



**NewPATH Project Final Report
and Recommendations**

New Person-centered Alternatives to Hospitalization

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**Oregon
Health
Authority**

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NewPATH Project Report and Recommendations

New Person-centered Alternatives to Hospitalization

Executive Summary

Between January and November, 2010, the NewPATH Core Team sought to identify the community-based programs and services necessary to achieve the ultimate goal of NewPATH, which is to develop a roadmap for reducing Oregon State Hospital (OSH) Junction City beds by 66 and creating community high-intensity long-term care replacement facilities with a 70-bed capacity by the year 2027. To accomplish the NewPATH goals, four work objectives were undertaken: analysis of the then current OSH Geropsychiatric Treatment Services (GTS) census and an admission sample; a community survey that consisted of interviews with community partners, advocates, and experts who work with the geropsychiatric population; examination of GTS referral, admission and placement planning processes; and a review of relevant geropsychiatric literature and the findings of past Oregon work groups on this population.

The GTS data analysis indicated that the large majority of patients, 85 percent, were likely to be Seniors and People with Disabilities (SPD) service eligible upon discharge.¹ Thirty-six percent of the patients in the data collection were living in an SPD facility prior to GTS admission. Acute care hospitals are the main referral source to GTS. It is most often the case that the first contact an older adult or a younger adult with disabilities has with a mental health or gerospecialist is at an acute care setting, suggesting a gap in community mental health services to older adults and younger adults with disabilities. It is primarily the behavior rather than diagnosis that brings a referral to acute care and ultimately to the state hospital.

¹ Throughout this paper, the larger population of older adults and younger adults with disabilities will be referred to as SPD eligible. To be eligible for SPD-licensed nursing home and community-based care services, seniors and people with disabilities must be both financially eligible for Medicaid and SPD service eligible. SPD service eligibility means to have impairments that limit abilities to perform activities of daily living, such as mobility, eating, elimination, and cognition.

According to U.S. census data, among the 50 states and the District of Columbia, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. It is clear that Oregon needs to provide more services for this age cohort. While a number of work groups and commissioned studies over the last two decades have recommended a stronger commitment to older adults, community mental health services to this growing population has consistently been under funded.

The fundamental position of the NewPATH core team is that new or enhanced services and supports tailored to meet the needs of older adults and younger adults with disabilities, which includes the sub-population NewPATH, will be effective only in the context of a robust system of services and supports for the SPD-service eligible population with serious mental illness and dementia, provided by both SPD and Addictions and Mental Health Division (AMH). Such a system of care begins with an effective internal structure. This report discusses both internal and external service gaps ultimately impacting utilization of the Oregon State Hospital GTS program.

New community models of crisis management, stabilization and habilitative long-term care are essential to divert unnecessary acute and psychiatric hospitalizations, and give Oregonian's the appropriate continuum of mental health services throughout the lifespan.

Recommendations made in this report include the establishment of a champion to lead a new cross-divisional unit dedicated to this population. SPD and AMH should align their policies for appropriate utilization of the Oregon State Hospital Geropsychiatric Treatment Services program and take joint responsibility, in partnership with the community mental health organizations, to deliver appropriate and accessible mental health services to older adults and younger adults with disabilities statewide. Finally, timely outcome data, a well trained workforce, and oversight of performance-based contracts, monitored and managed through the proposed older adults unit will ensure provider accountability and high-quality, cost effective person-centered care.

It needs to be acknowledged that this work was completed prior to the release of Governor Kitzhaber's Balanced Budget for 2011-13. However, recommendations made here are significantly aligned with his call for an investment in community services and supports for older adults and younger adults with disabilities and lay groundwork for a more integrated health approach that is now in development.

Introduction and Purpose

According to the Oregon State Hospital (OSH) Framework Master Plan (February 28, 2006), “enhancing the breadth and depth of community-based services is a critical piece of the state hospital master plan” (Page iii). To ensure the successful utilization of the new state hospital facilities as designed, community-based program enhancements need to be fully implemented.

The New Person-centered Alternatives to Hospitalization (NewPATH) project was created out of this recommendation, and is managed through the Oregon State Hospital Replacement Project (OSHRP). This Department of Human Services (DHS) cross-organizational initiative among Addictions and Mental Health (AMH), Seniors and People with Disabilities (SPD), and Oregon State Hospital (OSH), NewPATH was governed as an AMH Transformation Initiative (AMHO14) sponsored by Linda Hammond, administrator of the OSHRP. Team Leads are Jodie Jones, deputy administrator of the OSHRP, and Sandra Koelle-Stewart, diversion analyst with OSHRP. Core team members are Matt Bartolotti, older adult services coordinator, AMH, and Sandra Moreland, operations policy analyst, SPD. The OSH Liaison to the core team is Rebecca Curtis, director of social work at OSH.

Central to the work of the core team was the Oregon State Hospital Replacement Master Plan and two subsequent updates to the Master Plan completed by a community services workgroup. Originally, the Master Plan, along with replacing the aging Oregon State Hospital, recommended development of community-based residential programs and critical “front-end” services. In 2009 the Community Services Workgroup report noted that it is no longer sufficient to define needs for community diversion in terms of front-end and back-end services; rather “the system should be seen as a continuum of services that individuals may need to access at different points in their lives, as they manage their illness and progress in their recovery” (Page 2). Evidence from the core team’s work was consistent with these findings. It needs to be noted, however, that the Community Services Workgroup does not address the needs specific to

older adults or younger adults with disabilities who require psychiatric services, the focus of the NewPATH project.

The NewPATH core team was charged with exploring referral, admission and placement planning processes to identify gaps in the community for successful support of individuals referred to the Oregon State Hospital (OSH) Geropsychiatric Treatment Services (GTS) with the most challenging behaviors. The Team was also charged with recommending new services: diversion and community-based hospital replacement programs.

To accomplish these charges, the NewPATH team devised and completed four objectives. They were:

- (1) To analyze the current census of Oregon State Hospital Geropsychiatric Treatment Services to identify the NewPATH population;
- (2) To complete a community assessment to identify gaps in available services and supports necessary to provide for community stabilization and community-based long-term care needs for individuals with geropsychiatric/behavioral issues and complex medical conditions;
- (3) To identify possible internal discharge barriers that hinder or prevent timely discharge of stabilized GTS patients;
- (4) To review relevant literature related to geropsychiatric services for the population, in particular the reports and studies of workgroups convened in Oregon in the past two decades to address the needs of the population.

Data and findings from these objectives inform the NewPATH recommendations, detailed later in the report.

OSH Geropsychiatric Treatment Services

Background

Three Geropsychiatric Treatment Services (GTS) units, for people age 65 and older and 18 and older with nursing needs, were opened in 1983. One

unit was designated for younger neurologically impaired individuals. A fourth unit was opened in 1984, however it closed just two years later due to a failed Health Care Finance Administration (HCFA) survey. In the late 1980s a medical unit was opened, completing what is today's four-unit GTS program at Oregon State Hospital. Each unit currently houses about 30 patients, a total of 120 beds. However, in the new OSH-Salem hospital, GTS will be housed in the five-unit *Springs* housing unit with 24 beds in each, for a total of 120 beds.

In the early days of the GTS program, a Gero-Outreach Team existed that screened referrals, consulted with acute care hospitals, and trained community-based providers to ensure that all steps were being taken to stabilize and treat older adults in the community rather than make a hasty referral to OSH GTS.

In late 2006 the Gero-Outreach Team (1.5 FTE) was transferred from OSH to AMH to be integrated with the Extended Care Management Unit. In August 2007 AMH agreed to the transfer back to OSH of the full-time nurse practitioner to increase nursing coverage in the hospital. The original functions performed by the Gero-Outreach Team are not being performed by the remaining AMH staff.

Data Analysis

Methodology

An analysis of the four GTS units at OSH was undertaken between April 14 and April 30, 2010, by the NewPATH core team. Eighty patients were included in the data collection. They represent all individuals admitted to GTS prior to April 14, 2010. While the census on the four GTS units may have been higher than 80 on any given day, this study did not include any patients admitted during the data collection period (i.e. after April 14) and may not have included individuals who discharged prior to the contractors collecting data on a particular unit.² Data collection was conducted by two

² GTS daily census has trended downward over the last two years. In October 2008 census was at its highest at 101 patients. Census dipped to its lowest, 77 patients, in December 2009. Spring 2010 saw a spike in census to 93 patients, but numbers have steadily decreased and maintained between 80 and 90 patients since.

contractors with Northwest Senior Disability Services (NWSDS). The collection method included chart reviews, staff interviews, some patient interviews and patient observation on the unit. A survey form was used to collect the data (Appendix A), which included information on demographics, psychiatric and neurocognitive diagnoses, length of stay, legal status (e.g., guardianship, civil commitment, etc.), likely-SPD service eligibility,³ medical conditions, mental health or behavioral health symptoms, and barriers to community placement.

GTS Population Demographics

Of the 80 GTS patients surveyed, 55 were male and 25 female. Ages ranged from 32 – 88, with the median age 65. Despite the name of the hospital program, *Geropsychiatric*, half of the population was between 18 and 64 years old.

Mental Health Diagnoses.

For the GTS surveyed group, the three most common diagnoses in the category of psychiatric conditions (e.g., traditional psychiatric conditions excluding dementia or brain injury) were schizophrenia (26 patients, or 33 percent), polysubstance abuse (23 patients or 29 percent) and schizoaffective disorder (20 patients or 25 percent). Personality disorder diagnoses included antisocial (3 patients); borderline (2 patients); narcissistic (2 patients) and mixed or other (13).⁴ Fifty percent of the 80 surveyed were also identified as having dementia⁵ not otherwise specified (NOS) or cognitive disorder NOS. Another 25 percent had cognitive disorders related to a dementia or neurocognitive disorder such as

³ To estimate whether a patient was likely to meet SPD service eligibility upon discharge, SPD developed a 10-item questionnaire (Appendix B). Although formal eligibility could not be determined, the 10-item screening questionnaire provides a good estimate of whether the person will be eligible.

⁴ Other includes schizotypal personality disorder, schizoid personality, and personality disorder NOS as descriptors.

⁵ Dementia can arise as a result of a specific disease, for example Alzheimer's disease or HIV infection; a general medical condition; a substance-related condition; or a combination of conditions. It is characterized by memory impairment and individuals with dementia will decline to a point of being unable to care for themselves in all aspects of daily living.

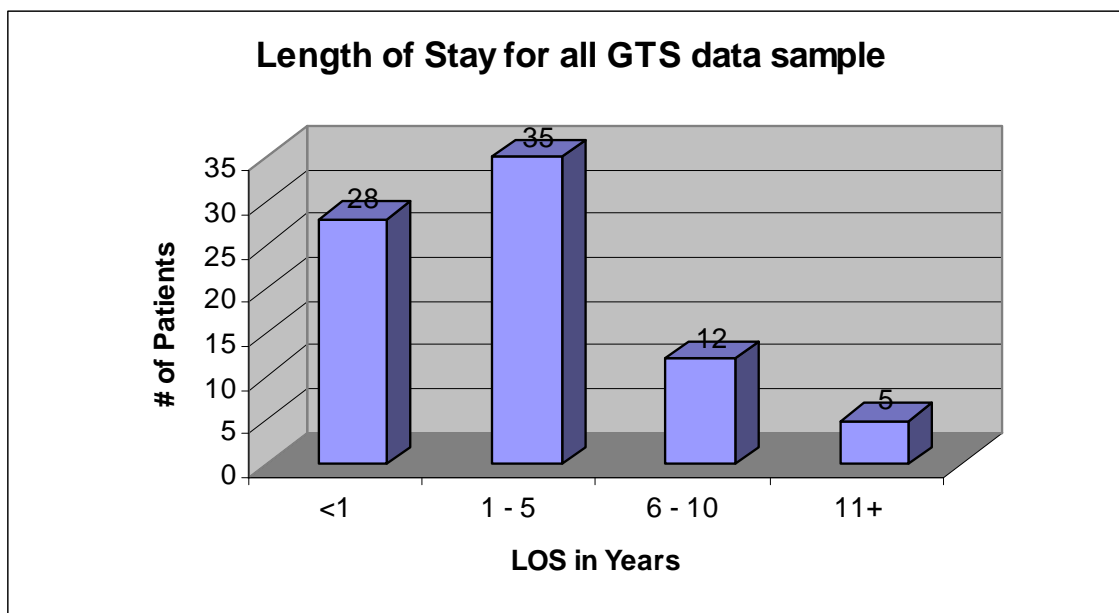
Huntington's disease, vascular disease, or Parkinson's disease. Patients may have multiple diagnoses.

The data collection tool did not seek delineation between primary and secondary/tertiary diagnoses.

Length of Stay

Current length of stay (LOS) for the 80 GTS patients surveyed ranged from fewer than 12 months to 16 years with groupings as follows: fewer than 12 months = 28 patients; 1–5 years = 35 patients; 6-10 years = 12 patients, and more than 10 years to 16 years = 5 patients. See Illustration 1.

Illustration 1



Since April 20, completion date for data collection, 27 individuals have been discharged. One individual has died. Sixteen (44 percent) spent 12 months or less as a patient at OHS GTS. Data regarding where they discharged to and whether or not their transition was successful was not available at the writing of this report.

Referral sources to GTS

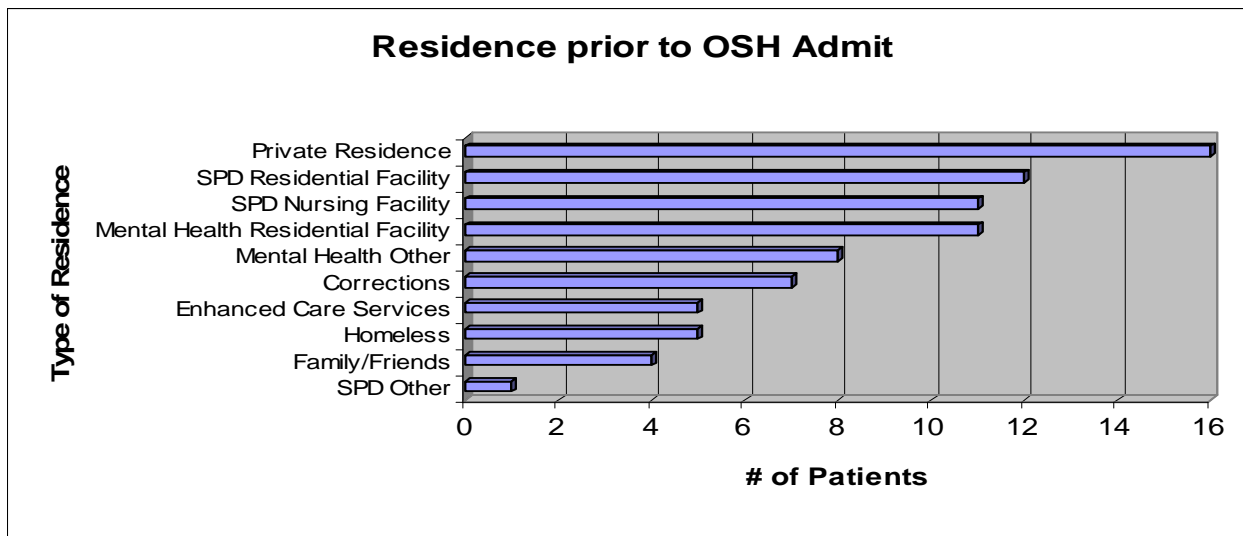
Acute care hospitals are the main referral sources to GTS. Other referral agents are corrections, unit transfers within the hospital, mental health

facilities, SPD-licensed nursing facilities, Eastern Oregon Psychiatric Center (now known as Blue Mountain Recovery Center)/Dammasch (no longer in existence) and the VA Medical Center.

Residence prior to GTS admission

A total of 29 patients (36 percent of the surveyed individuals) lived in an SPD facility⁶ prior to admission to GTS. Of the 29 patients previously living in an SPD facility, five individuals resided in Enhanced Care Services programs⁷ prior to GTS admission. Sixteen individuals (20 percent) lived in a private residence before GTS admission. Nineteen individuals lived in mental health-licensed residential facilities⁸ or other mental health licensed programs. Sixteen patients were previously housed in either a Corrections facility, were homeless or were living with a family member or friend. See Illustration 2.

Illustration 2



⁶ The SPD service system includes nursing facilities, residential care facilities, assisted living facilities, foster homes, in-home services as well as specialized programs such as Enhanced Care Services and Enhanced Care Outreach Services.

⁷ Enhanced Care Services is a jointly managed program between SPD and AMH. It is the state's highest level of community-based care for SPD service eligible people with behavioral and psychiatric disturbances. The program was designed to support the hard-to-place persons being discharged from GTS.

⁸ Non-SPD levels of care include Secure Residential Treatment Facilities, Residential Treatment Facilities, Adult Foster Care, supportive housing, and private residences.

Responsible system for discharge planning

Sixty-eight, or 85 percent, of the 80 GTS patients were assumed likely to be SPD service eligible based on the 10-item screening conducted by the data collectors. Of these 68 likely-SPD patients, eight were under the jurisdiction of the Psychiatric Security Review Board (PSRB).⁹ Mental Health Organizations were assumed to be the discharge planning partners for at least three GTS patients.¹⁰ PSRB was assumed to have responsibility to review appropriateness of community residence and services for a total of 12 GTS patients (including the eight that were also likely-SPD service eligible). See Illustration 3.

Illustration 3

Discharge Planning Partners Distribution N=80		
Planning Partner*	Sub Totals	%
Likely SPD	68	85%
PRS/MHO	3	4%
PSRB	12	15%
Unknown	9	11%
* not mutually exclusive		
<hr/>		
Age Distribution		
Discharge Planning Partner	Less than 65	65 or over
Likely SPD	28	32
PSRB -SPD	3	5
PSRB	4	0
PRS/MHO	2	1
Unknown	3	2
Totals	40	40

⁹ When someone commits a crime and is found by the courts to be “guilty except for insanity,” he or she is placed under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB). While under PSRB jurisdiction, an individual can be housed in the Oregon State Hospital or in a variety of residential treatment settings, ranging from secure residential treatment facilities to independent living. The PSRB determines what kind of facility is appropriate based on the level of treatment, care and supervision required.

¹⁰ AMH made county mental health program involvement a priority early in the discharge planning process.

Behavior

The 10 most common behaviors exhibited by GTS patients are: night time behaviors (65 percent);¹¹ isolation (62 percent); elopement risk (59 percent); intrusive behavior (58 percent); behaviors driven by fixed delusions (56 percent); aggressive behavior with risk of or actual injury to others (53 percent); verbal aggression (47 percent); resistance with activities of daily living (ADL)¹² (42 percent); physical sexually-inappropriate behaviors (35 percent); and verbal sexually-inappropriate behaviors (32 percent). Illustration 4 illustrates the point.

Illustration 4: Top Ten Behaviors

Top 10 behaviors being managed	% of sample	deemed barrier to placement by staff
Night time behaviors	65%	60%
Isolation	62%	6%
Elopement Risk	59%	54%
Intrusive behavior	58%	38%
Behaviors driven by fixed delusions	56%	49%
Aggressive Behavior with risk of or actual injury to others	53%	91%
Verbal Aggression	47%	63%
ADL Resistance	42%	85%
Physical sexually inappropriate behaviors	35%	75%
Verbally sexually inappropriate behaviors	32%	58%

These behaviors were categorized as being just an interruption or nuisance to staff and/or others at the low end, to a level of severity that put themselves or others at risk of harm or actually caused themselves or others harm. GTS staff indicates that for 91 percent of all GTS patients with aggressive behaviors, the aggressive behaviors are a barrier to discharge.

¹¹ It is important to note that 'night time behaviors' are the same behaviors exhibited during the day, but are more difficult to manage at night when staff to patient ratios may be lower and the disruptions may perturb other residents.

¹² ADLs are categorized as mobility, eating, elimination and cognition.

Recidivism

Ten of the individuals in the data survey had previous treatment episodes at OSH. See next section for a full analysis on recidivism for these individuals in the data survey as well as the 24 who experienced multiple acute hospitalizations before being referred to OSH GTS.

Guardianship

Guardianship was reported to be a significant barrier to discharge, most notably for individuals exhibiting the most challenging behaviors. Of the SPD-likely group seeking community options, 29 (42 percent) have guardians and 39 (57 percent) do not. It was reported by both OSH staff and community stakeholders that there are very little resources to employ and pay for professional guardians statewide.

Screening Analysis

The Addictions and Mental Health Division approves admissions into the four GTS units at Oregon State Hospital. To be admitted to Oregon State Hospital GTS, an individual must be civilly committed or have a legal guardian. In addition, the individual must have been evaluated by an acute medical team to ensure that a complete and thorough medical evaluation has occurred and ruled out all reversible causes of mental status changes. See Appendix C for the current GTS Admission Screening tool used by Addictions and Mental Health.

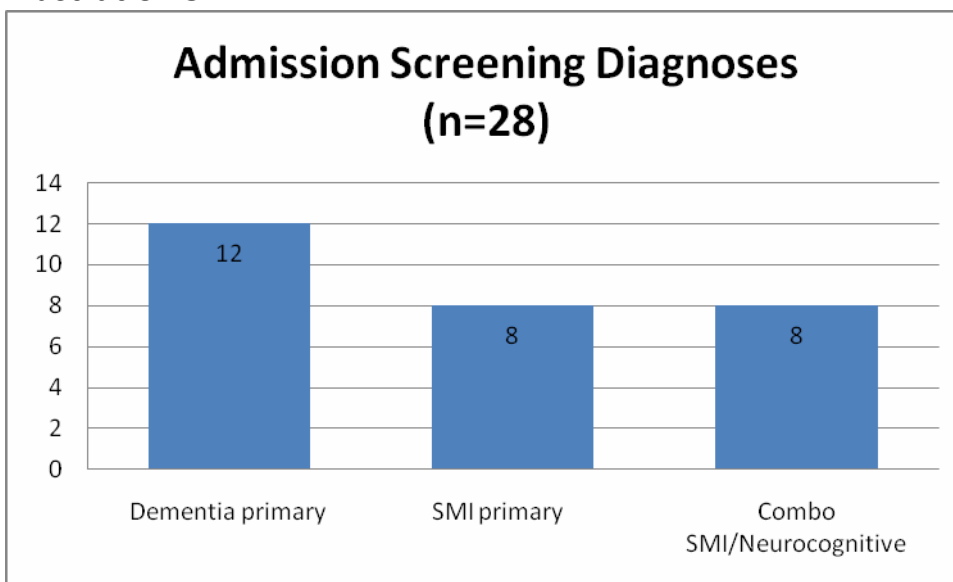
An analysis of individuals referred and admitted to the Geropsychiatric Treatment Services was conducted between January 2010 and August 2010. Twenty-eight people were admitted to one of the four GTS units. The sample comprised 18 males and 10 females ranging in age from 38 – 68. Seventy percent were over 65 years old. Nearly half of the 28 individuals admitted to GTS from January through August had a primary diagnosis of dementia but without a serious mental illness (SMI) diagnosis¹³. It is the

¹³ The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, also known as *DSM-IV-TR*, is a manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders. While the DSM-IV does consider dementia as a mental disorder, dementia is not a serious mental illness

opinion of OSH professional staff and the writer of this report that these individuals may not be appropriate for a state psychiatric hospital and are better served in low-stimulation community environments with caregivers trained in caring for individuals with dementia at all stages of the disease.

The remaining half of the sample had either a primary diagnosis of SMI without an accompanying dementia, or had some combination of dementia and SMI, acquired brain injury (ABI) and a co-morbid SMI diagnosis, or dementia related to an ABI. See Illustration 5.

Illustration 5



In this sample, the primary reasons for referral to acute care were physically aggressive behaviors and disorganization, and delirium with exacerbated psychiatric symptoms. Consistent with stakeholder information, **it is primarily the behavior rather than diagnosis that brings a referral to acute care and ultimately the state hospital.** Eighteen individuals were referred to acute care services for unpredictable physical aggression or physical aggression directed at others,¹⁴ and one person was

such as schizophrenia, a condition that an individual can manage and recover from with psychiatric rehabilitative therapies. See footnote 5.

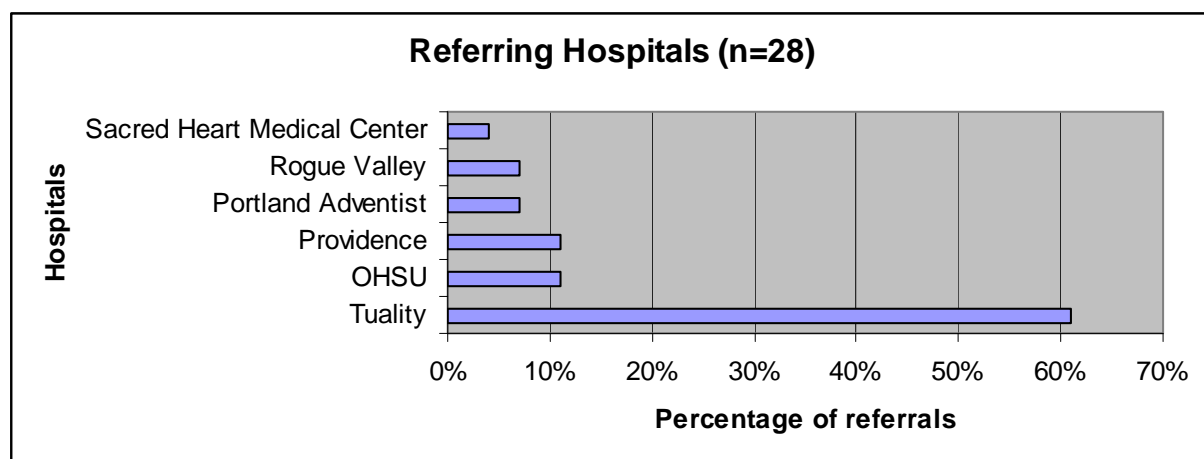
¹⁴ Admission reports described physical aggression as ranging from the most dangerous type of physical aggression, unpredictable severe physical aggression, to lesser degrees of physical aggression such as predictably severe physical aggression, predictable physical aggression and combativeness during nursing care or personal care services.

referred for significant property destruction and threatening behavior associated with HIV-positive status. The remaining nine were referred to acute care services because of significant disorganization, delirium and associated exacerbation of psychiatric symptoms.

Individuals who are not successfully stabilized at acute care hospitals are referred to OSH GTS. Generally, an unsuccessful stabilization means that either the individual needs continued medication management in order to reach a stable condition or the individual requires additional behavior management resources leading to an effective behavior plan that maintains an individual's stable periods. Neither condition represents an "acute" episode.

It is important to note that most GTS referrals in the screening sample come from Tuality Forest Grove Center for Geriatric Psychiatry (TFGCP), the only facility in the state specializing in geriatric psychiatry. Only 10 percent of their 400-plus yearly census is actually referred to OSH, a testament to the importance of gerospecialists to the success of community living for this population. See Illustration 6 for a breakdown of referring acute care hospitals.

Illustration 6



Admission reports from social workers, attending physicians and descriptions from community-based providers appeared to distinguish between these levels of aggression in their documentation.

Twenty-four (86 percent) individuals had two or more acute hospitalizations within the last five years. Fifteen people, whose primary diagnosis included both an SMI and a dementia or other cognitive disorder, had at least one previous hospitalization.

Of those individuals with a primary diagnosis of dementia, one-quarter had no previous psychiatric hospitalization noted in their clinical record. This suggests that dementia-related behaviors, behaviors that can be indistinguishable from behaviors related to severe and persistent mental illness, should be managed earlier and better in the community to avoid crisis and acute care hospitalization.

Among the individuals with multiple hospitalizations in the screening sample, three were also among the 80 in the OSH data sample. The three individuals appearing in both the screening sample and the OSH data sample had a serious mental illness and a dementia and/or cognitive disorder. Two of the three individuals in both the screening sample and the OSH data sample were receiving services from enhanced care facilities prior to their acute care hospitalizations and subsequent admission to GTS.

All levels of care from both the mental health and the SPD systems prior to admission to acute care hospitals are represented in the screening sample.

GTS Data Analysis Conclusions

The data analysis of persons screened for admission and receiving treatment at Oregon State Hospital Geropsychiatric Treatment Services shows two important trends. First, most individuals are likely to be SPD service eligible and approximately 43 percent were living in or being served by the SPD system before the acute hospitalization that led to their referral to OSH GTS. Moreover, 25 percent of the individuals receiving treatment at OSH and about 30 percent of the screening sample had a primary diagnosis of dementia or other neurocognitive disease and did not have a primary diagnosis of serious mental illness commonly or statutorily defined as “non-organic.” This suggests a significant gap in community services to older adults and younger adults with disabilities.

Second, despite the differences in diagnostic categories or the fact that some individuals had what is referred to as an organic brain syndrome and some had a serious psychiatric or mental illness, there was substantial overlap in the top 10 behaviors or symptoms which individuals presented. Symptom and service needs ranged from those needing complex psychiatric and medical services to those demonstrating self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, problematic medication needs (or medication non-compliance), sexually inappropriate behaviors, and elopement risk. Although these categories of behavioral disturbances are similar to those demonstrated by people receiving treatment in lower levels of care, such as Enhanced Care Services, managing these particularly severe behaviors requires interventions that have, to date, only been available in an acute psychiatric setting.

Therefore, the NewPATH population is defined as:

Older adults and younger adults with disabilities who present with chronic (rather than acute) or a disease course that includes severe and frequent behaviors and psychiatric symptoms such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, problematic medication needs (or medication non-compliance), sexually inappropriate behaviors, and elopement risk due to the degenerative nature of their disease or illness that cannot be cared for well in the SPD or community mental health system as they exist today.

Specific gaps in services within the current systems are discussed in the next section of this report.

At least 18 individuals (23 percent) in the survey who currently reside at OSH GTS can be considered NewPATH appropriate. Average length of stay for these 18 individuals is five years. According to US census data, among the 50 states and the District of Columbia, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Therefore, while today's OSH GTS census includes only 18 individuals that are candidates for a higher level of long-term community-based care, Oregon

faces a greater need annually over the next two decades. Unless this need is planned for now, the state psychiatric hospital will once again be over utilized and more costly to the state for the long term care of the NewPATH population. The earlier budget projection for a capacity of 70 community beds by 2027 reflects this growing population of Oregonians.

Community Resources

Current Systems Analysis

Overview of the SPD System

Seniors and People with Disabilities provides services to seniors, adults with physical disabilities, and children and adults with developmental disabilities through long-term care programs, financial assistance programs and through the administration of the Older Americans Act. Services to seniors and adults with physical disabilities are provided through the Aged and People with Disabilities (APD) section of SPD, which is referred to as SPD in this report. Long-term care services provided by SPD include home and community-based care services and nursing facility services.

Since 1981, Oregon has led the nation in developing lower-cost alternatives to nursing facility care. (See Appendix E for a full overview of SPD services.) Community-based care facilities provide 24-hour care and services for seniors and younger adults with physical disabilities. Services include assistance with activities of daily living, medication oversight, nursing and behavioral supports to meet complex needs, and social activities. Community-based care facilities must meet extensive state and federal guidelines related to health and safety.

SPD services are coordinated in the community by local offices of SPD or Area Agencies on Aging. SPD serves 18,000 older adults and 8,500 younger adults with disabilities through its Medicaid long-term care services in home and community-based care and nursing facilities.

SPD faces several challenges in the next decade. These include the state's changing demographics as Oregonians age, unsustainable growth in the cost of nursing facility care, lack of provider capacity, increased need to provide

protection for vulnerable adults, and recruitment and retention of a long-term care workforce.

Oregon has developed one type of program, Enhanced Care Services, with intensive psychiatric services and supports hosted in a home and community-based care licensed setting, to support SPD-eligible individuals in the community. There are currently 10 enhanced care facilities with a capacity of 140 residents. Additionally, Enhanced Care Outreach Services (ECOS) are available to some individuals living in a less restrictive environment; current capacity is 86 clients. While the ECS has functioned well and served many patients with challenging issues effectively in the past 20 years, it has not been able to meet the needs of the GTS patients with the most severe behavioral/ psychiatric needs—The NewPATH population.

Although the Enhanced Care Services program has been a successful discharge route out of OSH GTS and has served as a diversion option for some individuals referred to GTS, Enhanced Care Services was never designed to prevent individuals living in non-enhanced home and community-based care or long-term care (i.e. nursing) facilities from developing symptoms and behaviors that result in the need for a higher intensity of services currently only available at OSH or ECS.

Overview of Addictions and Mental Health (AMH) System for SPD service-eligible individuals

AMH is committed to an integrated health care delivery system that allows individuals with mental illness to live quality lives in the least restrictive environment possible. The Oregon Health Authority (OHA) was created by the 2009 Oregon Legislature to bring most health-related programs in the state into a single agency and transform the health care system in Oregon (http://www.oregon.gov/OHA/features/feature_what_is_oha.shtml). The Addictions and Mental Health Division will fully transition to this new agency by the end of June 2011.

In 2008, at the request of the Oregon Legislative Assembly, DHS was directed to conduct an assessment of the adult community mental health system. The Public Consulting Group (PCG) report provides a

comprehensive overview of funding, mental health programs, services and regulations, a gap analysis, investment analysis, summary of expected outcomes, a strengths and weakness analysis, as well as recommendations.

One of the most significant findings published in the PCG report was that the mental health needs of underserved populations were not being met and should receive more attention. Seniors (older adults over age 65) and individuals with disabilities were noted to be among the underserved populations (PCG, recommendation five, Page 15). Only two counties were recognized for providing services to older adults. In general, the report concluded that AMH support for services designed to meet the needs of older adults over the past decade was spotty at best. Enhanced Care Services and the attention toward older adult suicide prevention in 2003–2006 were noted to be the exceptions. It should be noted that the Addictions and Mental Health Division has consistently sought funding for this population through the state budget process without success.

The report noted that AMH does not have a specific office or program with multiple staff supporting community-based services for older adults and individuals with disabilities (PCG, page 74). Another important finding was the low penetration rate among older adults enrolled in Mental Health Organizations or a disparity in the number of individuals over the age of 65 who received services compared to the expected prevalence rates of mental disorders among the same population. The most recent data, prepared in January 2009 by the AMH Program Analysis and Evaluation Team, shows that enrollment in mental health organizations averaged 7.51 percent for individuals 65 years and older in the first two quarters of 2008. However only 3.73 percent of the 28,300 people age 65 and older enrolled in mental health organizations received services compared to about 34.24 percent of enrollees age 18-64. Penetration rates for older adults decreased slightly over the last two quarters of 2007.

The final position advanced by the PCG report was that a “silo” effect in the management of DHS programs may result in difficulty identifying who is responsible for meeting the needs of seniors with mental illness or individuals with a disability coping with a mental illness. The Community Services Workgroup also concludes that “traditional funding and targeted

programmatic funding silos do not serve the best interest of the individuals we need to serve” (2009 Community Services Workgroup Report, Page 4). On July 1, 2011, the newly created Oregon Health Authority (OHA) will have oversight of Addictions and Mental Health and DHS will have oversight of Senior and People with Disabilities programs. This realignment presents an opportunity for increased health care integration strategies on behalf of this vulnerable population.

AMH supports community mental health services for SPD-eligible individuals primarily through three Service Elements: SE 31, 35 and 36. (See Appendix F for a detailed look at funding and services provided through AMH Service Elements.) Funds from Service Elements are disbursed directly to the local mental health authority or in some cases to a specific contractor. Service Element 31 funds Enhanced Care Services.

In addition to the mental health benefit available to Oregon Health Plan SPD-eligible individuals, Service Element 35 funds services by geropspecialists in some, but not all counties, to Medicaid recipients. Services include, but are not limited to, outreach assessment and evaluation, brief engagement counseling, medication management, quarterly interagency ‘staffings,’ follow-up services after treatment in local or state inpatient psychiatric hospitals, screening and referral, and consultation and training to agencies and caregivers. It needs to be noted that access to the OHP mental health benefit is problematic for some individuals living in long-term care due to access and an interpretation of ‘mental illness’ that prevents individuals with dementia or acquired brain injury from being eligible for traditional mental health services.

Community assessment data discussed in the next section indicate that these two funding mechanisms are insufficient to adequately provide services to those in need.

Service Element 36 is used to fund the Oregon’s Preadmission Screening and Resident Review program (PASRR). PASRR is a federally mandated program and must be included in all state Medicaid plans. As the State Mental Health Authority, AMH is charged by the state Medicaid agency to implement PASRR. PASRR’s primary purpose is to screen individuals (both

older adults and younger adults with disabilities) referred to nursing facilities to deter individuals with a serious mental illness from being inappropriately placed in a nursing facility, or to ensure that individuals residing in a nursing facility are linked to mental health services if determined to have a serious mental illness. **According to federal regulations, this is not a clinical service, but rather an administrative determination.**

There remains a need to develop specialty services for this aging population.

According to the OSH GTS a significant number of current GTS patients lived in an SPD nursing facility or a home and community-based setting before their GTS admission. In Oregon, while a person needs to be qualified for nursing facility level of care to qualify for the 1915 (c) waiver,¹⁵ individuals forfeit many rights to services if they choose community-based care as opposed to living in a nursing facility. For instance, they do not receive PASRR screenings and therefore do not get early identification and mental health intervention, often resulting in acute or psychiatric hospitalization.

Among the individuals in the screening analysis not enrolled in ECS, the first contact with gerospecialists or licensed medical professionals trained in geriatric mental health and capable of conducting a comprehensive mental health assessment was in acute care. Gaps in early identification or preventive mental health services to SPD-eligible individuals can be explained by many factors, not the least of which is that many individuals are dual eligible or are Medicare beneficiaries and Medicare is the first

¹⁵ States may offer a variety of services to consumers under a Home and Community Based Services (HCBS) waiver program (1915 c) and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental modifications). States have the discretion to choose the number of consumers to serve in a HCBS waiver program. Once approved by Center for Medicare and Medicaid Services (CMS), a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval. In Oregon, the HCBS program is managed through SPD.

payer for acute care services. It is important that providers take steps necessary to bill all available sources.

Community Survey Data Analysis

A community assessment was conducted of SPD- and AMH-licensed providers, physicians, mental health staff, and SPD managers with expertise in serving people with complex psychiatric/ behavioral and/or neurocognitive issues (i.e. stakeholders) to determine community strengths, gaps, and needs. See Appendix D for a list of the stakeholders who participated in the community assessment interviews and the specific questions used to frame each discussion. The Core Team spoke with representatives of eight SPD/APD-licensed residential facilities, seven AMH-licensed residential facilities, five developmentally disabled residential facilities (including State Operated Community Programs), eight county offices, two state advocacy agencies, and four acute care hospitals. The interviews were largely conducted with an open format; interviewees were free to raise issues of interest.

Analyses of the content of the stakeholder discussions were qualitative with themes rank-ordered by the frequency various stakeholders raised them. For NewPATH purposes, relevant findings were organized into five broad themes: (1) Specialty models; (2) Service gaps; (3) Liability, client rights, and state involvement; (4) Components of successful community-based program; (5) Behaviors that have caused community-based programs to deny admission to discharging OSH GTS patients. The specific comments under each theme were rank-ordered based on the number of providers or community experts who offered the comment during the interviews. While not exhaustive, the comments *most voiced* by providers are noted under each theme below.

1. Specialty models

- The state should develop programs for different populations of individuals to be discharged from GTS. Populations include: (a) individuals with physical aggression and impulsivity; (b) individuals

with multiple, challenging medical and psychiatric issues; and (c) individuals with personality disorder.

- To admit more challenging residents into community programs, the provider needs the following service components: (a) higher staffing ratios; (b) ability to do show of concern and holds; (c) ability to give intramuscular injections; and (d) crisis behavioral support.
- Multidisciplinary Team (MDT) is a good community model to prevent institutionalization of vulnerable older adults and younger adults with physical disabilities who may have mental illness. It is a good model to support challenging clients in the community.
- Developmental disability four to five-bed home model includes important service components that support people with high behavioral needs in the community. Components include: (a) capacity much less than typical 16-bed ECS programs; (b) centralized extensive training program to develop excellent staff skills; (c) use of positive behavioral supports and individualized activities; and (d) use of more intensive behavioral interventions not implemented in current SPD-licensed settings.

2. Service gaps

- Lack of a range of mental health services in SPD community-based care
- Lack of coordination, collaboration and planning between SPD and MH for shared clients
- Lack of training for SPD providers, SPD case managers, and mental health providers for the management and intervention in combative or aggressive behaviors, and to address needs of residents with complex mental health issues
- Lack of training for law enforcement on how to intervene with individuals in long term care with aggressive behaviors
- There is need for formal process for discharge from OSH to SPD that includes local community mental health programs setting up treatment plans before discharge to community-based care
- There is a need to establish guardianship to expedite discharging GTS patients

3. Liability, client rights, and state involvement

- It is difficult to balance client rights with client safety and a mandate that providers keep residents safe
- Community perception that the state is expecting SPD and mental health providers to assume too much liability
- New abuse laws¹⁶ are punitive to providers and, as a result, some providers are unwilling to admit the more challenging individuals into their facilities

4. Components of successful community-based program

- Staff education
- Aides recognized as important members of the treatment team.
- Strong staff support and supervision
- Resident having own room

5. Behaviors that have caused community-based programs to deny admission to discharging OSH GTS patients

- Unpredictable aggression toward other residents and staff.
- Highly aggressive behavior
- Current or past history of sexually-offending or predatory behaviors
- Suicidal behavior
- Non-compliance with medications

Although qualitative, the comments of the SPD and mental health community providers, program managers, geropsychiatric experts, and advocates are illuminating. They identify community needs and provide direction for new community services. Community stakeholder comments supported the GTS clinical data that some groups of patients—those with

¹⁶ The authors of this report believe that the new abuse laws being referred to here are the amended definition of ‘abuse’ in OAR 411-020-0002, Adult Protective Services – General. Providers expressed a fear of being accused of physical abuse if they use hands-on interventions in the administering of care, or feeding through a gastro-tube, or use of a physical or chemical restraint, even if these interventions are well documented in an appropriate care and behavior plan.

dementia or acquired brain injury and highly aggressive behaviors; those with sexually-inappropriate or offending behaviors; and those with personality disorders—are difficult to serve in existing community resources.

The specialty model comments suggest the development of a new SPD service model that incorporates features and policies of the existing developmental disability (DD) home model. The DD model was developed in the early 1990s for clients with disabilities with intensive behavioral and/or medical needs who were discharged with the closure of Fairview Training Center. The DD home model includes important service components that could be implemented in a community-based hospital replacement model in lieu of GTS services at OSH-Junction City. This report recommends a higher level of community-based care for the NewPATH population that is not only person-centered, but also sustainable for the long term.

The most commented-upon gap in community services was the lack of outreach mental health services to individuals in the SPD community-based care and nursing facilities. For example, mental health organizations are not compensated for travel through Medicaid and are, therefore, reluctant to provide outreach and wrap around services to clients where they live. “In 2003, The President’s New Freedom Commission Subcommittee on Older Adults and Mental Health identified a fundamental problem in the way the mental health community provides treatment: a ‘mismatch between the current system of care and the needs and preferences of older adults.’ Although research points to the effectiveness of home- and community-based treatments, most mental health services are offered only in settings older adults may not have access to or may feel uncomfortable in, such as hospitals, mental health clinics, and psychiatrists’ offices” (Townsend, 2007, Page 5). This lack of access to services results in a lack of early identification of mental health needs, low enrollment of this population in mental health organizations, and increased crisis in the community leading to increased bed days at local acute care hospitals. State funding for the indirect costs would enable mental health organizations to provide services where the services are needed most.

The second most voiced service gap was the lack of collaboration and planning between local SPD and community mental health offices. This is consistent with previous reports that point to divisional silos as a detriment to the care and treatment for older adults and younger adults with disabilities.

Several SPD and mental health providers voiced concerns about liability once they have admitted a client with challenging issues to their residential programs. While referencing state licensing surveys, which occur every few years and are focused on a narrow view of 'health and safety,' they indicated the state should be supportive rather than punitive. Incidents of peer-to-peer injuries due to the nature of residents' disease effects and documented claims of abuse or neglect, whether substantiated or not, do happen from time to time in these types of communal environments. These incidents are documented and published as statistics without context. The fear of being reported or perceived as an unsafe program is real and providers are reluctant to assume the risks associated with individuals with a baseline of challenging behaviors found among discharging GTS patients identified as NewPATH.

Community partners made a number of statements about the components of successful community-based programs. The major theme in these was that providing good supervision, intensive training, and empowering caregivers or aides are critical features of a successful community-based program.

Five behaviors most noted as behaviors "not appropriate" for the community such that they are denied admission to community-based care environments, are referenced in the survey summary above. While some community-based providers may believe that individuals exhibiting or having a history of these behaviors are inappropriate for community living, this is not the opinion of the State of Oregon.

Finally, the lack of guardianship was identified as a barrier to discharge by SPD, OSH and mental health program staff. OSH GTS staff identified lack of guardianship as a barrier to discharge for 26 of the 80 individuals in the data collection, or 33 percent. Funding and availability of professional

guardians is one reason for the service gap. Work to more fully understand the guardianship issue is being undertaken in AMH at this time.

Conclusion

Oregon's current SPD system of care serves all but the most severely challenged (i.e. the NewPATH population) of SPD-eligible populations in an expansive network of providers and local SPD/Area Agencies on Aging offices. Addictions and Mental Health has been unsuccessful in obtaining funding to champion and develop programs and gerospecialists for older adults and young adults with disabilities. The community assessment done as part of this report suggests a need for increased provider accountability and state oversight. Areas of opportunity identified here include early identification and preventative mental health services to SPD-eligible individuals, better-coordinated mental health and SPD services, and additional long-term community-based care for the NewPATH population.

Identifying Internal Barriers: NewPATH Current State Process

The NewPATH team created a process map of the cross-divisional referral, admissions, and placement planning process for OSH GTS to understand internal barriers and identify opportunities to make immediate impact for the NewPATH population. (See Appendix G for current state map.) Staff from SPD, AMH, and OSH participated in multiple mapping sessions. Five points of the process were identified as opportunities for diversion from hospitalization or areas that slow or stop a patient's discharge from OSH. The five areas are: OSH GTS Admission Criteria; SPD involvement at admission for more appropriate and successful placement planning; OSH social worker to patient ratio; the function of the Exceptional Barriers Review Committee; and Enhanced Care Services Capacity and Referrals to OSH.

OSH GTS Admission Criteria

Twenty-five percent of individuals admitted to the OSH GTS do not have a serious mental illness amenable to psychiatric rehabilitation, but rather have severe behaviors or severe mental health symptoms related to their

dementia or other neurocognitive disorders, such as acquired brain injury or Huntington's Disease (See footnote 13). While mental health professionals use a recovery-based model of treatment for individuals with SMI, meaning the therapist helps the patient to maximize the stable phases of their lives, the approach for working with individuals with dementia and neurocognitive disorders is different. In this case, therapists rely on environmental and staffing interventions to minimize the symptoms. Cognitively, these individuals are not able to internalize ways of managing their disorder, and therefore aren't able to recover. Anecdotal reports from key Oregon State Hospital and AMH staff suggest that if there were appropriate community-based services to treat and manage the behaviors of individuals with behaviors related to only dementia or neurocognitive disorders, they would not be admitted to OSH GTS at all. Reduction of these admissions would negate the need for GTS beds in OSH-Junction City.

Early SPD Involvement in Placement Planning

Eighty-five percent of the current GTS population at OSH is likely SPD service eligible. Yet, there is no SPD representative involved early in the placement planning process to facilitate timely and appropriate community-based opportunities in preparation for discharge. This often delays or halts discharge for persons who are seeking ECS or NewPATH level of care.

While AMH initiatives have made county community mental health program involvement a priority early in the discharge planning process, the majority of GTS patients (SPD-eligible upon discharge) are not being served under the Adult Mental Health Initiative currently administering new co-management policies.

The NewPATH population would benefit greatly from one or both divisions taking proactive responsibility for the timely and appropriate discharge to less restrictive community-based care programs. This particular service gap is most evident in lengths of stay for individuals designated 'ready to place' by the treatment team.

While SPD has added a central staff member who is familiar with all the appropriate residences and facilities licensed by SPD to interact more

closely with the social workers at OSH GTS, it is yet unclear what impact this will have on timely and appropriate discharge for the NewPATH population.

OSH Social Worker to Patient Ratio

There is a debate at OSH about the role of a social worker. Liberty Healthcare Corporation issued a Quality and Compliance External Review Report to the OSH and DHS in August of 2010, stating that “The Social Work Department has primary responsibility for discharge planning, which is vitally important to a recovery-oriented public psychiatric hospital. With 15 reported vacancies, this function is being under-served, which has the potential for increasing the rate of hospital readmissions and other negative outcomes, including mortality. There is a critical need to bolster recruiting for Social Workers at OSH” (Page 31). At the time of this writing, the Oregon State Hospital is approved to hire new social work positions as new programs open at the new Salem facility, which means that staffing for the GTS units won’t increase until the new Springs units open. Additionally, the number of social workers hired for the Harbors units, the first to open in January 2011, was reduced from five to three.

The Oregon State Hospital is using the Liberty Healthcare report and hired Kauffman Global consultants to continue improvement efforts already under way.

Exceptional Barriers Review Committee

The Exceptional Barriers Review Committee (EBRC) was established at the time of the settlement (2004)¹⁷ of a law suit brought under the Americans with Disabilities Act (ADA) and the Olmstead Supreme Court decision to facilitate the discharge of individuals at OSH who had ‘exceptional’ barriers to community placement. AMH created 1 FTE position to manage this process. AMH development was involved in individualizing appropriate

¹⁷ A Class Action filed in 2000 on behalf of civilly committed patients in Oregon’s state hospitals. A Settlement Agreement was reached in 2004 which required DHS to develop 75 new licensed placements and/or supported housing, discharge at least 31 class members, begin discharge planning upon hospital admission, refer any patient who was not placed within 90 of being ready-to-place to an Extended Care Management Unit for assistance in placing, develop a fund to assist with exceptional barriers to placement which would start with \$1.5 million, and develop a process to monitor vacancies in community facilities.

community care facilities. The OSH data analysis conducted by the NewPATH project revealed that at least 16 individuals were designated “EBRC” from the sample of 80.

This committee is currently under review to determine the best use of these resources. The committee is not active at the time of this writing.

Enhanced Care Services Capacity and Referrals

ECS facilities are licensed by SPD and AMH funds on-site wrap-around mental health services to individuals discharged from OSH GTS. Currently, some ECS facilities have prolonged lengths of stay and low discharge rates. Nineteen referrals to ECS were made from GTS as of October 10, 2010. There was one residential treatment vacancy for a male available as of October 10. It is not uncommon for individuals ready to live in a less restrictive community environment to remain on multiple ECS waiting lists for months at a time.

An AMH/SPD collaborative workgroup is being created to map the current Enhanced Care Services (from referral to discharge into less restrictive environments) and begin looking for ways to relieve this bottleneck in the community-based care system.

One additional and important barrier discovered during the process of gathering data on the OSH GTS population and service systems is the lack of a comprehensive and meaningful data structure offering timely and user-friendly outputs and reports. No database used at Oregon State Hospital, central AMH or central SPD is comprehensive, in and of itself; nor do any of the database programs being utilized or considered interface with one another. The efforts necessary to gather, organize, and analyze institutional and community-based data with the disparate systems currently in place are far beyond the resources available at this time. Given the time it takes to create meaningful data sets and reports, there is very little data-driven front-line program management occurring.

Past is Prologue – Oregon Workgroup Analysis

The NewPATH core team reviewed other work group reports and mental health planning documents concerning community-based care and OSH GTS utilization dating back to 1988. It is clear that with few exceptions, the content in these reports paid little attention to the needs of older adults and younger adults with disabilities. The 2009 Report to the Oregon Legislature on the Progress of the Planning for Local Mental Health Services summarizes all local mental health authority implementation plans. Implementation plans are supposed to detail how each Oregon county will meet the mental health needs of its populations. The report noted that: “Almost universally, every local plan talked about the gap in mental health services for its older adult population (even those with programs for this particular population)” (DHS, 2009).

Version I and Version II of the Oregon Department of Human Services Community Services Workgroup Report (2007 and 2009) complement the Master Plan Phase II Report on the Replacement of the Oregon State Hospital. The Oregon State Hospital Master Plan is the overarching strategic plan from which the NewPATH team operates. The Master Plan and the subsequent community services work groups advance that age-specific services should inform the development of community services and supports, and that several types of community investment in so-called “front end” and “back end services” were critical to assure that the new hospital would be utilized as planned. One such recommendation was to fund 33 qualified mental health professionals trained as gerospecialists.¹⁸

The 2007 Community Services Workgroup Report for the Oregon State Hospital Master Plan recommended that about 6.1 million dollars should be allocated to hire gerospecialists in the 2007-2009 biennium (2007, p. 27). At the time of this writing this investment has not been made by the

¹⁸ Other pertinent areas for public investment identified by the Community Services Workgroup included early intervention and prevention services for individuals between the ages 15-30, more crisis services for community mental health programs, increased funding for acute care services, more case management services, assertive community treatment programs, supportive employment programs, jail diversion and jail release programs and co-occurring disorder consultation.

Legislature, and given the current economic circumstances, new investment for 2011-13 is unlikely.

Although many of the workgroups advance the need for a systemic approach to the design and delivery of mental health care generally, and some support the need for age specific services in particular, it is not clear whether these recommendations ever moved past the planning phase. For example, in the 2009-2011 legislatively adopted key performance measures for the Department of Human Services cites several performance measures related to the mental health needs of children, adults and some related to abuse prevention among older adults are identified, however no key performance measures for age-specific mental health services or services targeted to younger adults with disabilities are defined. Despite the lack of key performance measures, some age-specific services for older adults and younger disabled adults exist but represent only a small portion of the overall funds used by AMH to fund the community mental health system.

AMH funds a narrow range of age-specific services, some of which are available to SPD-eligible individuals. In general though, funding levels for age-specific services for individuals outside the enhanced care system are inadequate. In fact, Oregon Revised Statutes were amended in SB 781 (2005) to encourage the provision of age-specific services; however, delivery of those services was predicated on availability of funds.¹⁹

Oregon applied for community-based care technical assistance through the New Freedom Initiative State Coalition. The subsequent report (2010) through the Bazelon Center for Mental Health Law recommended that “States must have clear policies and systems in place clarifying the proper role of hospitalization in a public mental health system that should be focused foremost on maintaining and supporting consumers in the community” (Seltzer, 2010, Page 2).

¹⁹ SB 781 (2005) amended several OARS to include age specific services and promote a framework for a system of care, subject to available funding. OARs affected by SB 781 (2005) include 430.640, 410.720, 430.665, 411.026, 411.027, 411.065, and 411.050.

Past is Prologue –National Perspective

Nationally, there is a call for an appropriate system of care for this aging population that includes integration of medical and mental health treatment, changes in Medicare payment policies and rate adjustments, outreach, service coordination and public education to reduce the stigma of mental illness that prevents older adults and their families from seeking help. Stephen J. Bartels, M.D., a prominent geropsychiatric researcher, makes the case that “Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care. Without adequate and effective treatment, mental disorders in older persons are associated with significant disability and impairment, including impaired independent and community-based functioning, compromised quality of life, cognitive impairment, increased caregiver stress, disability, increased mortality, and poor health outcomes. Older adults with mental health problems also have higher utilization and costs of healthcare services, but providing effective mental health services can result in cost offsets” (Bartels, 2003, Page 486).

A shining example of what can be done when a state values and champions a significant population needing mental health services is Oregon’s Statewide Children’s Wraparound Initiative. This system of care initiative has begun to transform Oregon’s approach to service delivery for children and youth with complex behavioral health needs. Initiatives like this have been successful in many states and forged innovative funding strategies and cost savings; deinstitutionalization; new accountability structures; cross agency and community collaborations; and increased positive outcomes for children. Oregon’s older adults and younger adults with disabilities who need mental health services would benefit greatly from a similar system of care.

Future State - NewPATH Recommendations

The fundamental position of the NewPATH core team is that new or enhanced services and supports tailored to meet the needs of older adults and younger adults with disabilities (SPD eligible), which includes the sub-

population NewPATH, will be effective only in the context of a robust system of services and supports for the SPD-service eligible population with serious mental illness and dementia, provided by both SPD and AMH and coordinated regionally across the state.

Mental health services for the SPD-eligible population have never been adequately funded, bringing the state to a critical decision point in light of the construction and reprogramming of the new Oregon State Hospital. Significant investment now in the development of community services and supports for older adults and younger adults with disabilities, such as has been done with the children's initiative, Wraparound Oregon, will save Oregon from future problems as the largest generation, Baby Boomers, ages and requires long-term care.

New community models of crisis management, stabilization and habilitative²⁰ long-term care are necessary to divert unnecessary acute and psychiatric hospitalizations, and give Oregonians the appropriate continuum of mental health services throughout the life span.

Six key issues have been identified as a result of this NewPATH assessment project and warrant immediate action in order to meet the growing mental health needs of older adults and younger adults with disabilities. The summary of those issues and recommendations follow. Full details of the recommendations begin on page 38.

Issue Summary

Note that the core team's work and recommendations were made without the benefit of the Governor's Balanced Budget for 2011-13. Only

²⁰ Habilitation services are defined in section 1915(c)(5)(A) of the Social Security Act as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. They are usually provided, for example, to individuals with developmental disabilities who need to learn new skills to live more independently. They are distinct from rehabilitation services which are usually provided to individuals who need to regain skills that are lost as a result of disability or illness (Shirk, 2006, Page 22).

recommendation three reflects the Governor's initiatives released on February 1, 2011.

1. Addictions and Mental Health needs a champion for older adults and younger adults with disabilities, including the NewPATH sub-population.
 - a. Champion should lead a cross-divisional unit dedicated to this population
 - i. Areas of responsibility for this unit could include all NewPATH programs, Enhanced Care Services, GTS admission screening, MED reviews, PASRR program, technical assistance and policy oversight for providers, and leadership for county-level Aging Services and Mental Health cooperation.
 - b. Reorganize existing resources from both SPD and AMH to create the unit
2. Lack of funding for indirect and specialized outreach costs limits mental health services to Medicaid-eligible older adults and younger adults with disabilities, including the NewPATH sub-population.
 - a. Specialized state funds need to be allocated for older adults and younger adults with disabilities that will assist with indirect costs for community mental health (un-reimbursable through Medicaid) and to develop regional gerospecialists
 - b. CMS codes may contain available billing codes for services provided by gerospecialists; this should be investigated
 - c. Analysis of county mental health plans should begin to identify the funding need
3. SPD and AMH should fully integrate and manage physical health, behavioral health, mental health and long term care services for older adults and younger adults with disabilities, including the NewPATH population.

- a. Align divisional policies for appropriate utilization of OSH GTS
 - b. Co-management hybrid program for the older adults and younger adults with disabilities population discharging from OSH GTS
 - c. Reorganize existing resources from both SPD and AMH to create a new unit for program oversight (see No. 1)
4. Oregon needs a new community model for long term *habilitative* care.
- a. Reallocate mental health funds for institutional care to a new habilitative care model (NewPATH community beds) that provide community-based crisis/stabilization and habilitative long-term care
 - b. SPD should review and revise policies specific to the needs and rights of individuals who are eligible for nursing facility (i.e. institutional) level of care but chose to live in a less restrictive community-based environment
5. Oregon needs to ensure high-quality person-centered care and provider accountability through training, performance contracts, oversight and outcomes monitoring.
- a. Allocate gerospecialist positions in the new cross-divisional unit dedicated to this population and tasked with provider support and monitoring
 - b. Develop need-based performance contracts and recruit and train specialized providers
 - c. Develop a state training and certification program for providers
6. Data collection and analysis should be more timely (nearly real-time) and serve as a program management tool.
- a. Select key management measures and reporting cycles for all outcome data collected.

- b. Create an interface between OWITS (or other community data collection software that may be developed in the future) and Avatar, the electronic health record software being launched by the Behavioral Health Integration Project in the Spring of 2011.

Issue DETAILS and Recommendations

The following pages provide additional background information for each issue stated above.

1. Addictions and Mental Health (AMH) needs a champion for older adults and younger adults with disabilities—i.e. the individuals eligible for seniors and people with disabilities (SPD) services

Wraparound Oregon is a prime example of what can be done when there is an effective champion engaged statewide on behalf of a specific population. The Wraparound model could easily be adapted to older adults and younger adults with disabilities who need intensive mental health services.

- a. Champion should lead a cross-divisional unit dedicated to this population
- b. Reorganize existing resources from both SPD and AMH to create the unit

Metrics: increased community-based care programs for older adults and younger adults with disabilities; increased enrollment in regional mental health organizations.

2. New funding models will help to provide early intervention and outreach mental health services which are key to preventing and/or delaying acute and state psychiatric hospitalization

Medicaid is a direct service model, meaning that Medicaid will pay only for face-to-face contact. No travel, for instance, is billable; therefore mental health organizations are less likely to provide “in-

home” services, the very type of service delivery necessary to reach the older adults and younger adults with disabilities population. Likewise, the coordination activities of a case manager may not be billable, lessening the care coordination and cross-agency communication by the mental health therapist on behalf of a mental health client (i.e. indirect costs). While Assertive Community Treatment (ACT) teams do include the indirect costs mentioned here, ACT has not been a model used with older adults.

One of the chief complaints in the community is the lack of coordination between agencies (mental health and SPD/AAA), a symptom of this funding issue.

Center for Medicare and Medicaid Services (CMS) dictates the billing codes for services. Oregon uses only a portion of what’s available to states. There may be a CMS code specific to the older adults and younger adults with disabilities population, covering the unique nature of a gerospecialist’s work. This should be investigated in order to provide the older adults and younger adults with disabilities and NewPATH subset populations with better access to mental health services.

- a. State funds need to be appropriated to pick up indirect costs for community mental health (un-reimbursable through Medicaid) and to develop regional gerospecialists.
- b. CMS codes may contain available billing codes for services provided by gerospecialists; this should be investigated.
- c. Analysis of county mental health plans should begin to identify the funding need.

Metrics: Decreased number of referrals to GTS of people who have dementia but no serious mental illness; decreased number of GTS population who are SPD-eligible at admission; increased regional MHO service delivery; decreased vacant bed days in community-based care facilities due to unplanned acute care hospitalization.

3. SPD and AMH should fully integrate and manage health care services for the care and treatment of the older adults and younger adults with disabilities who need mental health services and wish to live in a community-based long-term care environment.

The two divisions, SPD and AMH, need to come into alignment on the appropriate use of the Oregon State Hospital. Using the state hospital for the stabilization and long-term care of patients with dementia and those with behaviors associated with an acquired brain injury precludes the two divisions from developing less restrictive community-based living opportunities for this population.

Service and administrative silos, which hinder effective communication and person-centered care coordination, leads to negative outcomes for older adults and younger adults with disabilities with mental illness. Costly negative outcomes include acute care hospitalization and long term psychiatric hospitalization.

The Adult Mental Health Initiative (AMHI) seems to be carving out the SPD-eligible population such that the mental health organizations do not have responsibility for helping to place and subsequently serve the older adults and younger adults with disabilities SPD-eligible population. As was the case prior to AMHI, this will continue to lead to lengthy stays in OSH GTS after a patient has reached 'ready-to-place' status.

SPD rates need to be higher for the NewPATH population needing long-term care²¹. Current rates won't support the level of staffing (ratio and specialized skill sets) to safely and effectively care for this SPD-eligible population. Current rate structures are minimally person-centered.

²¹ It needs to be stated that at the writing of this document the state of Oregon is experiencing a significant financial crisis and the Governor and the leadership of both the Department of Human Services and the Oregon Health Authority have called for drastic cuts and greater efficiencies in program administration. By following the Governor's plan to "lower cost through integration of services; incentives for prevention; and community-based management of chronic conditions," Oregon should see a decrease in the NewPATH population seeking more costly long-term care and be able to fund adequately the programs necessary to care for the most challenging when they truly do need the highest-level of community-based care possible.

- a. Align divisional policies for appropriate utilization of OSH GTS
- b. Increase SPD rates for the care of NewPATH clients
- c. Co-management hybrid program for the older adults and younger adults with disabilities population discharging from OSH GTS
- d. Reorganize existing resources from both SPD and AMH to create a new unit for program oversight (see No. 1)

Metrics: Decreased lengths of stay for GTS population; increased community-based care facilities for the NewPATH population; decreased referrals to OSH GTS from SPD-licensed community-based care facilities; decreased number of referrals to GTS of people who have dementia but no serious mental illness; decreased number of GTS population who are SPD-eligible at admission; increased regional MHO service delivery.

4. A new long-term care model for older adults and younger adults with disabilities and NewPATH needs to adequately fund a habilitative program for dual-eligible individuals.

Currently, community mental health services need to be rehabilitative to be billable to Medicaid. The NewPATH subset, especially, will most likely need habilitative services for the long term. While the new 1915 i state plan amendment will cover habilitative services, the 1915 c waiver individuals served by SPD cannot also receive i state plan services. This is a significant group of individuals living in home and community-based care settings that are at risk of not receiving the mental health services they need to continue living in the least restrictive level of care.

AMH is currently in discussions with CMS regarding their definition of “rehabilitative.” The NewPATH population is not necessarily going to ‘recover’ from their illness due to the high level of cognitive impairment they experience and the natural cycle of the disease (such as dementia or Huntington’s Disease). If the definition of

‘rehabilitative’ could include preventative activities or environmental and staffing interventions with the aim of making improvements in an individual’s condition, but not necessarily ‘recovery’ focused, appropriate mental health services could be delivered and billed.

Key to this would be training providers on how to complete appropriate documentation that represents the true nature of the delivered services.

Meanwhile, general funds would need to be appropriated to fill in the gaps where Medicaid falls short. General funds for this purpose would most certainly be less costly in the community than at the State Hospital once individuals reach a severe crisis due to the lack of community-based mental health services.

- a. Reallocate mental health funds for institutional care to a new habilitative care model (NewPATH community beds) that provide community-based crisis/stabilization and habilitative long-term care
- b. SPD should review and revise policies specific to the needs and rights of individuals who are eligible for nursing facility (i.e. institutional) level of care but chose to live in a less restrictive community-based environment.

Metrics: Increased number of community-based care providers for the NewPATH population; decreased evictions from SPD-licensed community-based care providers; decreased number of referrals to GTS of people who have dementia but no serious mental illness; increased regional MHO enrollment;

5. Provider oversight and regular program monitoring for positive person-centered outcomes will ensure success for individuals with high-intensity needs wishing to live in the community.

There are no human resources in SPD or AMH for program oversight beyond annual or every-few-years licensing surveys, bringing provider accountability into question.

Once a contract is written with a provider, no follow-up is done unless a problem is reported or a crisis occurs. There are examples of where this has led to a shift from the original scope of work contracted or a lack of appropriate services being provided such that a crisis and/or eviction occurs unnecessarily.

An example of this type of shift is the case of Riverside Living in Portland. Riverside Enhanced Care Services was conceptualized as a high-intensity care and stabilization facility for individuals discharging from OSH and representative of the NewPATH population. A lack of monitoring, enforcement and adequate resources quickly led to the facility's inability and unwillingness to admit the individuals from OSH Geropsychiatric Treatment Services with the most challenging behaviors and medical needs.

A gero-outreach team could provide admission follow-up, staff training and performance-contract monitoring on behalf of the long-term resident to ensure success in the community.

A special unit to coordinate and monitor SPD and mental health services for this population would lead to better resident outcomes and more competent and supported service providers, both imperative for a healthy system serving older adults and younger adults with disabilities.

Only a person qualified for nursing facility level of care is qualified for the 1915 c waiver (home and community-based care waiver). However, if a person chooses the community-based provider rather than the nursing facility, they are not entitled to a PASRR screening. Other rights, such as right of return upon acute hospitalization, are also not afforded to an individual choosing less restrictive community-based care.

Once qualified for 'nursing facility level of care' an individual would benefit from the same rights and community-provided services,

services that would most likely cost less from the community than it would in An institution such as a nursing facility.

Contracts with providers are negotiated based a shared understanding of program needs. Service expectations are agreed to prior to signing the contract. Failed placements have resulted in some instances where the provider could not provide the services agreed upon. Some contracts are developed for a population without knowing the specific clients to fill the facility; and while some contracts are written for specific clients, this has not guaranteed a successful placement. There are no state resources to provide follow-up fidelity monitoring.

While some contracts within AMH do have a line item in the operating budget for provider staff training, the state does not provide any training or specialist care certification of its own to ensure a skilled workforce to care for the individuals with the most challenging behaviors and neurocognitive impairments. Only those providers who have additional resources to invest in their staff exhibit real success with the NewPATH population.

- c. Allocate gerospecialist positions in the new cross-divisional unit dedicated to this population and tasked with provider support and monitoring
- d. Develop performance contracts and recruit and train specialized providers
- e. Develop a state training and certification program for providers

Metrics: Increased number of licensed SPD and mental health providers who complete a state approved training program

6. Data collection and analysis should be more timely (nearly real-time) and more accurately reflect the mental health system, particularly where older adults and younger adults with disabilities are concerned, for actual program management.

Accurate and timely data should be collected based on real outcome expectations (collect only the data that is meaningful and build a system based on collecting the meaningful data).

There is no central comprehensive repository for meaningful state-wide data regarding mental health and SPD services being provided in the community.

The MMIS system is currently collecting 'encounter' data. The upgrades to the system were made without end-user consult, which has proven to slow the reporting process. The launch of the new database is two-years past now, and still all features aren't being implemented.

Provider network data is forwarded on a scantron form to the state research office and scanned into an electronic file. Hard copies are filed.

CPMS currently collects provider information and may be replaced by OWITS (Oregon Web Infrastructure for Treatment Services). A pilot is currently under way and the state is seeking sufficient funding for statewide implementation in 2011-13.

Avatar electronic health record software is being developed through the Behavioral Health Integration Project (BHIP) within the Oregon State Hospital Replacement Project. It will capture data at the OSH that will be critical for community-based care planning.

BHIP's electronic health record and OWITS treatment record software programs are being developed separately. None of these databases currently talks to each other.

- a. Select key management measures and reporting cycles for all outcome data collected.
- b. Create an interface between OWITS (or other community data collection software that may be developed in the future) and Avatar, the electronic health record software

being launched by the Behavioral Health Integration Project in the Spring of 2011.

Metrics: Eliminate backlog on report requests;

The NewPATH core team also recommends some important projects to be undertaken by the new cross-divisional unit dedicated to older adults and younger adults with disabilities.

1. Comprehensive mapping and subsequent improvement initiatives related to the Enhanced Care Services program.
2. Improvements to the OSH GTS referral process for acute care hospitals and other community-based referral agencies.
3. Comprehensive review of Oregon's PASRR program and possible expansion to individuals choosing to reside in community-based care facilities.
4. Develop training programs to include certification in areas such as dementia care, acquired brain injury, and personality disorders. Additional training on core competencies for providers that focuses on psychiatric and neurocognitive conditions, high-risk behaviors and psychiatric symptoms, and stabilization interventions is highly recommended.
5. Comprehensive review of guardianship programs and opportunities for expansion.

Final Thoughts

Every day, more than 10,000 Americans turn 65 years old. In September 2001, the Governor's Commission on Senior Services wrote, "The current barriers to mental health services—stigma, poor access to care, inadequate treatment services, and disparities in insurance coverage—will be magnified as resources become increasingly limited and less likely to meet the service level needs of older adults" (Governor's Commission, 2001, Page 6). More than ever before it is critical to the overall health and

economic stability of our state to champion the mental health needs of older adults and younger adults with disabilities.

Early identification and prevention services, intense long-term wrap around programs, and new and innovative funding strategies are necessary to meet the incoming wave of the 'new elderly' population. Continuing to neglect this population in the community threatens the state's ability to maintain proper utilization of the Oregon State Hospital.

A paradigm shift is necessary from the top level of leadership to the front lines that seeks positive outcomes rather than provides services.

The recommendations in this report are not only fiscally imperative given today's global economic climate, but they are the right thing to do to transform the health care system in Oregon to ensure better outcomes for our older adults and younger adults with disabilities.

As Oregon faces a major shift in the way health care is provided in the state, this work will help to inform the work of other committees now charged with integrating all health care, including mental health and long-term care, to ensure that older adults and younger adults with disabilities can remain in their homes while receiving the care they need.

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List of Appendices

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Appendix B – Likely-SPD Questionnaire

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