County's children's crisis specialist, the children's team has been highly successful in finding therapeutic and supportive placements for children who need residential supports; however, there are few such resources in Lane County, and these resources are mostly located in the Portland metropolitan area. Development of local resources is an area that has been prioritized by the children's team for the Cascade regional team development specialist to pursue. The Cascade regional development specialist has been very helpful in attempting to address this need through discussions with provider agencies about increasing their capacity to serve more children in proctor care in Lane County, specialized foster care for children with complex behavioral and developmental issues. Without these types of local residential resources for children needing a higher level of care, it puts a large strain on their families, as well as on the children who have had to leave behind the support, friends, and connections to professionals in Lane County.

In the area of supports and services to children and their families in Lane County, LCDDS had two ongoing areas of growth in Children's Services that have been very positive, though challenging to address. One has been the expansion of our local Family Support program which provides flexible funding to families to provide extra supports to their children in areas of respite care, community inclusion activities, and specialized equipment and in home support. We now have over 300 families who can potentially access this program which almost quadruples the amount of support LCDDS has been able to provide to children with developmental disabilities in our community from two years ago. Families have been grateful for this funding and it has been

rewarding for staff to be able to provide proactive funding to more families than we have in the past. The challenge for service coordinators comes from the large increase in children eligible for these supports, while at the same time seeing an allocation decrease from Springfield Police Department (SPD) of approximately 50% per child.

The other ongoing area of growth has been in the area of High School Transition (HST) supports for adolescents and their families in DD services. By hiring a another HST specialist, the children's team has transitioned children 14-18 years old to a service coordinator whose primary focus will be supporting the individual and their families as they prepare for supports beyond their high school years. This is a key development, since; beginning in July, 2009, all young adults eligible for DD Services turning 18 years old are now able to receive community supports from brokerages in Lane County, while still being able to receive their special education benefits from school districts. Previously, this wasn't available to the individual until they turned 21 years old. This has and will be a great resource for students and their families, though it has the potential to significantly increase the demand on service coordinators, as the community becomes more aware of HST supports and earlier access to brokerage supports for young adults.

## **SERVICES TO ADULTS**

### **Comprehensive Services**

Lane County Developmental Disabilities Services provides comprehensive services to 565 adults who live in group homes, foster care, supported and independent living programs, and who participate in vocational and community inclusion programs. This is an increase of 40 over last year's total. The additional individuals were due to out-of-county transfers and individuals new through intake. .

Currently, the average comprehensive services caseload is 1:62, in contrast to the state caseload standard of 1:49. This was reduced over the past year from 1:92. This reduction was possible by the increase in the statewide allocation formula, allowing LCDDS to hire three new services coordinators for the Comp Team, and one additional supervisor. Although needed, these increases are small in comparison to the increases in the actual cost of services delivered.

The LCDDS foster home system in Lane County has expanded and currently provides foster care for 288 adults and 46 children, increases of 14.2% and 18%, respectively, over last year. There are 112 adult foster homes, and 16 children's foster homes. Foster providers are increasingly asked to provide services for individuals who have complex support needs, and have a corresponding increased need for specific training and technical assistance.

Comprehensive case managers assure the completion of the annual ISP (considered the Medicaid Plan of Care) as well as reviewing the Medicaid Title XIX waiver each year. The implementation of the Unicare Profiler Database has allowed us to more

effectively capture and record TCMs (Targeted Case Management, the unit of billing in DD Services) and to establish and track baseline goals for these. In addition service coordinators continue to implement monthly monitoring visits to group homes and foster homes, and we have seen a 13% increase in the numbers of these visits since bringing the new staff on board. . Case managers collect valuable information regarding individuals and the operation of the homes during these visits. A residential data base tracks information collected on the visits and this information is periodically reviewed by the LCDDS quality assurance committee.

It is estimated that 45 new individuals will be added into the comprehensive service system in 2010, including 9 individuals through T-18 (turning 18 years old); 15 individuals added through the Long Term Diversion Crisis system; 10 people from out of county transfers including State Operated Community Program (SOCP) step-down, prison exits and out of county crisis referrals.

### **Brokerage Liaison Services**

As of July 1, 2009, the Support Services team officially disbanded. This was a result of the impending completion of the brokerage wait- list roll-out, which shifts most of the day-to-day responsibility for DD individuals from LCDDS to the two Lane county brokerages, Full Access, and Mentor Oregon. An approximate total of 755 individuals with developmental disabilities will have been rolled out to the brokerages when it is completed.

Support services staff was reassigned to other program areas. Two of those LCDDS positions were designated by the state to work as Systems Improvement Coordinators with local brokerages in Lane County. One coordinator was designated for each brokerage, Full Access (serving 450 individuals) and Mentor Oregon Mid-Valley Brokerage (currently serving 302 individuals and growing). The Systems Improvement Coordinator positions, which are continuing to evolve, currently include the following 5 functions.

- 1- Focus on systems and communication between support services brokerages and LCDDS. This includes but is not limited to customer referrals, wait-list issues, community and home based waiver issues, grievances and complaints, crisis management, protective services and emergency preparedness.
- 2- Focus on strategic opportunities to enhance system performance in the community, including but not limited to provider capacity, staff training and enhancing relationships with community partners.
- 3- Quality assurance and improvement
- 4- Technical assistance with brokerage staff regarding individuals in pre-crisis situations

#### 5- Participation in state level activities as prescribed.

The two systems improvement coordinators also meet with individuals found newly eligible for DD Services. People must be found eligible for DD Services before being referred to a local brokerage. During 2009, the average has been 4-5 new people referred through intake per month. If they are unable to be referred immediately to a brokerage due to capacity issues, the systems improvement coordinators maintain those individuals in a wait-list capacity, including development of annual plans, information and referral, and referral to other parts of the LCDDS system as necessary, such as protective services and/or comprehensive services.

#### **Cascade Region**

LCDDS participates in the delivery of regional crisis services with partnering counties, Crook, Jefferson and Deschutes. Deschutes County operates as the fiduciary lead; however, program coordination is overseen from, and the program coordinator is employed by Lane County. The Cascade Regional team assists counties to access long term funding from four mandated caseload streams. The most utilized funding streams are adult and children's crisis services, or long term diversion. In addition, the region facilitates access to funds for children in residential care who are turning 18 and adults who are exiting school entitlement programs at age 21, who remain in residential services. Additionally, we partner with other counties and regions to identify available resources statewide, assist and facilitate funding for State Operated Community Program group homes entries and exits, nursing home and residential step down activities, and access to forensics dollars for individuals being released from the department of corrections.

Cascade Region, along with the other four regions statewide, is redefining its role. This year, the state ReBAR (Restructuring Budgets and Rates) Unit, has assumed primary responsibility for the determination of service rates for group homes and adult foster care. It is planned that they will also determine vocational rates in the near future, also. Since these areas have historically been the purview of Cascade Region and the other regions, the five statewide regions are currently discussing with Seniors and People with Disabilities (SPD) future regional roles.

Locally, the service delivery system continues to struggle with a population of children and young adults who exhibit challenges related to fetal alcohol/drug effect, mental health issues, autism/Asperger's, alcohol/drug abuse and increased incidents of serious criminal behavior. In addition, a population in care, which is aging and has increased needs, is accessing resources at a greater rate than before. As a result, there have been increased incidents of civil court commitment statewide for DD clients, which include mental health commitments. Current community capacity is ill-equipped to expand services, or provide the level of service that these new challenges present, providing direction to the development specialist.

## **Regional Development**

The Cascade Region has been able to utilize the Development specialist position in all four counties to work with providers to increase capacity and provide client requested services. Currently “hard” capacity projects include development of additional children’s proctor foster care, in Lane County, and crisis beds and additional adult foster care on the east side of the region. In addition, a Lane county, training cooperative is being explored, as well as emergency preparedness training for foster care providers throughout the region is being presented. In addition, the Development specialist continues to work with the foster license/certifiers and foster providers to address issues that have prevented them to serve more of our clients by providing training or bringing in supports to the home.

There has been a change in the way that the rates for persons in foster care and group homes are calculated. This now comes from the state ReBAR agency and has allowed the region to focus more on proactive supports for families and providers that may serve people going into Crisis. The Cascade Region now has two diversion specialists who are able to provide the Oregon Intervention Systems training that promotes positive behavioral interventions to support clients that have challenging behaviors both in comprehensive services and in their family home in hopes of averting a person having to be moved in a crisis situation.

The region continues to develop resources that will support people in our communities

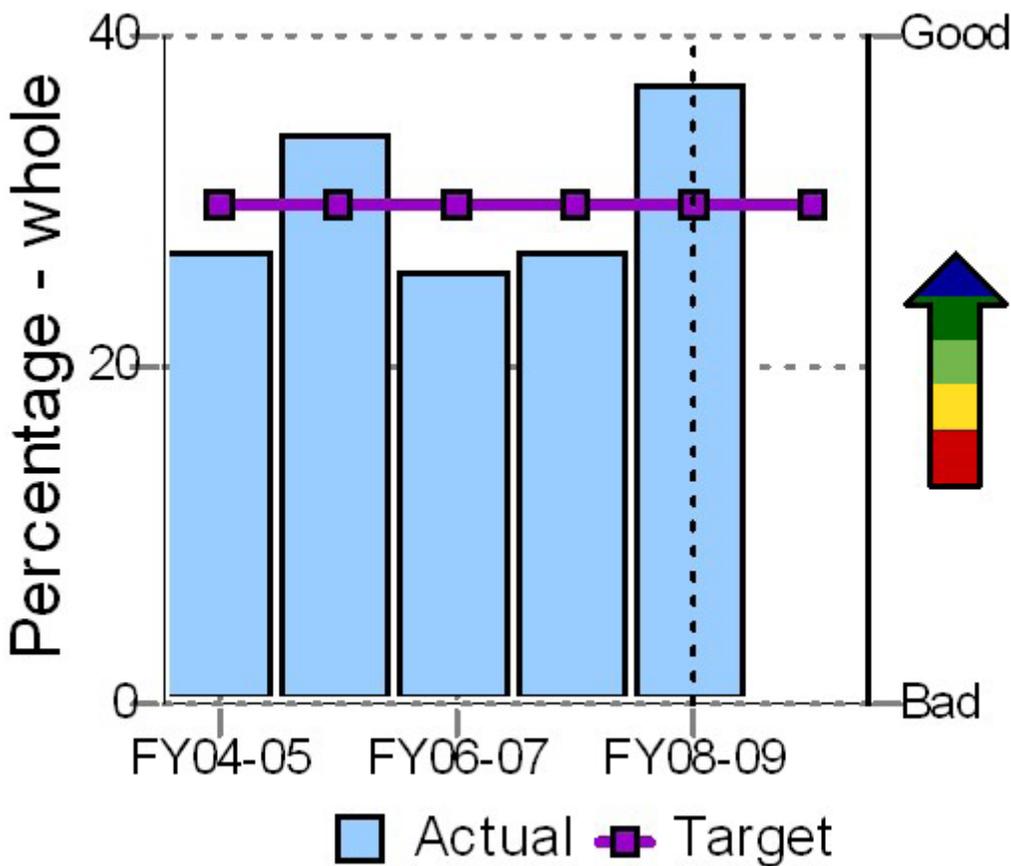
## **Quality Assurance**

The Quality Assurance (QA) Program measures performance outcomes related to the services provided by LCDDS to ensure that outcomes stay within a specified acceptable target range, and to ensure compliance with state and federal Medicaid requirements. This includes developing an annual QA Plan which complies with applicable Oregon Administrative Rules. The QA Plan addresses seven participant-centered focus areas identified by the Federal Home and Community-Based Quality Framework. These seven areas address participant access to services, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and overall system performance.

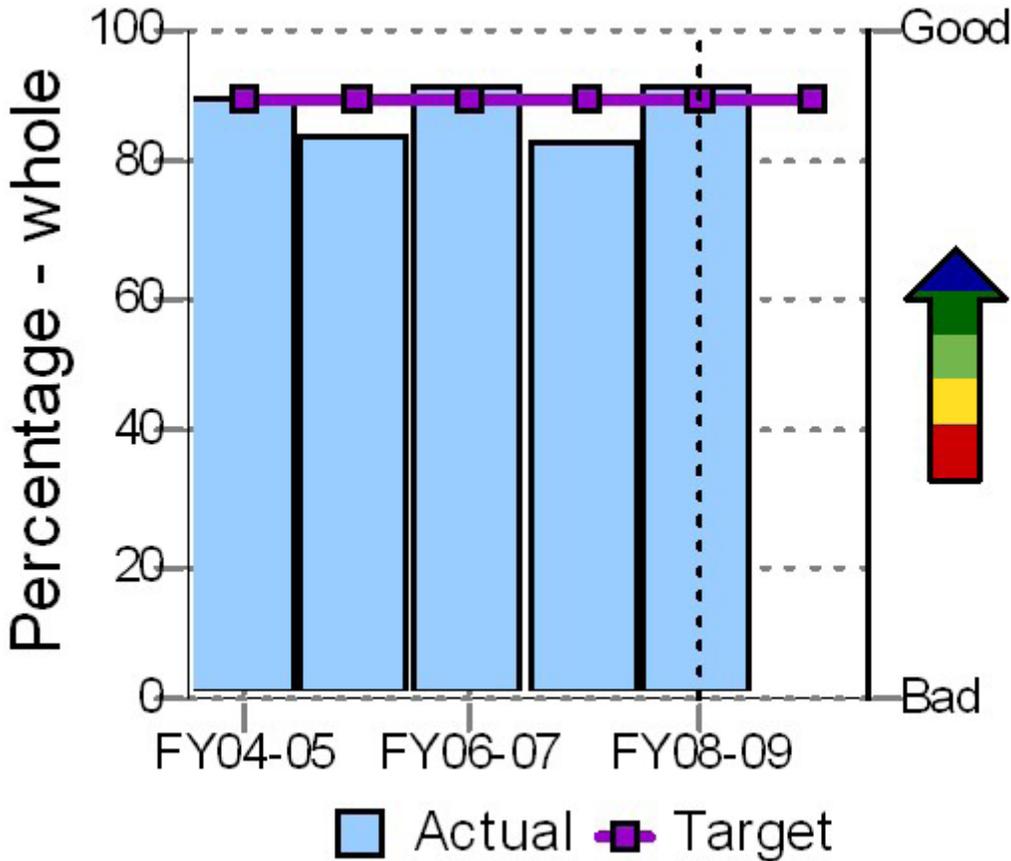
Performance outcomes and accountability measures are featured for each area, including specific percentage targets for each quality measure. In addition, the LCDDS Quality Assurance Committee of stakeholders meets quarterly to review the QA Plan and quality assurance activities. This includes providing review and comment on data gathering methods, results of information gathered, and the effectiveness of any corrective actions taken. The QA Committee makes suggestions for quality improvements of funded services for individuals with developmental disabilities in Lane County.

For performance measures, data is collected and tracked on established performance measures in the areas of case management services, contracted services, and quality assurance. Below is an example of graphs from an LCDDS performance measure:

**Customer Satisfaction Survey** - This was the fifth year for the DD Quality Assurance Program to conduct its annual customer satisfaction survey. Surveys were mailed to targeted populations by random sampling. This year we mailed about 250 surveys, and had a 37% response rate for completed surveys returned to our office. This exceeded our target response rate of 30% (which is a very good rate), as shown below:



For measuring customer satisfaction from our survey results, a target of 90% was set. The satisfaction outcomes from our fifth annual customer satisfaction survey exceeded our target, and showed that 91% of respondents rated the case management services and support they received as “good” or “excellent.” In addition, this is an 8% increase from last year’s survey results, as shown below:



**Emerging Issues in Developmental Disabilities**

- **Current Fiscal Issues** - Late in the last legislative session, there were reductions made to the vocational, family support, transportation, and rent subsidies programs. Because of the reductions, new procedures were put into place by SPD to control expenses, particularly aimed at limiting 1-on-1 plans to individuals with a documented need for such services.

In addition, SPD has done away with “base,” and has begun a new statewide procedure, called “sweeping,” which will be conducted quarterly. In sweeping, service money that becomes available due to an individual dying or otherwise permanently leaving paid services, will be swept and reallocated to counties, based on need. This will change how funding is done in the crisis system, since the lack of base will require that clients remain on Short-Term Diversion (STD) funding longer before it is decided whether their residential and/or vocational will be funded with Long-Term Diversion. STD is allocated annually to the counties, and counties historically have been expected to stay within that allocation. With the new sweeping

procedure, counties may be asked for additional STD funds, which will be taken from the pool of swept funds. Using this system, SPD hopes to be able to more accurately demonstrate to the legislature the true need for crisis services, which was artificially hidden in the previous system.

- **Staley Settlement** – As mentioned in the Brokerage Liaison section above, the Staley Agreement will be complete sometime around the beginning of November, 2009. In anticipation of the completed transition of all of those individuals receiving DD services into one of the two brokerages serving Lane County, members of the former Adult Support Team have been distributed to other program areas in LCDDS. Two service coordinators who provide high school transition services have become part of the children’s team. One service coordinator will become part of the Comp Team. One service coordinator will provide protective services to adults. There will also be two service coordinators who have take on a new role, as service integration coordinators. They are working with the brokerages to do pre-crisis staffing and provide technical assistance with brokerage staff, related to DD individuals experiencing complex needs and potential crisis, systems and communication issues, strategic opportunities, quality assurance and improvement.
  
- **Development Issues** – Cascade Region has been able to utilize the Development specialist position in all four counties to work with providers to increase capacity and provide client requested services. Currently, “hard” capacity projects include development of additional children’s proctor foster care, in Lane county, and crisis beds and additional adult foster care on the east side of the region. In addition, a Lane county, training cooperative is being explored, as well as emergency preparedness training for foster care providers throughout the region is being presented. In addition, the Development specialist continues to work with the foster license/certifiers and foster providers to provide technical assistance in addressing issues that have prevented them to serve more of our clients by providing training or bringing in supports to the home. The goal is to provide increased capacity for the crisis and crisis-diversion systems in serving individual with complex needs, including autism, criminal backgrounds, mental health issues, mild and moderate intellectual disabilities, serious medical conditions, and/or difficult behaviors, and therefore complex, needs.

Particularly for children, the presence of local resources has been extremely limited, requiring that children needing out-of-home placement be placed in the Portland area. This creates a strain on the family structure, and later causes other difficulties when a child turns 18 years old, and needs to return home to Lane county, but has no real connection here. To that end, LCDDS is working to establish children’s proctor foster care and/or residential care in Lane county. Proctor foster care can provide support to children with complex needs and behavioral issues in a more homelike atmosphere of a foster home, but under the auspices of an organization that provides residential care.

Funded children's residential programs are at capacity, and movement is slow due to lack of resources that may allow the transition of a child into another setting. Increased efforts to partner with outside agencies remain critical in meeting the needs of our children. Though there is interest in Lane county in developing a children's group home, it is a complicated process, due to the manner in which the children's residential system is set up statewide.

Development for adults is concentrating in several areas: technical assistance and training for existing providers; and development of adult proctor foster homes, pursuant to the imminent Federal approval of the new state adult proctor foster rules. We are also working to encourage providers to utilize empty beds in established adult foster care homes, increasing capacity for adults with complex needs.

- Technical assistance is being provided especially to adult foster care providers who have indicated that they are interested in serving at least one more DD individual, but who need assistance in developing skills needed to serve those individuals with complex needs.
  - Other training methods, such as a training co-operative, are being developed and rolled out, in order to provide inexpensive or free training to staff at group homes, also designed to increase providers' abilities to serve those individuals with complex needs.
- **Sex Offenders** - One fast-growing client population is comprised of individuals with developmental disabilities and sex offending behaviors. Though the individuals served by LCDDS are individuals with developmental disabilities who have sex offending behaviors, this trend is being seen nationally in a number of social service agencies, including those serving children and seniors. There are a number of issues which need to be addressed in a proactive, planful manner, including appropriate service planning, development of additional residential settings, access to specific training; and community communication and education. With the impending listing of all convicted sex offenders on the Internet, interagency planning and discussion is needed. LCDDS has been meeting regularly for several years with other programs that serve DD sex offenders, such as law enforcement and the justice system, in order to develop a more complete picture of the issues involved, and to develop interagency strategies.

Currently, LCDDS is working with a residential provider, who is developing a new group home that will serve DD sex offenders, and who expects to open its doors to three individuals, by January, 2010.

- **Aging and Individuals with DD** - The DD population is aging, and we are beginning to see a population in care which has increased needs and is accessing resources at a greater rate than before. We also have a significant increase in aging caregivers, who are unable to continue to support their family

members in their homes. Current community capacity is ill equipped to expand services or provide the level of service that these new challenges present.

- **Provider Issues** - Low provider pay, and inadequate training and provider oversight provide a constant challenge in meeting the needs of the population accessing comprehensive services. High provider turnover rates and lack of adequate respite providers are ongoing issues for the DD population. Adult foster care is expanding and supporting some of the most challenging of individuals in our services. Group home and vocational providers struggle with typical turnover rates of roughly 65%, though the downturn in the economy has lessened this somewhat. Recruitment and retention issues within our infrastructure are having a direct impact on our ability to provide adequate resources for the needs being presented. Federal Medicaid rules make portability of funding for services across programs such as DD and mental health challenging, if not impossible.

This year, through the GRO project, administered by OTAC (Oregon Technical Assistance Corporation) services were available to group home providers, such as ongoing training and program development services, all designed to increase providers' abilities and skills in serving those individuals with complex needs. One Lane county provider was selected and has been participating in the program development activities.

- **Behavioral Issues** - The LCDDS service delivery system continues to struggle with a population of young adults who exhibit challenges related to fetal alcohol/drug effect, mental health issues, autism/Asperger's syndrome, alcohol/drug abuse, are increasing in eligibility criteria of children and many young adults, leading to increased incidents of serious criminal behavior. From that group, seems to come a greater number of individuals who are potentially extremely dangerous to themselves and others. Our need to protect them from confrontations with law enforcement, who don't always understand disability-related behaviors, is a growing consideration in our assurance of health and safety for these adults.
- **State-Operated Community Programs (SOCP)** - Access to state operated facilities for adults also faces capacity challenges. The crisis delivery system has worked collaboratively and creatively with county and state partners to meet the needs of individuals needing services despite our funding and resource limitations.

## **VI. FAMILY MEDIATION PROGRAM (Donna Austin, Program Manager)**

During the last six months, the Family Mediation Program completed a total of 202 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 577 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.

## **VII. HUMAN SERVICES COMMISSION (Steve Manela, Program Manager)**

### **Human Services Commission**

#### **Human Services Plan**

On October 19<sup>th</sup>, 2009, the proposed Human Service Plan for Lane County, a year long effort to help develop a 10-year long-range blueprint for human services, was presented to the Human Services Commission (HSC) by Program and Policy Insight, LLC (PPI). The plan is intended to serve as a strategic policy guide for HSC and jurisdictional decision making for funding human services. Priorities identified in the planning process will guide the distribution of operating funds for human service programs offered by community-based non-profit and public agencies, on behalf of Lane County and the Cities of Eugene and Springfield.

The planning process had two primary goals: 1) to provide an assessment of human service priorities based on targeted community and stakeholder input; and 2) to provide a strategic framework for funding decisions in a variety of funding climates. The plan envisions the impact that varying levels (four options) of financial support would have on what can be accomplished to prevent, intervene and treat the root causes of social problems for people in Lane County.

Human service priorities will be based on the changing needs of county residents, and will note the fluid state of the economy, the growing diversity, the aging population, and increasing capacity to collaborate within the service providing community.

PPI relied on a combination of primary and secondary data to inform the development of the plan, including the key data sources described as follows:

#### **Review of existing data**

- Reviewed existing economic and service indicators to describe the context in Lane County during the planning process.

#### **Stakeholder interviews**

- Interviewed key community stakeholders suggested by the HSC for their input on the economic and political climate and its impact on the development and delivery of human services
- Nine community stakeholders interviewed.

### **Focus groups**

- Conducted five focus groups with a diverse range of stakeholders, including youth, seniors and persons with disabilities, families, singles and homeless individuals, and Latino individuals
- Five focus groups conducted, representing over 50 focus group respondents.

### **Community survey**

- Developed and administered a stakeholder survey administered online and in writing via Project Homeless Connect, community forums, and project focus groups;
- 476 responses were collected.

### **Survey Results**

The 2009 Human Service Plan survey found that child abuse; domestic violence, food insecurity, housing and access to mental health and substance abuse treatment were “very important” issues and would be a “best use of public resources”. Similarly in 2007, the Lane County Commission on Children and Families assessed community sentiments on issues related to children and youth. Similar to our results, nearly all issues were considered "very important," with child abuse, hunger, health care, poverty, and teenage drug use at the top of the concerns.

### **Prevention**

Like other human service agencies across the county, the HSC is increasingly interested in supporting prevention services. Research suggests that well-defined and well-implemented prevention programs can provide significantly more benefits than costs. Furthermore, stakeholder survey results suggest support for HSC funding of prevention programs. When asked how the HSC should allocate resource across prevention, crisis intervention, and treatment services, respondents indicated that nearly 40 percent of resources should be targeted to prevention services, and 30 percent each to crisis intervention and treatment services. Finally, HSC members and staff expressed strong support for ensuring the availability of prevention services, and the HSC endeavors to incrementally increase dollars allocated to prevention-related services as funding increases.

An implementation plan will be developed that will focus on measurable outcomes for individuals, families, and communities.

### **Human Service Needs**

Like other jurisdictions, Lane County faces a challenging human service environment. Local funding for human services is limited, especially, but not exclusively, under poor economic conditions. Lane County residents remain vulnerable to unemployment, poverty, lack of housing, mental illness, and related social issues. These, and other similar indicators, informed the priority-setting and planning process, along with community input.

#### Unemployment

- In 2009 Lane County unemployment rose 8 percent over 2008, reaching 14 percent in May 2009

#### Poverty

- The percent of all people living in poverty in Eugene increased from 17 percent in 2007 to 20 percent in 2008

#### Housing

- Fifty-two percent of Lane County renters were unable to afford fair market rent for a two bedroom apartment

#### Hunger

- One in five households in Lane County experience food insecurity

#### Medical Access

- Twenty percent of Lane County residents had had been uninsured for part or all of the previous two years.

### **Human Service Funding Policy**

HSC staff has completed the analysis of jurisdictional human services funding policy to present at the November 16, 2009 HSC meeting. The intent is to establish a recommendation for a rate for human service funding contribution for Eugene, Springfield and Lane County to the Human Services Commission (HSC) beginning with the FY 2010-2011 budget.

We compared the City of Eugene's human service funding with five other cities with populations above 120,000 to 200,000 in Oregon and Washington. With the group of cities studied the average population size was 167,000, compared to Eugene's population of 154,620.

For the City of Springfield we were able to analyze human services funding level for Oregon cities that averaged a comparable population that are federal HUD Community Development Block Grant (CDBG) entitlements.

For Lane County we were not able to find a comparable in the State of Oregon or the Region based on the unique nature of Lane County demographics. We used a criteria based upon population size, per capita income and unemployment figures to come up with three comparable counties nationally for population size and socio economics. We also took into consideration the role that County governments play with each state as a human service provider.

### **American Recovery Act Implementation**

As of October 1<sup>st</sup> the HSC federal stimulus projects were implemented. a limited number of eligible Lane County residents affected by the recession are now able to receive assistance with paying their rent, food, employment assistance, transportation assistance, behavioral health services, budget education training, rental education training, legal services, respite nursery, childcare services and help with lowering their

energy costs through the weatherization of their homes. Most services are only available this fiscal year and some will be phased out during next fiscal year.

Among the larger new AARA projects HSC has implemented is the Homelessness Prevention and Rapid Re-Housing Program (HPRP) which is designed to serve persons who are still housed but at imminent risk of becoming homeless and persons who are already homeless.

HPRP rental payment and support service assistance is focused on housing stabilization, linking program participants to community resources and mainstream benefits, and helping them develop a plan for preventing future housing instability. HPRP assistance is to help for a short period of time 90-day to six months and is not intended to provide long-term support for participants. We strive to provide the smallest subsidy needed, for the shortest essential time period, so that we may assist the greatest number of households possible. During the period of the subsidy, an effort will be made for these individuals and families to be connected to the resources and services needed for them to become self-sufficient by the time their subsidy expires.

The rent being charged for a unit must be reasonable in relation to rents being charged in the same area for the same time period. In addition to meet rent reasonableness requirements, the maximum amount of monthly HPRP financial assistance shall be equal to or less than the federal Fair Market Rents (FMR) for a dwelling size, plus up to 100% of utility costs. Participants must pay the balance of their rent above FMR. This policy allows us to serve a greater number of households with limited HPRP funds. Participation of the participants in payment towards their rent is consistent with other local and federal housing subsidy programs. When appropriate, our contractors will implement graduated subsidies to assist in transitioning families from rental supports. Criteria such as employment status, income level, employment experience, education level, job skills and training experience, and willingness to address barriers to self-sufficiency will be considered as factors for targeting those that are likely to be able to sustain housing beyond the timeframe of HPRP supports. Households will be reassessed at 3-month intervals for continued eligibility for housing supports. As needed, the program will provide supportive services.

### **Energy**

As of September 30<sup>th</sup> HSC staff completed the federal FY09 Low-Income Home Energy Assistance Program (LIHEAP) serving 12,586 Lane County households with energy bill assistance. The total number of individuals served as members of those households was 29,053. This was made possible by record federal funding received by Lane County of \$3,389,486.

HSC staff is the final stages of negotiating a renewal three-year agreement with EWEB to continue to manage and provide their low-income energy assistance and conservation services beginning January 1, 2010 through December 31, 2013.

## **Veterans**

During the First Quarter of 2009-10, the VA awarded benefits to 272 Lane County Veteran Services Office clients. These awards totaled over \$1.2 million in lump-sum retroactive benefits, \$237,264 in short-term education benefits and \$199,270 in continuing monthly benefits. One claim in particular is noteworthy as the veteran has been seeking benefits since his discharge in the 1970's. He started to work with the Lane County Veterans Service Office about 5 years ago and was homeless. In August, 2009, he was finally awarded full disability benefits, retroactive to 2004. This award included almost \$120,000 in retroactive benefits and over \$2500 per month. After putting a new roof on his mom's house, he's currently working with a realtor to buy a home of his own.

## **VIII. LANE CARE (Bruce Abel, Program Manager)**

LaneCare is the County's program that manages the capitated mental health component of the Oregon Health Plan (OHP). LaneCare integrates and coordinates community mental health responsibilities in partnership with Lane County Mental Health, provider agencies, system partners, and mental health consumers. 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.

In 2009, LaneCare had site visits by the State and by Acumentra, representing the Centers for Medicare & Medicaid Services (CMS) and the Feds. Both review teams were extremely positive and complementary of LaneCare. The Federal review team stated that we were the most impressive managed care organization they have reviewed in Oregon, Washington or California. Each of these site visits resulted in some recommendations for further improvement. At the final meeting with the State in September they reviewed and approved LaneCare's responses.

In Contract Year 2009, LaneCare has continued the successful partnership with consumers, contractors and system partners. The average monthly membership has increased from 32,500 to 37,000 OHP members. This has resulted in an increase in capitation payments. Due to the economic downturn enrollment in OHP increased beyond projections and membership and capitation increased beyond projections. LaneCare expects this trend to continue for a couple more years.

In addition, in 2010 OHP enrollment will increase significantly as OHP Standard membership increase statewide (3,000-4,000 more members in Lane County) and as children are enrolled in the federal health care expansion (7,000-8,000 more members in Lane County).

LaneCare expected a 9% capitation increase in 2010. We have had a couple of years of significant rate increases (6.5% in 2008 and 4.5% in 2009). Unfortunately, due to a poor economy and to a State rebalancing approach to managed care, LaneCare's capitation rates will be flat for 2010. This will make increases in payment rates more challenging.

In 2008 and 2009 LaneCare allocated reserves to balance the operational budget. LaneCare continues to pay for claims for dates of service in 2008 through all of 2009. At this time it appears that LaneCare will not use all of capitation received for 2008 and 2009 in paying for claims. LaneCare will implement a one time risk share return distribution with our contractors to provide additional economic support to our local mental health system.

LaneCare implemented an across the board 10% rate increase for all reimbursement rates in 2009. We are projecting a smaller increase of approximately 5% for 2010. We will also need to increase system capacity as additional individuals are enrolled in LaneCare. We are discussing ways to help contractors expand their staff to better meet consumer demand.

LaneCare still maintains the highest utilization and penetration rates in the state, preserving a vibrant continuum of services, while remaining fiscally sound. We have excellent partnerships with local organizations and have a system of services and supports that is recognized as the best in the State.

Demand for mental health treatment continues to be high, particularly for psychiatric services. As more members are enrolled in LaneCare the provider panel must expand in order to have sufficient capacity. We are currently in the process of developing the LaneCare provider panel for 2010. We expect a smooth selection process.

LaneCare is continuing efforts to move the system toward evidence-based practices and has sponsored several trainings to help providers develop new skills. LaneCare has contracted with a well known trainer to offer a 12-month Cognitive Behavioral Therapy training with ongoing technical supervision and support. This training was initiated in September.

LaneCare continues to use funds for prevention, education and outreach projects. This year we have funded 7 community projects that include services for: homeless, at-risk youth; teen parents; life skill classes for adults; and parenting classes for at risk moms. The RFP for PEO projects funded in 2010 will be released in October, 2009.

LaneCare has established a committee to review prevention and treatment services for children under the age of 5 and is requesting recommendations by the end of 2009. There is a recommendation for LaneCare to invest up to \$100,000 in a project.

LaneCare developed guidelines for hospital admissions and continuing stay at a hospital. LaneCare has had several meetings with psychiatric staff from Sacred Heart to discuss the impacts of these guidelines.

The last Board of Health report identified concerns with services for transition age youth. Transition age youth, 16-25, who have a serious mental health condition, typically do not access the mental health treatment that they need. LaneCare convened the Transition Age Youth planning committee to review the barriers and make

recommendations to better meet the needs of this population. Recommendations resulted in a proposal submitted to CMS for federal funds to support a project. Unfortunately, Lane County was not selected as a recipient of these funds. LaneCare will consider funding a smaller projected targeted toward meeting the transitional needs of youth enrolled in LaneCare and having significant challenges in negotiating the transition to adulthood.

LaneCare is recognized by the State as being a high performing MHO. The Department of Human Services (DHS) appreciates the cooperative working relationship that LaneCare has with the regional DHS program and in particular, child welfare services. We have had teams from different communities observe our meetings and consider adopting our local practices. The LaneCare Manager has been invited to participate on several State committees addressing mental health and DHS integration and service development issues. These committees include:

- Health care integration
- Wraparound Implementation
- Mental Health Assessments of kids in Foster Care
- Kids in Foster Care and psychotropic medications

There are several areas of concern that LaneCare is dealing with. These will be briefly described below.

**Concern:** Oregon has implemented a provider tax that will raise sufficient funds to open enrollment in Medicaid and to cover an additional 40,000 adults and 80,000 children. This potentially means an increased LaneCare membership of 12,000 Lane County residents. This will require a significant expansion in the number of providers that LaneCare contracts with.

**Concern:** The State budget is showing a huge deficit for the remainder of 2009 and for the next biennium. While there are no reductions anticipated for LaneCare, it is always possible that the legislature will find reductions necessary.

Of greater likelihood is the reduction of State funds for local indigent care, senior services, hospital care, and other community supports that are essential to maintaining people in their living situations. As the economy declines the stress increases for individuals and families and the demand for all governmentally supported services increases.

**Concern:** The State continues to address healthcare reform, integration and regionalization plans of Oregon. The healthcare system in the United States is in serious trouble and there are many improvement efforts underway both at the State and Federal level to develop improvements. It is unclear what effects these changes may have on Lane County or LaneCare.

**Solution:** The LaneCare Manager is involved in tracking these issues and is on many committees addressing healthcare reform. LaneCare has an excellent relationship with LIPA, the fully capitated health plan in Lane County. LaneCare is involved in discussion of expanding the FQHC as a resource in Lane County, especially integrating mental health services. LaneCare and LIPA are coordinating several shared performance improvement activities.

**Concern:** In October, 2008 the State implemented a new MMIS system. As of October, 2009 it is still not working well. This has been a significant disruption in accurate information on enrollment determination, member information, and payment. The intensity of staff engagement in problem solving has been an unanticipated consequence and cost. It will be many months before there is a final reckoning of the impact on the provider system.

**Solution:** LaneCare staff and contractors have had a significant amount of extra work in assuring that enrollment discrepancies were addressed.

**Concern:** LaneCare has met with Senior and Disabled Services, Lipa, and PeaceHealth to discuss the mental health needs of seniors. We recognize that the elderly often have a combination of physical and mental health ailments that are difficult to treat.

**Solution:** LaneCare has developed and funded a mental health consultant position that works with nursing homes, foster care providers, seniors, and staff at Senior and Disabled services to better integrate and coordinate mental health assessments, supports and interventions. After 2 months, this position is providing stabilization supports and behavioral interventions for seniors with behavior challenges.

**Concern:** The State is planning on implementing the Statewide Wraparound Initiative in 2010. This initiative will blend MHO funds and DHS funds into a blended pool and contract for administration to an Administrative Service Organization. This could be a local MHO or some other organization. Lane County has developed significant infrastructure investments in the services developed for the child system change initiative and is currently managing these services in partnership with DHS. While funds could be moved from LaneCare to another organization, we feel well positioned to serve as the regional ASO in Lane County.

**Solution:** The LaneCare Manager is on the State planning committee representing MHOs and the mental health system and will participate in system design. The Manager will also position LaneCare to provide the administrative services for this project and will consider whether Lane County should apply to be a pilot project.

## **IX. MENTAL HEALTH SERVICES (Behavioral Health) (Al Levine, Program Manager)**

This previous fiscal year saw Alcohol, Drug and Offender Services coming under what is now called the Behavioral Health Division. Due to increasing revenue shortfalls primarily a function of decreased DUII arrests and increased failures to appear, a decision was made to recommend the elimination the DUII Evaluation Unit. This is not seen as a core County function and in fact we are one of the very few counties providing this service.

Meetings have been held with the various courts involved and as of this writing the DUII Evaluation Unit has stopped accepting new referrals. The courts have developed a contractual relationship with private Alcohol and Drug Evaluation Specialists, Quality Research Associates, and the County has negotiated a contract to have this same organization take over the “tail” of the reporting and referral process for those clients that has already been evaluated by the LCDUII program.

This next year will be a challenging year for Behavioral Health Services as we struggle to maintain staffing and services despite the threat of significant funding reductions. Much effort will be placed on the implementation of Phase II of the electronic medical records and practice management system. Phase II focuses on clinical orders and treatment planning and will occupy a large amount of staff time.

In addition, we will be continuing to implement and expand integrated mental health, addictions and primary care services under the FQHC umbrella. Mechanisms for improving care coordination are already underway, and there is discussion about Lane County becoming a pilot for the State’s interest in developing models of integrated care.

An additional emphasis will be placed on improving staff productivity in terms of providing face to face clinical services that are eligible for the FQHC PPS Wrap payments. It is these payments that will enable the LCBHS programs to be fiscally viable going forward if we can assist staff in meeting their productivity targets. Finally, the Methadone Treatment Program was engaged in a Commission on Accreditation of Rehabilitation Facilities (CARF) site review in October, and all indications are that this review went quite well.

### **OUTPATIENT MENTAL HEALTH CLINIC**

**Adult Services:** The Adult outpatient clinic continues to serve large numbers of clients. We are currently serving 1,141 Lane County consumers. Access and enrollment data suggest that increasing numbers of uninsured Lane County citizens are seeking services through County programs. We have been unable to increase access due to serious staffing constraints, and have virtually stopped all admissions, except for those citizens coming out of inpatient psychiatric care or at imminent risk for requiring care. A committee had been formed to develop strategies to increase access, and continues its efforts to look at additional ways to accomplish this.

Lane County Mental Health continues to see more consumers with varying involvement with the criminal justice system. We continue to contract with the City of Eugene to provide Mental Health Court treatment services, for misdemeanor offenders in civil court, although it is not certain at the time of this report whether City of Eugene will be able to maintain the current level of funding. We continue to get increasing pressure from Parole and Probation services to provide more mental health treatment to this population, yet the CCA funding that funds the dedicated MHS position that serves that population is seriously at risk. Our pilot project to assist the courts in providing support and treatment services for consumers who are found “unfit to proceed” in their trials and sentencing hearings is well underway. This project is funded by the State and we are joined by two other counties for the pilot. It is not clear if State funding will continue for this project either. Our PSRB supervision activities have increased as well. We are now supervising 23 citizens under the Board’s jurisdiction.

Mental Health continued in the current fiscal year to contract out more than \$350,000 in funding to the adult-serving mental health agencies to increase their capacity to serve clients who lack Oregon Health Plan. With increased pressures on our budget, and the unknown future of State and Federal funds, we expect that we will likely reduce this amount significantly in the next couple of years. These cuts may come as early as February, 2010. It seems all but certain the State is moving the public mental health system into a Medicaid only system.

We have “gone-live” with “phase one” of our new electronic health record and practice management system. Key personnel continue to be temporarily re-assigned to assist in the implementation, which is adding additional pressures on an already resource poor system. Due to lost productivity, we anticipate a loss in revenue during the learning curve direct care staff will have while adjusting to a new electronic system. We anticipate this loss will be temporary as the staff develops skill with the system and eventually we believe we will be able to increase our revenue through the automated billing of services provided.

The adult program has increased its treatment groups to 13, which are well attended. We continue to stress the importance of continued education for the staff and are looking at a variety of newer treatment models being developed (Assertive Commitment Therapy, and Person Centered Treatment are two examples of this). In addition, we continue to manage the programs that were formally under the Alcohol, Drug and Offender Programs. These include the Sex Offender Treatment Program, and the Methadone Treatment Program. We have just completed interviews for a much needed Clinical Services Supervisor position. At the moment our management staff is stretched very thin and bringing on this management position will help is to organize in a way that allows us to support direct care staff in meeting billing productivity goals and targets.

While we have gained some psychiatry time back in this past year, we continue to be challenged to provide quick access to requested medication management services, and we remain short on clinician time for therapy and case management services.

We are rapidly moving towards a truly integrated system, with mental health, drug and alcohol, and primary care services all in the same location. We firmly believe this integration will position Lane County Behavioral Health Services to be a strong and successful provider of direct service in the health care needs of our citizens. It is also clear that fully integrated care is the direction the Feds and the State want services to be moving towards.

***Child and Adolescent Services:*** The Child and Adolescent Program of LCBHS continues to provide rapid access and psychiatric care to Lane County children and families with acute and chronic, moderate to severe, complex psychiatric disorders. The average monthly enrollment in outpatient community based services is 320 children and families. From 4/1/09 – 9/30/09 the Child and Adolescent Program enrolled 95 children/families into clinic services. 14 of these 95 children enrolled in Intensive Services. In addition to screening, comprehensive evaluation, psychiatric care and care coordination/case management we are providing a wider array of evidenced based clinical services including Dialectical Behavior Therapy Groups for chronically suicidal high risk teens, Individual and Family Therapies, Child and Family Team meetings, Wraparound services, Expressive therapies (Art Therapy, Sand Tray Therapy, Play Therapy), Care Coordination, Multi-Family Group Therapy, Consultation Services and Circle of Security Interventions for high risk infants, toddlers, preschool children and their primary caregiver. 66% of all CAP encounters are wrap-eligible encounters (face to face) resulting in higher payments under the Community Health Center. We have added Parent Orientation and Foster Parent Orientation groups to better inform families of the services and supports offered at LCBHS, including patient and provider rights and responsibilities. Since 1/1/09 57 children's parents/foster parents/Legal Guardians have attend a Parent Orientation meeting. In addition we have added an evidence based practice Collaborative Problem Solving Parent Book Club, based on the work of Stuart Ablon and Ross Greene Treating The Explosive Child.

The past 6 months LCBHS continues to roll out new practice management software including an electronic medical records (EMR) system which over time will give us strategic reports/data which will drive decision making in clinical practice and program management.

Based on preliminary data pulled from LC Cares aka 'Elsie' (our EMR) from 4/1/09 – 9/30/09 the child program screened 128 Lane County children requesting LCBHS services. 10% of the screening calls required an emergent or urgent response (within 24-72 hour response time). We admitted 81 children into outpatient services and 14 children into intensive services (75%) The remaining 33 children were redirected to other community based mental health providers/programs, including private providers. As technical reports are designed, tested and approved we will gather additional information re: source of referral, primary mental health diagnoses, payer mix (OHP/uninsured/underinsured), primary care access, legal status, gender, race, socio-economic level, service utilization and overall health outcomes.

Lane County Behavioral Health Services is a designated Community Health Center (CHC) and provides rapid access to Primary Care Services at our mental health offices (co-location). We have both referred and received child referrals from Primary Care practitioners at LCBHS. In addition the Child Program has extended outreach to Springfield High School via the school-based clinic (another CHC) and we have a dedicated child staff member who provides a portion of her FTE delivering mental health services on-site at the high school. In the current school year we are available to co-lead a variety of skills groups with high school counseling staff, fostering the departmental cross cutting principals of collaboration, reducing stigma, community focus, integrated care and increase access irrespective of insurance status.

As noted above Lane County Behavioral Health Services is a credentialed Intensive Community Treatment Service provider for uninsured/underinsured and OHP eligible youth ages 5-18. We average 18 uninsured/underinsured children and families in our Intensive Services track per month. These community children receive a Level of Needs Determination and a clinical authorization for high levels of state care. As children stabilize they 'step-down' to our outpatient services.

From 7/1/07 to 6/30/09 LCBHS has served 57 non Medicaid eligible Lane County children and families with intensive needs. From 4/1/09 – 6/30/09 we served 12 non-Medicaid intensive children providing comprehensive evaluations, Level of Need Determination, individual therapy, family therapy, group therapy, psychiatric services, care coordination, child and family team meetings, wraparound services, pharmacy and consultation services.

The Child Program continues to sub-contract for a 0.5 FTE Family Ally position with the parent to parent organization Oregon Family Support Network (OFSN). The Family Ally provides outreach and parent engagement to LCBHS parents and caregivers who have difficulty navigating complex mental health, health, education, child welfare, juvenile justice, and DD systems for children with complex needs. The Family Ally is a co-provider with LCBHS in monthly Parent Orientation meetings, provides parent support groups and education, youth groups, respite and recreation events. As mentioned above we added the Collaborative Problem Solving Parent Book Club, a partnership with LCBHS CAP and OFSN. 10 families attend 10 week parent education and training support groups at LCBHS offices. Child care and pizza are provided to encourage and ease parent participation. We continue to use LCBHS child crisis dollars to support the Family Crisis Response Program providing 24/7 county-wide access to emergency services including crisis phone line, crisis intervention response, (face to face), crisis respite (in or out of the home) and crisis consultation.

Members of the LCBHS Child Program participate on a variety of prevention and planning committees including the Lane County Suicide Prevention Steering Committee, the Family Advisory Committee, and the Juvenile Subcommittee of the PSCC, the Perinatal Health Team, the Early Childhood Intervention Committee and the LaneCare Clinical Issues Committee. In addition we chair the local State Hospital Coordinating Committee.

## RESIDENTIAL PROGRAMS

Lane County Mental Health staff has been involved in coordinating the development of several new residential programs funded by the state Addictions and Mental Health (AMH) division that have recently opened in Lane County. These programs include two small residential treatment homes (generally 5 beds) to assist specialized populations. One program (Danebo House) serves a population of individuals with severe and persistent mental illness who are in need of “stepping down” from community programs that provide more intensive residential services or from hospitalization. This program will speed the integration of these mental health consumers back into the community. A second home (Myers Road House) will address the residential needs of individuals with mental illnesses involved in the local criminal justice system. This home will address the needs of a forensic population known as “unfit to proceed” (due to mental illness) in the judicial system. Siting of projects such as these can sometimes present challenges in working with neighborhoods where the homes will be located. Lane County Mental Health staff has worked with the provider (Shangri La Corp.) and representatives from the state Addictions and Mental Health Division to coordinate forums for communication and discussion with concerned neighbors and other stakeholders.

Lane County Mental Health has discontinued its direct participation in the operation of two local residential facilities:

The Summit Residential North program had been operated in conjunction with Elder Health and Living. Elder Health and Living (EHL) provided the residential care services (e.g., food services, medical care) and LCMH staff provided mental health services to the residents. This 10-bed secure, residential treatment center was replaced by 16 bed facility jointly operated by Gateway Living and Cascadia Behavioral Health at a new site.

The Summit Residential South program was another joint venture between LCMH and EHL. This home is a four person home designed to serve a particularly difficult population of women with complex mental health and physical health conditions, as well as challenging behaviors who have spent long stays in the State Hospital. This program is now operated by EHL with Cascadia Behavioral Health providing the mental health services.

Lane County Mental Health continues to oversee a broad system of Adult Foster Homes (AFH) for individuals with mental illnesses. The LCMH Residential Team is engaged in development of AFHs, placement of residents in the homes and the monitoring the quality of existing homes. Currently, there are over 20 mental health AFHs in Lane County, mostly in the Eugene area, but several homes are also located in outlying areas such as Cottage Grove and Pleasant Hill. These homes normally have up to 5 residents per home and often receive outpatient mental health services at LCMH.

## ACUTE CARE SERVICES

As reported in the past few Board of Health Reports, with the closure of the Lane County Psychiatric Hospital, the County, in cooperation with PeaceHealth, the State Addictions and Mental Health Division and other system stakeholders did create the Transition Team. This Team is modeled after a number of very successful programs in other states and is considered an evidence-based practice, and 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 works with these individuals for 8-12 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 consists of a PeaceHealth Clinical Supervisor, three QMHP level (Master's or above) clinicians (contributed by PeaceHealth as in-kind support to this program), two QMHA level staff paid for by LaneCare and hired by PeaceHealth, a psychiatrist (Dr. Paul Helms, former Medical Director of LCPH), a Psychiatric Nurse Practitioner, and a business support staff and clinical supervision provided by the County.

We contract with three or four community providers to provide mobile crisis support, in-home services and linkage to peer supports. These providers have had funding added to their existing contracts so they can have adequate capacity to serve Transition Team clients, who will, for the most part, be indigent. The team did expand its staffing with LaneCare funding to begin serving LaneCare members who have impacted the hospital system. The Team is housed at the LCMH clinic. Lane County Mental Health has added additional psychiatric time and business support to the team, funded as well by LaneCare.

A planned annual review of how the Transition Team has done in meeting its mission has been completed, and preliminary analysis seems to indicate that they are providing a high quality and effective service to the target population. The average time of Transition Team involvement is ten weeks, and they have successfully prevented most of the clients served from needing to be readmitted to the hospital. At the present rate, Transition Team will serve around 150 clients in the current fiscal year. Data indicates that transition team has reduced inpatient days for the clients it serves by an average of 1.5 beds per day for an entire year. That translates to almost 550 bed days saved, and since this team has been targeting primarily indigent clients, that is a considerable savings to PeaceHealth in non-reimbursed care and thus has resulted in a continued commitment from PeaceHealth to remain in partnership in this successful venture with their contribution of the costs of 3 QMHP staff and a Clinical Supervisor (over \$300,000). At present PeaceHealth is reviewing all its behavioral Health Services in light of a large revenue shortfall, but we have received assurances that their commitment to Transition Team is firm. One concern for us is that we don't as of this writing know what sorts of reductions in State funding we will see in the current FY, but early indications are that we could use a significant percentage of the "indigent adult funds" as well as the "regional acute care" funds, which will create serious fiscal issues for the County's ability to continue to support our portion of this critical partnership.

A new analysis to evaluate the effectiveness of the Transition Team's efforts with LaneCare clients has been completed and shows similar positive results in terms of both reduced lengths of stay and reduced readmissions to inpatient care within 6 months of Transition Team involvement. This year the focus will also be on diverting individuals from admission at the point of Emergency Department contact. Transition Team has hired additional staff that will function as liaison from the team to the ED crisis workers to facilitate referrals.

With the closure of LCPH, the County again became 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 gentleman'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 (March 31, 2004), we have already seen a dramatic increase in out of area admissions. If anything, that trend has continued and has the potential to get worse as there are threats of closure of additional beds across the state, which will further add to the acute care bed crunch statewide and the likelihood that Sacred Heart's Johnson Unit will be full most of the time. 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 increase our FTE devoted to commitment to stay compliant with the statutory requirements and to bring that service back up to historical staffing levels.

In addition, we had learned that Lane County historically received the lowest funding of Regional Acute Care dollars per capita of any County in the state. Discussions have occurred with the Addictions and Mental Health Division of the State to correct this significant inequity. Those discussions have been fruitful and Lane County was awarded an additional \$800,000+ in Regional Acute Care funding for the current biennium. These funds were used to increase the contract with Sacred Heart for indigent services at the Johnson Unit and to help offset the costs of out of area admissions and secure transports for Lane County residents. In addition, we will be expanding the pool of flex funds used for Transition Team clients and adding some additional psychiatric prescribing time. It is important to note that this very funding (Regional Acute Care) is slated for possible reduction if the State moves ahead with reductions in the current FY, and would seriously challenge our ability to meet statutory requirements.

A final area of significant planning and development is for crisis system enhancements to help create alternatives to expensive inpatient care and to allow earlier intervention

where possible. On the child side, a comprehensive, county-wide crisis response system has been developed, provided by a partnership of three child-serving agencies (SCAR-Jasper Mountain, Looking Glass, and Child Center) which has mobile crisis outreach and support 24/7, in home crisis respite, foster care based crisis respite and facility based crisis respite for children and adolescents. This serves the entire County from Florence to Oakridge and McKenzie Bridge and from South Lane to Coburg. Funding for these enhanced services is from increased State crisis funds provided by AMH and LaneCare reinvestment funds. This program has now been in operation for 4 years, and is proving to be well utilized and highly effective in reducing referrals to area emergency rooms and in resolving crises at an earlier point than previously possible. A 3 year evaluation report was prepared and distributed which highlights the accomplishments of this program, compares the program favorably to nationally recognized best practice guidelines, and does this at a fraction of what similar programs have cost in other states.

Finally, we worked with the Sheriff and Eugene Police to develop and roll out Crisis Intervention Team training for all law enforcement jurisdictions in the County to improve the officers' ability to deal with mentally ill subjects or subjects in mental health crisis in ways that can hopefully avoid the kind of tragic intervention that was witnessed with the Ryan Salsbury shooting. A grant was submitted to help support this effort, but unfortunately was not funded. There is a desire to resubmit for the next round of funding. Nevertheless, Eugene Police Department remained committed to rolling out CIT training, with the first wave of 20+ trainees going through the week long training the week of December 15, 2008, with lots of involvement by LCMH staff in teaching the curriculum. Another training for an additional 20 officers is currently in the planning stages.

## **ALCOHOL, DRUG, AND OFFENDER PROGRAMS**

On July 1, 2008, the Alcohol Drug, and Offender Programs (formerly part of Supervision and Treatment Services) were integrated into Behavioral Health Services when Parole and Probation moved to the Sheriff's Department. For many years, the Alcohol, Drug, and Offenders Programs (ADO) were comprised of the DUII Evaluation Unit, the Sex Offender Treatment Program, and the Methadone Treatment Program. The DUII Evaluation Unit recently closed due to lack of recourses. Of the two remaining programs, Al Levine is currently supervising the Sex Offender Treatment Program, and The Methadone Treatment Program is being supervised by Walter Rosenthal.

### ***Sex Offender Treatment Program:***

The Sex Offender Treatment Program (LCSOTP) provides individual and group treatment for adult men (18 and over) convicted of sexual offenses. The former women's program was eliminated due to budget reductions in January 2008. All program clients are on supervised probation, parole, or post-prison supervision in Lane County and are mandated to complete sex offender treatment. The program's goals are to promote community safety and prevent further sexual abuse by treating men who

have engaged in sexual offense behaviors. The program uses therapeutic approaches which are research-based and proven to be effective in reducing recidivism. We provide a rigorous treatment modality that focuses on offender accountability and provides interventions designed to maximize community safety.

LCSOTP has been an important part of sex offender treatment in Lane County for over 20 years. It is well known in the treatment community that we work with the most challenging subset of this already difficult population. We not only provide sex offender and mental health treatment to our clients, we also work closely with Parole and Probation to help our clients become stable in the community. Research has shown a direct connection between a lack of community stability and increased recidivism. LCSOTP has a recidivism target rate of 5% a year while in treatment. The program has consistently maintained a rate of less than 3% a year for new sex crimes by clients while in treatment. Since April, 2008, no clients have committed new sex crimes while in treatment.

LCSOTP prioritizes admission of clients based on the level of offenders' risk to reoffend. Many of our clients have been assessed as medium to high risk. We also specialize on providing treatment to the indigent population. Most of this agency's clients are men who have many barriers to rehabilitation and would not receive treatment elsewhere due to these issues. Many of these barriers are financial, including poverty, unemployment, and homelessness. Frequently these issues are exacerbated due to their status as convicted sex offenders. Other barriers include mental health issues and illiteracy. In spite of these barriers, LCSOTP has had many successes working with clients others might view as "untreatable."

Another barrier to treatment has been this agency's dwindling resources. Ten years ago, LCSOTP consisted of four offender therapists and one family therapist. Since that time, staff reductions have resulted in this agency functioning with 1.8 FTE clinicians. The program is currently providing intensive treatment services to 32 offenders. We believe that it is in the public's best interest that our FTE is increased, expanding our ability to work with more clients and thus help ensure community safety.

LCSOTP has increased its collaboration with Lane County Developmental Disability Services in order to provide intensive treatment to this important population. We also have a strong aftercare component, offering a safe environment for continued support in addressing troubling mental health or lapse behavior problems around client sexuality. Some clients will continue to access this support up to 3 years after completion of their treatment goals. The program currently has 9 clients in aftercare services.

The program works closely with Portland State University and the University of Oregon as a training clinic for Bachelor's and Master's level students. We currently have 4 student interns who combined provide more than 21 hours a week of service, including participating in individual and group treatment sessions, clinical note taking and evaluations. The treatment team has also been active in community education efforts

and outreach, presenting to classes at the University of Oregon and the Child Advocacy Center (Kids' FIRST).

***Methadone Treatment Program:***

The Methadone Treatment Program provides outpatient opioid replacement therapy, which includes methadone maintenance, counseling services and medical evaluation for individuals dependent on opiates. The program provides daily dispensing of methadone medication. Individual, group, couples and family counseling are provided as well as extensive case management/coordination of services on behalf of program participants. The goal of treatment is the reduction or elimination of harm associated with the use of any and all substances of abuse.

The Methadone Treatment Program is currently serving 105 individuals including three pregnant patients, and two HIV+ patients. There are currently twenty-eight individuals on the waiting list.

The Methadone Treatment Program has been made financially stable in recent months, but continues to be short staffed. While we have stabilized the Office Assistant position, the loss of a Mental Health Specialist position has also caused the remaining two mental health specialists to serve more patients than is considered best practice. In terms of risk management, we are concerned about staffing in the event that one of the MHS is unable to work for any extended timeframe.

In spite of these negative impacts, the methadone program continues to provide high quality services to their clients. The staff is comprised of committed professionals that have a high investment in the mission of the program and the clients they serve. They have attempted to offset the loss in general fund dollars by increasing billable contacts. This was partially achieved by having our Office Assistant position start at 6:00 AM, thereby freeing up clinical staff to see their clients during dispensing hours. This continues to work well and as a result we have seen improved revenue. This commitment to excellence is also exemplified by their on-going commitment to providing community education to other programs about methadone treatment. The counselors make regular presentations to community partners and stakeholders, and have several scheduled in the coming months.

The program's current lack of financial resources has created an unfortunate situation for our community. The treatment needs for opioid dependence continues to far surpass our current staffing levels. It is estimated that 3000 county citizens are opiate dependent and are abusing their use of prescribed medication or are using heroin. One significant challenge for staff in the coming months will continue to be providing high-quality treatment in this resource-thin environment, serving only 100+ patients. It is estimated that the only other methadone program in this community is also serving around 100 patients. This leaves somewhere in the neighborhood of 27-2800 citizens without methadone as a treatment option. We are looking into bringing the methadone treatment program under the umbrella of the Federally Qualified Health Center upon our

move to a new location in 2010. If becoming part of the FQHC is an option, we will be able to hire back the lost counselor, and perhaps we'll be able to expand further.

The Methadone Treatment Program has just completed their CARF review, and expecting to be awarded a three year accreditation. We should know the results in a few weeks.

## **X. PUBLIC HEALTH SERVICES (Karen Gillette, Program Manager)**

### **COMMUNICABLE DISEASE SERVICE**

The Lane County Public Health (LCPH) Communicable Disease Programs include the following elements: Immunization, Tuberculosis, Sexually Transmitted Disease, HIV Testing and Prevention, and reportable communicable disease investigation, reporting, and prevention as well as outbreak control.

#### **Immunizations:**

The LCPH immunization program has provided 1,435 immunizations in the past six (April 2009 – September 2009) months. In addition, the LCPH immunization delegate clinics have provided 3,255 immunizations in the same time period. These numbers represent a 24% and 7% drop respectively, when compared to the same six month period in 2008. A significant reason for the drop in LCPH provided general immunizations for children is the tremendous decrease in available appointment times to provide these services. This is a direct result from the surge in communicable disease effort and human resources aimed toward preparation, planning, and providing services to slow the spread of H1N1 Influenza in our community. In addition, the LCPH volunteer nurse who was providing hepatitis A & B immunizations at the HIV Alliance needle exchange van has left the community and we have not had the available resources to train and credential another provider for this important activity. Lane County is somewhat unique in relation to other Oregon counties of similar size in that our Immunization program is integrated within the communicable disease program and does not have staff dedicated solely to this program. Thus surging demand for resources in communicable disease control have a negative effect on this public health prevention effort.

In September of 2008, LCPH in conjunction with the state of Oregon hosted an Oregon Partnership to Immunize Children (OPIC) Roundtable including 72 public and private immunization providers throughout the County. The focus at the roundtable included vaccine recommendations update, school review, vaccine storage and handling.

Lane County's primary immunization effort during the fall of 2009 is directed toward assuring the distribution and provision of H1N1 immunization to identified at-risk populations throughout the county.

LCPH remains a good steward of our expensive and fragile vaccine resources. Our immunization program continues to exceed the performance measure target of 95% in vaccine accountability.

**Tuberculosis:**

In 2008, the incidence of active tuberculosis in Lane County fell below 1 case per 100,000 people for the first time since before 1991. There have been just 2 cases of disease in 2009. Currently, Lane County Public Health is providing case management services for one individual who is a transfer from California.

LCPH continues to provide twice yearly monitoring of the ultraviolet light TB prevention system at the community homeless shelter which sustained an outbreak of tuberculosis in 2001/2002.

County wide, our preventive treatment program for latent tuberculosis infection (LTBI) currently has 6 clients receiving medication and evaluation services. At present budget and staffing levels, LCPH evaluates and treats only those LTBI clients who are contacts to active cases of tuberculosis or have other problems which make them, statistically, at greatest risk of breaking down into active disease, causing further spread of tuberculosis in the community.

The decline in incidence of tuberculosis in Lane County is welcome news. None-the-less, LCPH must continue to provide labor intensive, diligent tuberculosis investigation and management services. An individual case can become a serious outbreak without an effective public health response.

In May of 2009, an exchange student living and attending high school in rural Lane County was found to have infectious active pulmonary tuberculosis. An extensive investigation which involved the host family, children on the school bus, in class, and in school activities was initiated and completed over 3 months. The investigation also involved students from multiple countries and states who had attended a camp together while the student was contagious. Ninety-two contacts were interviewed and tested initially and again 10-12 weeks later. One new case of latent tuberculosis infection was identified and treated. Tracking contacts and communicating follow-up requirements to students returning to home countries or leaving the community was challenging because the case was identified at the very end of the school year. LCPH conducted two large evening tuberculosis testing and follow-up test interpretation clinics at the school and provided daily Directly Observed Therapy (DOT) to the student until she was no longer infectious and could return to her home country.

**Other reportable communicable diseases:**

During the months of March 2009, through September, 2009, LCPH processed or investigated 525 reportable communicable diseases including confirmed, presumptive, and suspect cases.

Reports of previously acquired hepatitis C continue to surge – 300 in the past six months. Most of these continue to be chronic cases from the years before affordable testing and referral became available. At our present capacity, surveillance and

reporting of chronic hepatitis C is the extent of public health services that we are able to offer. There were also 4 cases of acute hepatitis C reported from March through September, indicating that the disease continues to be transmitted in our community.

The arrival and continuation of H1N1 Novel Influenza A pandemic to Lane County in May of this year has required a large scale public health response both here and throughout the county. From May through August, 95 cases were reported to Lane County Public Health and 1 death. In recognition of widespread influenza in Oregon and throughout the country, case reporting requirements were changed in mid-August. We currently track only those cases of influenza that are lab confirmed and hospitalized or die. During the last weeks of August and the month of September, just 4 individuals were hospitalized with confirmed influenza. More were ill in the community and there was great anticipation that there would be a surge of influenza illness as classes resumed for school children and at colleges and universities.

Indeed, as of October 23<sup>rd</sup>, there have been 75 lab confirmed hospitalizations and 3 influenza deaths. Many schools are reporting increased absences. No schools have been closed in Lane County this fall due to influenza absences, reflecting the changed CDC recommendations from the spring when several schools were briefly closed in an attempt to prevent transmission of the H1N1 Influenza A virus.

### **Sexually Transmitted Diseases:**

The majority of reported cases of STDs come from private providers and not from public health clinics. Lane County Public Health, unlike private providers, is the entity responsible for assuring treatment of contacts of reportable STDs and, therefore, reducing the spread of these diseases throughout the population. The STD treatment and prevention work is labor intensive and requires not only the work of the state Disease Information Specialist (DIS), but also the collaborative work of the LCPH STD nurses and cases report staff as well as use of the county acquired STD database. Surveillance, investigation, and assurance of treatment of cases and contacts are included in the county required Program Elements of the LCPH contract with the state.

The capacity to complete our surveillance and reporting of sexually transmitted diseases has improved with the addition of a Community Service Worker 2 to the Communicable disease team. By September 30<sup>th</sup> 2009, cases of both Chlamydia and gonorrhea climbed above last year's levels. There were 972 reported cases of Chlamydia and 114 cases of gonorrhea reported between January 1<sup>st</sup> and September 30<sup>th</sup> 2009. During this same time period in 2008 there were 791 cases of Chlamydia and 57 cases of gonorrhea reported. There is some indication that gonorrhea cases may be diminishing during the last 3 months, which is welcome news.

In 2008, LCPH changed to an appointment only model and refocused our services to those who are contacts of reportable STDs or are symptomatic for Chlamydia, gonorrhea, or syphilis. Opportunities for screening appointments at LCPH for clients have decreased substantially since the onset of H1N1 work in May of 2009, and an increased number of clients are referred to private medical providers or Planned

Parenthood screening STD services. Since April of 2009, Planned Parenthood has been able to offer low or no cost services to some individuals needing STD exams, which have increased the accessibility to these services.

From April 2009 through September 2009, LCPH served 148 individuals through STD appointments. This represents a 43% drop in the number of STD clients that LCPH was able to provide direct clinical services when compared to the same 6 month period last year. During the previous time frame the change from drop-in clinics to appointment only services had resulted in an increased number of clients seen as well as an increased percentage of clients who were contacts or had symptoms.

### **HIV Prevention:**

As specified by our principal funding source, the Oregon Department of Human Services, the mission of this program is to deliver the following service objectives in a way that has the highest impact on the populations at greatest risk for HIV transmission:

- 1) HIV counseling, testing, and referral services
  - 2) Evidence based Health education and HIV risk reduction programs
  - 3) Structural activities that facilitate the delivery of HIV prevention services to high-risk populations
- **HIV counseling and Testing:** During the 6 months from April through September 2008, LCPH and HIV Alliance conducted a total of 548 HIV counseling and testing sessions. The Performance Measure target for this program is that 65% of HIV tests will be for members of populations who are at highest risk for infection – men who have sex with men (MSM), people who inject drugs, and sexual partners of people with these risks. During this 6 month period 64% of HIV tests were provided to individuals in these groups. Epidemiologically, the highest risk group in Oregon for HIV infection is MSM and 31% of testing was given to people who identified this risk.
  - **Needle Exchange Services (NEX) for Injection Drug Users**  
NEX helps prevent the transmission of HIV, Hepatitis B & C, and the development of serious wound infections, such as MRSA, which may lead to hospitalization and negative impacts on our community health care system.
    - HIV Alliance provides NEX at several location in the Eugene-Springfield area and empties syringe drop boxes at community locations including a site at LCPH
    - LCPH 10-packs with harm reduction supplies are offered at the LCPH office. From April through September, 2009, 2,449 of these 10-packs were given to individuals
  - **Harm Reduction Coalition:** LCPH participates in this community-based coalition which is a structural activity that facilitates the delivery of prevention services to high-risk populations, particularly in support of the Needle Exchange Program at HIV Alliance.

## Environmental Health

The purpose of the Environmental Health Program is to give quality inspection services to facility owners and to protect the health of residents and visitors in Lane County as they use any of our 2,963 restaurants, hotels, public swimming pools, schools, and other public facilities. Environmental Health (EH) employs 8 FTE Environmental Health Specialists that are responsible for 4,680 total inspections completed annually 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 facilities (921), mobile units (144), commissaries and warehouses (17), vending machines (5), temporary restaurants (994), pools/spas (296), traveler's accommodations (116), RV parks (72), schools/correctional facilities/treatment centers (170), summer lunch program (6), day cares (168), organizational camps (13). EH continues to work closely with the Communicable Disease (CD) team and Preparedness Response team as needed to ensure safe food and tourist accommodations for everyone in Lane County.

Environmental Health provides a portion of one Environmental Health Specialist to work specifically on public school kitchens and day care facilities which are not licensed by the County but, nonetheless, contract with us for inspection services. The person assigned to this position also assists in conducting training sessions, acts as a public information liaison and is available for presentations on a variety of environmental health issues. EH is in the process of planning a comprehensive 7 hour food manager's training to be held in November of 2009. Food industry workers will be invited to participate.

The Environmental Health Program was expanded in 2009 to include the State Drinking Water Program and that segment of the work is now fully funded through fee based inspections and consultations.

Testing and certification of food handlers in Lane County continues to be a priority, as a preventative measure against food-borne illnesses. Between the months of October 2008 and September 2009, 58,578 Food Handler Cards were issued statewide through our on—line food handlers' testing e-commerce website [orfoodhandlers.org](http://orfoodhandlers.org). 7726 of those cards were issued to Lane County residents. An additional 2,007 were issued onsite.

Since March of 2008, when the site was launched, EH has extended services statewide and has contracted with seven Oregon counties to offer on-line testing and revenue to those counties. The counties agree to list [orfoodhandlers.org](http://orfoodhandlers.org) on their website or as a link through the DHS website. In exchange, Lane County pays each contracted county \$8.00 per test. We currently have participating agreements with 22 counties across the state and are generating a healthy revenue stream from the program. We will continue to work with other Oregon counties to get them signed agreements. Prior to this new site, it was costing the program \$5 per test to use the Chemeketa Community College testing site.

In the summer of 2009, Lane County EH conducted the West Nile Virus program. EH staff collected and shipped state approved specimens to the state laboratory for testing. Mosquitoes were also trapped, identified and tested. Lane County EH interns generated GIS maps for the Lane County and for other programs in the state as part of our agreement with the WNV funding program. Our funding has been renewed for 2009.

The EH team continues to work closely with the Communicable Disease (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.

The EH Program continues its Internship Program in cooperation with the U of O and OSU Environmental Health Programs. The EH interns have completed a user friendly mapping project for locating vulnerable populations as a part of the disaster preparedness endeavors and are working on expanding that project to a statewide registry. We continue to look for projects for which university interns can be involved.

The program is currently training staff in GIS technology and will be using this tool on internal mapping projects related to our food protection efforts. In conjunction with the State Food Program and other counties, the EH Program continues to be committed to becoming standardized through the FDA Standardization Project. We have recently completed five of nine FDA standards and have passed pre-audits on those completed standards.

## **MATERNAL CHILD HEALTH**

The goal of the Maternal Child Health (MCH) program is to optimize pregnancy, birth, and childhood outcomes for Lane County families through education, support, and referral to appropriate medical and developmental services. MCH services for pregnant and postpartum women and for young children and their families are provided through the following program areas: Prenatal Access (Oregon Mother's Care), Maternity Case Management, Babies First, and CaCoon.

***Prenatal Access/Oregon Mother's Care:*** The Prenatal Access/Oregon Mother's Care (OMC) program helps low income pregnant women access early prenatal care. Program staff determines eligibility for Oregon Health Plan (OHP) coverage during the prenatal period and directly assist with the completion and submission of the OHP application and verification of coverage. The program helps pregnant women schedule their first prenatal visit by providing prenatal health care resource information. Improving access to care is the most effective means of increasing the percentage of women who receive first trimester prenatal care, and early and comprehensive prenatal care is vital to the health and well being of both mother and infant. Studies indicate that for every \$1 spent on first trimester care, up to \$3 is saved in preventable infant and child health problems. This program served 218 low-income women access OHP and prenatal care during the past 6 months. This is down from previous years due to a 20%

reduction in staffing. Additionally, the percentage of OMC clients who accessed prenatal care in the first trimester of their pregnancy is down to 64.5% due to the requirement for a certified birth certificate prior to OHP eligibility and care.

***Maternity Care Management:*** The Maternity Case Management program provides ongoing nurse home visiting, education, and support services for high-risk pregnant women and their families during the perinatal period. Community Health Nurses help expectant families access and utilize needed and appropriate health, social, nutritional, and other services while providing pregnancy and preparatory newborn parenting education. Perinatal 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, increase realistic parental expectations of the newborn, improve nutrition during pregnancy, and decrease maternal smoking – all of which increase positive birth and childhood outcomes. This program served 174 at-risk, low-income, pregnant teen and adult women in the past six months

***Babies First!:*** The Babies First program provides nurse home visiting for assessment of infants and young children who are at risk of developmental delays and other health conditions. Early detection of special needs leads to more successful interventions and outcomes. Nurses provide parental education regarding ways to help children overcome early delays, and they provide referral to appropriate early intervention services. Other benefits of nurse home visiting are: improved growth in low birth weight infants, higher developmental quotient in infants visited, increased parental compliance with needed intervention services, increased use of appropriate play materials at home, improved parental-child interaction, improved parental 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. This program served 162 at-risk and medically fragile infants during the past six months.

***CaCoon:*** CaCoon stands for Care Coordination and is an essential component of services for children with special needs. The CaCoon program provides nurse home visiting for infants and children who are medically fragile or who have special health and/or developmental needs. Nurses educate parents/caregivers about the child's medical condition, help families access appropriate resources and services, and provide support as families cope with the child's diagnosis. CaCoon provides the link between the family and multiple service systems and helps them overcome barriers to integrated, comprehensive care. The program's overall goal is to help families become as independent as possible in caring for their special needs child. This program served 53 medically fragile, special needs infants over the past six months.

***Challenges and Opportunities in MCH:*** Public Health has continued to lead the community initiative to address Lane County's disturbingly high rate of fetal-infant mortality. The initiative has received broad community support and interest.

The Perinatal Periods of Risk (PPOR) approach has continued to be used as the analytic framework for investigating local fetal-infant mortality. PPOR results have indicated an overall high rate of fetal-infant mortality (higher than the U.S., Oregon, and comparable Oregon counties). Additionally, the results indicate that the highest excess mortality is occurring in infants between one month and one year of age; and, that 60% of those deaths are attributable to SIDS or other ill defined causes and to accidents and injuries—all of which are potentially preventable.

Public Health established a Fetal-Infant Mortality Review (FIMR) in order to review individual, de-identified, case-findings and to help determine what common factors represent community-wide problems. Public Health received a second year of March of Dimes Community Grant funding to support efforts to reduce fetal-infant mortality.

Members of the community-wide fetal infant mortality initiative chose to name their overall effort—Healthy Babies, Healthy Communities—to reflect the significance of infant mortality as an index of community health and well-being. The large community group continues to meet quarterly and serves as the Community Action Team (CAT) of FIMR with the role of planning and implementing systems changes designed to reduce fetal-infant mortality. The multidisciplinary Case Review Team (CRT) meets monthly to review case findings and develop recommendations for the CAT. The Perinatal Health Team is composed of service providers who work together to implement actions to reduce fetal and infant mortality.

Through review of individual fetal and infant death case findings, the CRT identified the following issues: lack of pre-pregnancy health, health care, and reproductive planning; lack of understanding of negative impact of alcohol, tobacco, and other drugs (ATOD) on fetal health and development; lack of consistent, completed prenatal psychosocial, mental health, ATOD, and domestic violence risk screening, follow-up, and referral; lack of consistent infant/family screening for health, development, and safety (including safe sleep); and lack of consistent grief support and counseling. Those issues and recommendations for suggested community action were shared with the larger community group or CAT. The suggestions included: outreach and education to community and providers regarding importance of (preconception health) pre-pregnancy health, health care, and reproductive planning; community-wide tobacco education and cessation effort development of a user friendly, electronic screening record with corresponding referral and follow-up algorithm and resource guide for providers; development of newborn/infant health and safety screen, referral algorithm, and resource directory for providers; promotion of safe sleep practices by all caregivers; and, outreach to perinatal mood disorders group to coordinate efforts to ensure counseling and support. Work will continue to identify additional resources, and to implement strategies to address the issues and to reduce fetal and infant mortality.

### **Preparedness**

Preparedness for disasters, both natural and man-made, is a public health priority. This priority is realized through the Lane County Public Health Services Public Health Emergency Preparedness and Communicable Disease Response Program (“PHP Program”). The program develops and maintains the capacity of the department to:

1. rapidly mount an effective response to any emergency; and
2. prevent, investigate, report and respond to outbreaks or the spread of communicable diseases.

Whether an outbreak of a highly infectious disease is intentional, or whether it is caused by a new virus the public health response will be similar, and Lane County Public Health will be ready. Lane County Public Health Services is improving disease detection and communication, training its work force, and conducting exercises to test its readiness to respond.

### **Plan Development**

The PHP program addresses public health mitigation, preparedness, and response and recovery phases of emergency response through plan development, exercise and plan revision. Since the last Board of Health report, the Lane County Public Health applied for and received a \$15,000 grant to begin continuity of operations planning for Lane County Public Health and Health and Human Services Administration. By conclusion of the project, the divisions will successfully write, adopt worksite specific plans to enhance its potential to carry out its mission during and after any emergency. Implementation of this grant began in early October.

The Public Health Emergency Operations Plan has also been updated to address the management of public health and medical resources under emergency circumstances. Updates included the following:

- Drafting of new “Mass Vaccination” protocols and procedures to insure timely distribution of vaccines and other medications during a public health emergency.
- Development of new procedures for assisting hospitals in obtaining additional supplies and personnel in a community wide emergency.

### **Public Health Emergency Response:**

Occasionally, local events require LCPH to implement its emergency plans to protect the health and safety of the public. The recent H1N1 Influenza Pandemic has required such a response. Lane County Public Health has continued to plan for and respond to the H1N1 crisis. As of October 23, 2009 approximately 50 employees and volunteers were actively involved in the response. An elevated response is expected to continue through the 2009-10 influenza season.

As part of an ongoing program improvement process, the division’s initial two-week response in May of 2009 was evaluated, including strengths identified and areas for improvement in a post event debrief. A summary report can be made available upon request from the Public Health Preparedness Coordinator.

### **Community Planning and Outreach**

Lastly, Lane County Public Health is part of a system. It has certain regulatory powers to protect people that no other entity has. But it can’t do it alone. In partnership with

local and state government agencies, businesses, schools, and the media, Lane County Public Health galvanizes the community to tackle local preparedness needs. Recent partnering efforts are summarized below:

### Vulnerable Populations

Recent efforts have focused upon bringing together local partners to plan for the needs of the community's most vulnerable populations and the advancement of community planning for a pandemic illness event.

In support of this goal, Lane County Public Health applied for and was the recipient of a \$194,046 competitive grant to design and implement an emergency planning mentoring program for community-based organizations (CBOs) serving homeless populations. In October 2008 Lane County Public Health (LCPH) began designing and implementing the grant, an emergency planning mentoring program for CBOs serving homeless populations in Lane County, Oregon. This project concluded in September, 2009. Since its implementation, the grant has achieved several goals:

- Surveyed local non-profits about preparedness and training needs
- Conducted focus groups with non-profits on project curriculum
- Identified and adapted the project curriculum
- Conducted 3 workshops, attended by 52 people, representing 37 local agencies
- Conducted at least 3 visits for one-on-one mentoring for 26 participating agencies.

Over the life of the project, project staff assisted local CBOs to successfully write, adopt, and test worksite specific plans and policies. It enhanced their capability to safely and effectively carry out their mission during a pandemic illness or other public health emergency. Emphasis was placed upon preparations for a pandemic illness, but incorporated strategies applicable to all hazards. This project built upon already successful collaborations with the members of several local preparedness efforts, including the Vulnerable Populations Emergency Preparedness Coalition, the Lane Preparedness Coalition, and the Lane Mental Health Disaster Response Alliance. A final summary report of the project's accomplishments is expected to be available in December.

### **Chronic Disease Prevention:**

#### HEALTHY COMMUNITIES PROGRAM

In the United States today, seven of ten deaths and the vast majority of serious illness, disability, and health care costs are caused by chronic diseases, such as obesity, diabetes and cardiovascular disease. Key risk factors—lack of physical activity, poor nutrition and tobacco use—are major contributors to the nation's leading causes of death. More than 75% of health care expenditures in the United States are spent to meet the health needs of persons with chronic conditions ([www.cdc.gov/nccdphp/overview.htm](http://www.cdc.gov/nccdphp/overview.htm)). Many Americans die prematurely and suffer from diseases that could be prevented or more effectively managed.

Understanding patterns of health or disease requires a focus not only on personal behaviors and biologic traits, but also on characteristics of the social and physical environments that offer or limit opportunities for positive health outcomes. These characteristics of communities – social, physical, and economic – are a major influence on the public’s health and have both short- and long-term consequences for health and quality of life. Research has shown that implementing policy, systems, and environmental changes, such as improving physical education in schools, improving safe options for active transportation, providing access to nutritious foods, and other broad-based policy change strategies, can result in positive behavior changes related to physical activity, nutrition, and tobacco use, which positively impact multiple chronic disease outcomes.

The primary goal of Lane County Public Health’s Healthy Communities Program is to implement community-wide policies, systems, and environmental changes that reach across all levels of the socio-ecological model and include the full engagement of the leadership in city government, boards of health, schools, businesses, community and faith-based organizations, community developers, transportation and land use planners, parks and recreation officials, health care purchasers, health plans, health care providers, academic institutions, foundations and many other community sectors working together to promote health and prevent chronic diseases. Our program builds on existing programs and resources in the community.

Major programmatic activities in the last six months include:

- A wrap up of local menu labeling policy efforts (preempted by passage of a weaker state-wide bill)
- Adaptation of Lane Code to provide the Board of County Commissioners, acting as the Board of Health, authority to pass county-wide policy in matters related to public health.

### Tobacco Prevention

Tobacco is still the leading cause of preventable death in the US, Oregon, and Lane County. In Oregon, tobacco causes more than five times as many deaths as motor vehicle crashes, suicide, AIDS, and homicide combined. These deaths are mainly due to one of three causes: cardiovascular diseases, cancers, and respiratory disease.

Each year, in Lane County:

- 646 people die from tobacco use (on average);
- 12,626 people suffer serious illness caused by tobacco use;
- 54,356 adults regularly smoke cigarettes;
- Over \$101 million is spent on medical care for tobacco-related illnesses; and
- Over \$108 million in productivity is lost due to tobacco-related deaths.

The Lane County Tobacco Prevention & Education Program (TPEP) continues to reduce tobacco-related illness and death in Lane County by: reducing exposure to secondhand smoke through the creation of smoke-free environments and enforcement

of existing public health laws, decreasing youth access to and initiation of tobacco use, and increasing access to cessation services.

Highlights from the last six months include work in the following areas.

### **Enforcement of revised Indoor Clean Air Act (ICAA), January 1, 2009**

- Changes in Oregon's Indoor Clean Air Act (ORS 433.835-870) expanded the list of indoor workplaces that are required to be smoke-free. The State Department of Health & Human Services has delegated authority for enforcement of the state law, at the local level, to Lane County Health & Human Services. Lane County Public Health Tobacco Prevention staff responds to complaints of violation regarding the ICAA. Upon receiving a complaint and verifying that the business is not exempt from the law, an initial response letter (warning letter) is sent to the establishment, along with educational materials and required signage. If a second complaint is received, an unannounced site visit is conducted by staff. During the site visit, if a violation of the law is noted a remediation plan is created with the owner or person in charge. Staff conducts a follow-up site visit, within 45 days of the signed remediation plan, to verify that appropriate action was taken by the business to come into compliance with the ICAA. If a business is found to be out of compliance during the second site visit, staff documents their findings and forwards all complaint information on to the State Tobacco Prevention staff for further enforcement proceedings. Businesses out of compliance with the law can receive a \$500 fine for each day that they remain out of compliance (not to exceed \$2,000 in a 30 day period). In the last six months, staff responded to 45 complaints, of which 33 were actionable. Of these 33 actionable complaints, 19 required initial warning letters, and 9 were referred to the City of Eugene for enforcement action. County staff conducted 1 initial site visit in which no violation was found and 2 follow-up site visits (to businesses originally found to be in violation of the law) in which the businesses had followed through with their remediation plans (no subsequent violations found).

### **University of Oregon Tobacco Free Campus Initiative**

- On April 8<sup>th</sup> the UO Senate voted yes to the following motion: "The UO Senate endorses the report of the smoke free task force and recommends that the University of Oregon move toward becoming a smoke free campus." Following this resolution, UO health advocates attempted to get President Frohnmeyer to make a public statement regarding the Senate vote and to declare a date for the policy to take effect. Despite calls to the President's office and a very supportive Editorial appearing in the Register Guard, President Frohnmeyer retired at the end of June without taking a position. Advocates are currently in the process of strategizing how best to present information on the work that has been done, regarding this issue, to the new UO President.

### **Lane Community College Tobacco Free Campus Initiative**

- In June, the Lane Community College, College Council voted in support of the following policy, "Effective the beginning of Fall term 2010, the College smoking

policy shall be amended as follows: Smoking and other tobacco use is prohibited in all core areas of LCC campuses; smoking and tobacco use may be allowed in some designated peripheral areas”. Health advocates are currently working with LCC College Council to clarify if smoking will be allowed in peripheral areas of the campus. Additionally, a policy implementation/enforcement team will soon begin meeting.

### **Smoke-free Multi-Unit Housing**

- In July, the U.S. Department of Housing and Urban Development, the Office of Public and Indian Housing and the Office of Healthy Homes and Lead Hazard Control jointly issued a notice on the topic of non-smoking policies in public housing authority buildings. Notice PIH -2009-21 (HA) clearly explains its purpose: “This notice strongly encourages Public Housing Authorities (PHAs) to implement non-smoking policies in some or all of their public housing units.” The HUD notice stressed that secondhand smoke exposure especially affects the health of the elderly, the young and those with chronic illnesses such as respiratory infections, asthma, cardiovascular disease and cancer. Residents between the ages of 0-17 and those over 62 comprise 54 percent of public housing tenants. Reports from the Centers for Disease Control and Prevention document that “children in poor families are more likely to have ever been diagnosed with asthma or to still have asthma than children in families that are not poor”; and “adults in poor families have higher percentages of emphysema, asthma and chronic bronchitis than adults in families that are not poor.”

The HUD memo provided staff with the perfect opportunity to contact Housing and Community Services of Lane County to ascertain their interest in adopting a smoke-free housing policy for the properties that they oversee. HACSA has agreed to partner with public health to commission a tenant survey of attitudes/beliefs around secondhand smoke exposure and smoke-free policies. (This is typically the first step taken to move a smoke-free multi-unit housing policy forward). Tobacco prevention staff is also working with private and affordable housing landlords to encourage the adoption of smoke-free multi-unit housing policies.

### **Women, Infants and Children (WIC)**

The WIC Program serves pregnant and postpartum women, infants and children under age 5 who have medical or nutritional risk conditions. Clients receive health screenings, specific supplemental foods and nutrition education to address their individual risk conditions. WIC Registered Dietitians provide nutrition counseling to clients identified as high risk. These WIC services are a critical part of public health efforts to address Lane County’s high rate of infant mortality.

In September 2009, the WIC Program was serving 8,508 clients. The number of vouchered participants (actual number of participants redeeming WIC vouchers for that month) was 8,168. The state has increased the Lane County WIC caseload assignment

in order to allow the program to continue at a higher service level beyond the previously assigned level. The new assigned target vouchered caseload level is 8,294 vouchered participants per month. The program is currently maintaining at 98.5 percent of this new assigned caseload level.

During August 2009, the WIC Program began implementing a series of new USDA regulations regarding culturally appropriate and healthier foods that are now issued through the WIC food vouchers. Staff training is completed and client education is ongoing. The changes require greater coordination with local health care providers and medical documentation for issuance of new foods to clients with particular health care needs.

Smoking cessation interventions continue to be provided to postpartum women who smoked during pregnancy or are currently smoking. These interventions are conducted by WIC Registered Dietitians and WIC Community Service Worker staff.

The WIC program issued Farmers' Market coupon booklets to 1,550 clients during the months of June-July, 2009. These \$20 coupon booklets are used to purchase fresh fruits and vegetables from Farmers' Market and farm stand vendors. WIC families who received coupons were educated about the nutritional value of fresh fruits and vegetables and the benefits of shopping with local farmers.