Introduction

The Local Plan and Budget templates were developed in collaboration with the Association of Oregon Community Mental Health Programs (AOCMHP) to align with the new County Financial Assistance Agreement (CFAA) which grants funding for services and supports provided **January 1, 2026, through June 30, 2027**.

This alignment helps Local Mental Health Authorities (LMHA) and Community Mental Health Programs (CMHP) to better design and run programs that fit their communities' needs, while ensuring OHA receives the necessary information to carry out its oversight and financial stewardship responsibilities.

A draft Local Plan and accompanying Budget must be submitted to BHD.Contracts@oha.oregon.gov no later than **October 1, 2025**. BHD will notify each LMHA/CMHP of any areas needing additional information, and when their Local Plan and Budget has been approved.

To assist in the review process, please:

- Read the Local Plan and Budget templates thoroughly and review the referenced material in Appendix **A** & **B**.
- Send an email to the CFAA Administrator, Marisha Elkins, at Marisha.L.Elkins@oha.oregon.gov as soon as possible if you have questions or need any clarification.
- Use the headers and corresponding question numbers from this template in your submission.
- Provide complete responses to each question. Please do not include answers such as “see response to question 3”.
- Submit your Local Plan and Required Attachments #2-#4 in either **.docx** or **.pdf** format.
- Submit your Budget (Required Attachment #1) in **.xlsx** format.

Technical Assistance

BHD is available to provide technical assistance, as needed, to ensure that Local Plans and Budgets are completed and approved no later than **December 31, 2025**.

Virtual office hours will be held on July 2, 2025, and then weekly beginning July 23, 2025

Wednesdays at 11:05 am – Noon
Join the meeting
Meeting ID: 243 890 325 861 9
Passcode: ka6Ki7g3

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Definitions

"Adult" has the meaning given in OAR 309-019-0105.

"Child" has the meaning given in OAR 309-019-0105.

"Community Mental Health Program" or **"CMHP"** means an entity established under ORS 430.620 that is responsible for planning and delivery of Services for Individuals with or at risk of developing a Behavioral Health Disorder in a specific geographic area of the state under an agreement with OHA or a Local Mental Health Authority.

"Coordinated Care Organization" or **"CCO"** has the meaning given in OAR 410-141-3500.

"Culturally and Linguistically Responsive and Appropriate Services" has the meaning given in OAR 410-141-3500.

"Local Mental Health Authority" or "**LMHA"** has the meaning given in ORS 430.630(9)(a).

"ODHS" means the Department of Human Services of the State of Oregon.

"Older Adult" means an individual 60 years of age or older.

"**Peer"** has the meaning given in OAR 309-019-0105.

"**Trauma Informed Services"** has the meaning given in OAR 309-019-0105.

"**Young Adult in Transition"** has the meaning given in OAR 309-019-0105.

Part I: Description of County's Current Continuum of Behavioral Health Care

1. Describe how the County's publicly funded behavioral health system is organized, including a description of the roles of/collaboration with the applicable entities below:
    - The Local Mental Health Authority;
    - The Community Mental Health Program;
    - Tribe(s);
    - Coordinated Care Organization(s);
    - Community hospitals;
    - Courts;
    - Law Enforcement and Community Corrections;
    - Schools;
    - Community Action Agencies and Housing Authorities;
    - ODHS; and
    - Other local entities with respect to the delivery of publicly funded mental health and substance use disorder services.

Part II: Description of Core Service Areas

1. Explain how the County will deliver or ensure delivery of the Required Services, as well as any Other Allowable Services, for each Core Service Area outlined in Exhibit B of the new CFAA differentiating between systems of care for children and adults including discussion of services for young adults in transition and older adults, as appropriate.
    - System Management & Coordination
    - Crisis Services
    - Forensic & Involuntary Services
    - Outpatient & Community-Based Services
    - Residential & Housing Supports
    - Behavioral Health Promotion & Prevention
    - Block Grant Funded Services
    - Invoiced Services

2. Describe the role of peers in provision of the Core Service Areas.

3. Describe how the County will ensure the delivery of trauma informed behavioral health services.

4. Describe how the County will ensure delivery of culturally and linguistically responsive and appropriate behavioral health services.

5. Describe the County's care coordination and transition planning processes for clients including how the County will:
    - Coordinate discharge from Oregon State Hospital, community hospitals, residential treatment programs, and jails;
    - Determine the most appropriate service provider for clients among a range of qualified providers;
    - Ensure that appropriate behavioral health referrals are made for clients;
    - Ensure that clients are served in the least restrictive setting possible based on their strengths and needs; and
    - Engage in transition planning between levels of care or components of the system of care including transitioning from the youth to the adult services system and transitioning out of forensic/involuntary services.

Part III: Description of Community Needs Assessment & Planning Process

1. Describe the population-based community needs assessment process conducted by the County, including how the County:
    - Coordinated its local planning with the development of the community health improvement plan under ORS 414.575 by the coordinated care organization(s) serving the area.
    - Involved consumers, advocates, families, service providers, schools, and other interested parties in the planning process.
    - Involved the local mental health advisory committee described in ORS 430.630(7).
        - Coordinated with the local public safety coordinating council to coordinate services among the adult and juvenile criminal legal systems, adult and juvenile corrections systems and local behavioral health programs to ensure that persons with behavioral health disorders who come into contact with the legal and corrections systems receive needed care and to ensure continuity of services for adults and juveniles leaving the corrections system.

- Determined the types of behavioral health services needed locally including developmentally appropriate, culturally, and linguistically specific services.
- Determined the types of housing supports needed locally for individuals with behavioral health disorders and their families including, but not limited to, capacity development, rental assistance, and other barrier removal assistance.

2. Describe the data or information the County used to select their activities and strategies for Behavioral Health Promotion and Prevention (BHPP).
    - Describe how selected activities align with existing local prevention and promotion strategies.
    - Describe how BHPP activities prioritize the determinants of behavioral health wellness including, but not limited to, development and maintenance of healthy communities, skill development, and social emotional competence across the life span.

Part IV: Description of Unmet Service Needs & Critical Gaps

1. Describe the unmet service needs and critical identified during the needs assessment described above including the unmet needs and critical gaps of required priority populations listed in **Exhibit B** of the CFAA. Counties should take a data-driven approach in identifying and describing these unmet needs and gaps.

2. Describe how the County plans to address the unmet service needs and gaps identified in the needs assessment. In describing services and activities, Counties must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed in **Exhibit B** of the CFAA are addressed in these implementation plans.

3. Describe any planning activities related to development or expansion of Crisis Stabilization Center services including location and capacity, if applicable.

Part V: Metrics

1. At minimum, the metrics used to track performance under this plan should include those listed for each Core Service Area described in **Exhibit B**.

2. If there are additional metrics the county wishes to report that are specific to its plans, please list them including the expected outcome associated with the metric.

Part VI: Budget Narrative

1. Did the County coordinate with the budgetary cycles of state and local governments that provide funding for behavioral health services?
   ☐ Yes ☐ No

2. Describe how County will maximize resources for consumers and minimize administrative expenses.

3. Describe how County will ensure that Block Grant funds are used to supplement not supplant existing resources.

Part VII: Description of Technical Assistance Needs

1. For purposes of the Local Plan and to begin any technical assistance needed now please describe any concerns the county has with the required outcome and financial reporting.

2. Please describe what training and technical assistance is needed from OHA to support the County's implementation of their Local Plan.

Part VIII: Required Attachments

1. Attachment #1 – Budget (template available here)

2. Attachment #2 – Current org chart with estimated FTEs & vacancies

3. Attachment #3 – List of key contacts and their contact information (template available here)

4. Attachment #4 – List of subcontractors used by the LMHA/CMHP to provide any or all of the services funded through the CFAA. The list must include:
   - Subcontractor name
   - Amount of CFAA funds allocated/awarded to the subcontractor
   - Description of CFAA-funded services and supports provided by the subcontractor

Appendix A: Statutory Requirements

ORS 430.630(9)(a) As used in this subsection, "local mental health authority" means one of the following entities:

(A) The board of county commissioners of one or more counties that establishes or operates a community mental health program;
(B) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or
(C) A regional local mental health authority comprising two or more boards of county commissioners.

ORS 430.630(b) Each local mental health authority that provides mental health services shall determine the need for local mental health services and adopt a comprehensive local plan for the delivery of mental health services for children, families, adults and older adults that describes the methods by which the local mental health authority shall provide those services. The purpose of the local plan is to create a blueprint to provide mental health services that are directed by and responsive to the mental health needs of individuals in the community served by the local plan. A local mental health authority shall coordinate its local planning with the development of the community health improvement plan under ORS 414.575 by the coordinated care organization serving the area. The Oregon Health Authority may require a local mental health authority to review and revise the local plan periodically.

ORS 430.630(c) The local plan shall identify ways to:

(A) Coordinate and ensure accountability for all levels of care described in paragraph (e) of this subsection;
(B) Maximize resources for consumers and minimize administrative expenses;
(C) Provide supported employment and other vocational opportunities for consumers;
(D) Determine the most appropriate service provider among a range of qualified providers;
(E) Ensure that appropriate mental health referrals are made;
(F) Address local housing needs for persons with mental health disorders;
(G) Develop a process for discharge from state and local psychiatric hospitals and transition planning between levels of care or components of the system of care;
(H) Provide peer support services, including but not limited to drop-in centers and paid peer support;
(I) Provide transportation supports; and

(J) Coordinate services among the criminal and juvenile justice systems, adult and juvenile corrections systems and local mental health programs to ensure that persons with mental illness who come into contact with the justice and corrections systems receive needed care and to ensure continuity of services for adults and juveniles leaving the corrections system.

ORS 430.630(d) When developing a local plan, a local mental health authority shall:

(A) Coordinate with the budgetary cycles of state and local governments that provide the local mental health authority with funding for mental health services;
(B) Involve consumers, advocates, families, service providers, schools and other interested parties in the planning process;
(C) Coordinate with the local public safety coordinating council to address the services described in paragraph (c)(J) of this subsection;
(D) Conduct a population based needs assessment to determine the types of services needed locally;
(E) Determine the ethnic, age-specific, cultural and diversity needs of the population served by the local plan;
(F) Describe the anticipated outcomes of services and the actions to be achieved in the local plan;
(G) Ensure that the local plan coordinates planning, funding and services with:
(i) The educational needs of children, adults and older adults;
(ii) Providers of social supports, including but not limited to housing, employment, transportation and education; and
(iii) Providers of physical health and medical services;
(H) Describe how funds, other than state resources, may be used to support and implement the local plan;
(I) Demonstrate ways to integrate local services and administrative functions in order to support integrated service delivery in the local plan; and
(J) Involve the local mental health advisory committees described in subsection (7) of this section.

ORS 430.630(e) The local plan must describe how the local mental health authority will ensure the delivery of and be accountable for clinically appropriate services in a continuum of care based on consumer needs. The local plan shall include, but not be limited to, services providing the following levels of care:

(A) Twenty-four-hour crisis services;
(B) Secure and nonsecure extended psychiatric care;
(C) Secure and nonsecure acute psychiatric care;
(D) Twenty-four-hour supervised structured treatment;

(E) Psychiatric day treatment;
(F) Treatments that maximize client independence;
(G) Family and peer support and self-help services;
(H) Support services;
(I) Prevention and early intervention services;
(J) Transition assistance between levels of care;
(K) Dual diagnosis services;
(L) Access to placement in state-funded psychiatric hospital beds;
(M) Precommitment and civil commitment in accordance with ORS chapter 426; and
(N) Outreach to older adults at locations appropriate for making contact with older adults, including senior centers, long term care facilities and personal residences.

ORS 430.630(f) In developing the part of the local plan referred to in paragraph (c)(J) of this subsection, the local mental health authority shall collaborate with the local public safety coordinating council to address the following:
(A) Training for all law enforcement officers on ways to recognize and interact with persons with mental illness, for the purpose of diverting them from the criminal and juvenile justice systems;
(B) Developing voluntary locked facilities for crisis treatment and follow-up as an alternative to custodial arrests;
(C) Developing a plan for sharing a daily jail and juvenile detention center custody roster and the identity of persons of concern and offering mental health services to those in custody;
(D) Developing a voluntary diversion program to provide an alternative for persons with mental illness in the criminal and juvenile justice systems; and
(E) Developing mental health services, including housing, for persons with mental illness prior to and upon release from custody.

ORS 430.630(g) Services described in the local plan shall:
(A) Address the vision, values and guiding principles described in the Report to the Governor from the Mental Health Alignment Workgroup, January 2001;
(B) Be provided to children, older adults and families as close to their homes as possible;
(C) Be culturally appropriate and competent;
(D) Be, for children, older adults and adults with mental health needs, from providers appropriate to deliver those services;
(E) Be delivered in an integrated service delivery system with integrated service sites or processes, and with the use of integrated service teams;
(F) Ensure consumer choice among a range of qualified providers in the community;

(G) Be distributed geographically;
(H) Involve consumers, families, clinicians, children and schools in treatment as appropriate;
(I) Maximize early identification and early intervention;
(J) Ensure appropriate transition planning between providers and service delivery systems, with an emphasis on transition between children and adult mental health services;
(K) Be based on the ability of a client to pay;
(L) Be delivered collaboratively;
(M) Use age-appropriate, research-based quality indicators;
(N) Use best-practice innovations; and
(O) Be delivered using a community-based, multisystem approach.

Appendix B: New CFAA Exhibit B

EXHIBIT B
SERVICE DESCRIPTIONS

County shall provide the Services described in this Exhibit B with the Financial Assistance Award provided by this Agreement, in accordance with the approved Local Plan and corresponding Budget, as may be amended from time to time. In providing the Services described in this Exhibit B, County shall follow the Service priorities identified in Section 2. of this Exhibit B. To the extent that the Section 2.a. priorities are adequately funded with the Financial Assistance, then, to the extent that Financial Assistance remains available, County shall provide the lower priority Services in Section 2. In no event will County be required to use funds other than the Financial Assistance to fund the Services.

1. **Goals**. The Parties agree that the goals of this Agreement are to:
   - **a.** Provide a coordinated crisis system to all Individuals within the geographic service area of the County(ies).
   - **b.** Provide individualized services to ensure that people are served in the least restrictive most integrated setting possible allowing Individuals across the lifespan to live as independently as possible.
   - **c.** Coordinate access to stable housing to prevent Individuals with Behavioral Health Disorders and their families from being unhoused.
   - **d.** Services address the unique needs of Individuals without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, intellectual and/or developmental disability, IQ score, or physical disability.
   - **e.** Reduce risk of unnecessary emergency department utilization, criminal/legal involvement, and acute psychiatric hospitalizations by providing upstream services.
   - **f.** Provide a trained, competent and compassionate system for Individuals at risk of involuntary civil or forensic commitment that focuses on diversion these services, when appropriate.
   - **g.** Engage, and when appropriate, lead in community efforts that decrease deaths by suicide.
   - **h.** Engage, and when appropriate, lead in community efforts that decrease overdose and overdose deaths.
   - **i.** Engage, and when appropriate, lead in community efforts that decrease unnecessary criminal/legal involvement for Individuals with Behavioral Health Disorders.

2. **Service Priorities**

a. **County shall give first priority in providing Services to the following, based on community need:**

(1) Aid & Assist – Individuals who the court:

(a) Has reason to doubt are fit to proceed by reason of incapacity (as defined in ORS 161.360) under ORS 161.365;

(b) Has determined lack the fitness to proceed under ORS 161.370 but has not yet determined what action to take under ORS 161.370(2)(c);

(c) Has found to lack fitness to proceed under ORS 161.370 and are committed to the custody of the superintendent of the Oregon State Hospital (OSH); or

(d) Has determined lack of fitness to proceed under ORS 161.370 and are ordered to engage in community restoration services.

(e) Has determined to have no substantial probability of gaining or regaining fitness under ORS 161.367 and who are being discharged to the community.

(2) Psychiatric Security Review Board (PSRB)/ Juvenile Psychiatric Security review Board (JPSRB) – Individuals who:

(a) Are found guilty except for insanity of a criminal offense under ORS 161.327 or responsible except for insanity under ORS 419C.529; or

(b) Are committed as extremely dangerous persons with qualifying mental disorders under ORS 426.701, or recommitted under ORS 426.702.

(3) Civil Commitment - Individuals who:

(a) Are currently committed to OHA for treatment under ORS 426.130 or recommitted to OHA under ORS 426.307;

(b) Are diverted through the civil commitment process to voluntary treatment, conditional release, outpatient commitment, and assisted outpatient treatment (AOT) as described in ORS 426.125 through ORS 426.133, or ORS 426.237; or

(c) Require emergency hold, custody, or secure transport services under ORS 426.228, ORS 426.231, ORS 426.232 and ORS 426.233, or are being held on a warrant of detention pending a civil commitment hearing under ORS 426.070.

b. **Depending on the availability of funds, County shall give second priority in providing Services to Individuals who are 18 years or older, and have a mental illness(es), including co-occurring mental health and Substance Use Disorders, and who as a result of their**

symptoms from their mental illness:

(1) Have had law enforcement contact that could have resulted in an arrest, citation, booking, criminal charge, or transport to jail, but have instead been referred to County for Services;

(2) Are in jail and are in need of mental health treatment; or

(3) In the previous six months, have been twice detained on an emergency hold under ORS 426.232 or on a warrant of detention under ORS 426.070 but have not yet, as a result, been civilly committed.

c. Depending on the availability of funds, County shall give third priority in providing Services to all other Individuals, who do not otherwise qualify under Subsection 2.a and 2.b of Exhibit B, who:

(1) Are at immediate risk of hospitalization for the treatment of Mental or Emotional Disturbances, or are in need of Services to avoid hospitalization or posing a health or safety risk to themselves or others;

(2) Are under 18 years of age who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of removal from their homes for treatment of Mental or Emotional Disturbances or exhibit behavior indicating high risk of developing disturbances of a severe or persistent nature;

(3) Because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; or

(4) In accordance with the assessment of professionals in the field of mental health, are experiencing Mental or Emotional Disturbances but will not require hospitalization in the foreseeable future.

d. Depending on the availability of funds, County shall give fourth priority in providing Services to all other Individuals who do not otherwise qualify under Subsections 2.a through 2.c of Exhibit B, and who have or are at risk of developing a Mental or Emotional Disturbance or Substance Use Disorder.

3. Core Service Areas

a. System Management and Coordination

(1) Planning and Service Delivery

(a) Description: County is responsible for developing a comprehensive Local Plan that describes how County will deliver mental health Services for Individuals that are responsive to the needs of Individuals in their community, as described in ORS 430.630(9).

(b) Population: County shall provide a delivery system for

Services responsive to Individuals with Behavioral Health needs in their geographic service area, which specifically addresses the needs of Individuals described in Section 2.a of Exhibit B.

(c) Required Services: County shall:

i. Establish and maintain a structure for meaningful system design and oversight of Services funded with the Financial Assistance;

ii. Submit a comprehensive Local Plan, consistent with ORS 430.630(9) and this Agreement;

iii. Implement the delivery of Services as described in the County's Local Plan approved by OHA;

iv. Monitor the delivery of Services described in the County's Local Plan approved by OHA;

v. Evaluate delivery of Services described in the County's Local Plan approved by OHA;

vi. Ensure adequate administrative support for:

A. Activities related to contract negotiation, administration, and monitoring as needed to meet the Service needs of Individuals receiving Services under this Agreement;

B. Data collection, performance measurement, and reporting;

C. Activities to support the County's mental health advisory committee required in ORS 430.630(7); and

D. Activities to support collaboration in new developments for residential treatment, foster homes, crisis stabilization centers supported housing, and independent living resources.

vii. Provide complex case consultation, care coordination, and transition coordination as appropriate to the needs, preferences, and choices of each Individual including, but not limited to:

A. Coordination of Services not funded by Medicaid;

B. Providing assistance to interested Individuals in applying for public assistance, medical assistance, and any other state or federal benefits that they may be eligible for;

C. Collaborate with OSH, OHA, or ODHS to verify that entitlement enrollments (e.g. Medicaid, Medicare, SSI/SSDI) are in place and anticipated

to be active upon discharge from a community hospital, residential treatment program, or OSH.

D. Facilitate access to quality, individualized community-based Services so that Individuals are served in the most integrated, least restrictive setting possible.

(d) Other Allowable Services (Subject to Availability of Funds): County may provide:

i. Public education and information related to Behavioral Health.

ii. Guidance and assistance to other human Service agencies for joint development of prevention programs and activities to reduce factors causing alcohol abuse, alcoholism, drug abuse and drug dependence.

iii. In the event of a disaster declaration, disaster response, crisis counseling Services to include responding to local disaster events by:

A. Providing Crisis counseling and critical incident stress debriefing to disaster victims; police, firefighters and other "first-responders"; disaster relief shelters; and the community-at-large.

B. Coordinating crisis counseling Services with County Emergency Operations Manager (CEOM); and providing crisis counseling and stress management Services to Emergency Operations Center staff according to agreements established between the County and CEOM.

C. Assisting other counties in the provision of these Services as part of a mutual aid agreement.

(e) Required Metrics: County shall be in Substantial Compliance with all reporting deadlines associated with the local plan and as otherwise noted in this agreement.

(2) Protective Services:

(a) Description: Protective services are the necessary actions taken by the County to prevent abuse or exploitation of an adult, to prevent self-destructive acts, and to safeguard the adult's person, property and funds, including petitioning for a protective order as defined in ORS 125.005.

(b) Population:

i. Adults with severe and persistent mental illness who receive mental health treatment from a community program as defined in ORS 430.735. Services may be

provided posthumously in the event a person who would otherwise be eligible if living was reported to have died in a manner other than natural or accidental means.

ii. Severe and Persistent Mental Illness means DSM-V-TR diagnostic criteria for at least one of the following conditions as a primary diagnosis for an adult age 18 or older:

A. Schizophrenia spectrum and other psychotic disorders;
B. Depressive disorders;
C. Bipolar and related disorders;
D. Obsessive Compulsive Disorder;
E. Post Traumatic Stress Disorder and Other Specified Trauma- and Stressor-Related Disorder due to cultural syndromes; or
F. Borderline personality disorder.

iii. The prioritization categories, described in Section 2 of Exhibit B, do not apply to Protective Services.

(c) Required Services: County shall provide protective services, and ensure they are completed in the least intrusive manner feasible and support the greatest level of independence. Protective services including, but not limited to:

i. Screening and investigating allegations of abuse, neglect, wrongful restraint, involuntary seclusion, or exploitation;

ii. Making a finding and completing a report as described in OAR Chapter 419 Division 110;

iii. Providing protective Services to prevent further or future harm which may include, but are not limited to:

A. Case management;
B. Crisis support;
C. Information and referral;
D. Linkage to Services;
E. Support in completing protective orders or making law enforcement reports;

iv. Investigating deaths of eligible Individuals that appear to not be caused by accidental or natural means and providing a death review report.

b. Crisis Services

(1) Description: Crisis services are designed to prevent or ameliorate a Behavioral Health crisis or reduce acute symptoms of a mental

illness or a Substance Use Disorder.

(2) **Population:** Individuals experiencing a Behavioral Health crisis as defined by OAR 309-023-0110. The prioritization categories, described in Section 2 of Exhibit B, do not apply to crisis services.

(3) **Required Services:** County shall provide or ensure provision of mobile crisis intervention services (MCIS) and mobile response and stabilization services (MRSS) delivered in accordance with OAR Chapter 309 Division 72 as may be revised from time to time.

(4) **Other Allowable Services (Subject to Availability of Funds):** To the extent that MCIS and MRSS Services are in Substantial Compliance with OAR Chapter 309 Division 72, as may be revised from time to time, funds may also be allocated to support the following Services provided at a certified location:

(a) Crisis stabilization centers operated in accordance with OAR Chapter 309 Division 73 as may be revised from time to time.

(b) Walk-in Crisis Services: Outpatient clinics that operate for walk-in visits with no appointment needed for immediate mental health and substance use support during day hours. Services may include, but are not limited to:

i. Screening;

ii. Assessment;

iii. Brief intervention;

iv. Prescribing capabilities; and

v. Referrals and linkages to longer term Services.

(c) Crisis line services provided in accordance with OAR 309-019-0300, as may be revised from time to time.

(5) **Required Metrics:** County shall be in Substantial Compliance with the following requirements:

(a) MCIS and MRSS responses are conducted within the timelines required in OAR Chapter 309 Division 72.

(b) Individuals receiving an MCIS response are contacted (or contact attempts are made and documented) for follow-up within 72 hours of the MCIS response.

(c) Adults receiving MCIS receive the Services necessary to remain in the community following the initial MCIS response.

(d) Youth receiving MRSS receive the Services necessary to remain in the community following the initial MRSS response.

(e) Youth are screened for stabilization services following the initial MCIS response.

(f) Youth and families that consent to stabilization services are enrolled in stabilization services.

(g) Youth enrolled in stabilization services are referred to the

recommended ongoing Services prior to discharge from stabilization services.

c. Forensic & Involuntary Services

(1) Aid and Assist and Competency Restoration Services:

(a) Description: Competency restoration services are provided to assist Individuals in gaining or regaining their competency in the most integrated, least restrictive setting possible. Competency restoration services, for Individuals found unable to aid and assist in their own defense, are provided either in the community or at OSH. Services include, but are not limited to, community transition planning, treatment designed to restore competency, placement in appropriate community-based care, monitoring and coordination of Services, coordination with providers and the court, and periodic assessment of the Individual's fitness to proceed.

(b) Population: Individuals who are described in Subsection 2.a(1) of Exhibit B.

(c) Required Services: County shall:

i. Ensure that community consultations are conducted as required in OAR 309-088-0125;

ii. Provide community restoration services as defined in OAR 309-088-0115 including, but not limited to:

A. Competency restoration services as defined in OAR 309-088-0115;

B. Forensic care coordination as defined in OAR 309-088-0115; and

C. Supportive services as defined in OAR 309-088-0115 necessary to support community integration.

iii. Provide competency restoration services during commitment at OSH including, but not limited to:

A. Community transition planning defined in OAR 309-088-0115;

B. Forensic care coordination defined in OAR 309-088-0115; and

C. If applicable, the plan of resolution described in Exhibit D.

iv. Ensure compliance with OAR 309-088-0130 including, but not limited to:

A. Developing within 30 calendar days of admission

and updating at least once every 30 calendar days a community transition plan for the Individual in the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices, and strengths;

B. Have both a primary community transition plan and at least one backup community transition plan;

C. In developing the community transition plan, County shall be primarily guided by the State Hospital's treating clinical team's recommendations. County may provide information to the State Hospital's treating clinical team to inform their recommendations.

D. The community transition plan must provide information about the availability of the State Hospital treating clinical team's clinical recommendations in the community, including any reasonable and clinically appropriate alternatives if the State Hospital treating clinical team's clinical recommendations are not present or available in the community.

E. Completion or coordination of any referrals, screenings, or other work to implement the community transition plan: and

F. Monitoring the status of any referrals, screenings, or other work to implement the community transition plan.

G. At least every 30 calendar days, County staff are required to:

I. Meet with the hospital to facilitate an effective transition back to the community. These meetings are required to create, update, or implement a community transition plan that aligns with the Individual's specific treatment needs outside of a hospital level of care setting. These meetings must include, but are not

limited to:

(A) Attending Treatment Team meetings; or

(B) Speaking with the assigned qualified mental health professional (QMHP).

II. Meet with the Individual (in-person or by phone call or video conference) to discuss transition planning and treatment available in the community. These meetings also help with creating, reviewing, updating or implementing a community transition plan.

III. Determine whether community restoration services have become present and available. Consulting with Providers, agencies, CCOs, exceptional needs care coordinators (ENCCs), and Tribes (if applicable) helps to inform the 30-day review.

v. After OSH issues notice that an Individual is ready to place (RTP) under ORS 161.371(3)(a) or (4)(a), and the court orders a community consultation, County shall:

A. Attempt to consult with the Individual and with any local entity that would be responsible for providing community restoration services, if the Individual were to be released in the community, to determine whether community restoration services are present and available in the community;

B. Identify appropriate Providers that are able to meet the Individual's Behavioral Health needs and willing to provide that care, treatment, and Services to the Individual;

C. Identify Providers and planning for a community restoration placement, primarily guided by the level of Services, supervision or type of placement identified by OSH in its RTP notice, and advise whether those resources are present and available in the community;

D. Coordinate access to Services provided in the least restrictive and most integrated setting appropriate to meet the Individual's Behavioral Health needs;

E. Facilitate timely discharge from OSH and diversion from placement at a secure residential treatment facility (SRTF) when consistent with the level of Services, supervision or type of placement identified by OSH in its RTP notice, whenever possible;

F. Obtain any necessary approvals from the Provider to allow admission, if it is a residential placement;

G. Continue to send referrals to Providers until the Individual is accepted and can be immediately placed, if and when the court orders community restoration for the Individual;

H. Complete the standardized consultation report template available at https://www.oregon.gov/oha/osh/legal/pages/information-mental-health-providers.aspx; and

I. Within five judicial days, provide a copy of the consultation to OHA at aidand.assistadmin@odhsoha.oregon.gov, the court and OSH if applicable at cmhp.consults@odhsoha.oregon.gov.

J. If the court does not discharge the Individual from OSH due to a lack of an available and appropriate Provider, continue to send referrals and update the community transition plan until the Individual is discharged from OSH, collaborating with the extended care management unit (ECMU); and

K. If OSH does not issue an RTP notice but County determines that community restoration services that would mitigate any risk posed by the Individual are present and available in the community, file a notice of that determination with the court under ORS 161.371(3)(b)-(4)(b).

vi. County shall provide Services to youth under juvenile fitness to proceed who the court:

A. Has determined lack of fitness to proceed as defined in ORS 419C.378 and court has ordered into a OHA designated facility for restoration services.

B. Services include case management and placement in appropriate community-based care.

vii. As directed by OHA, County shall attend and participate in weekly ECMU care coordination meetings and collaborate with ECMU staff to:

A. Facilitate timely Client transition across the residential system from OSH to supported housing.

B. Facilitate effective utilization of Services and facility-based care in the community.

C. Collaborate with care coordination teams and other state agencies as necessary to secure placements that meet individual Client needs.

D. Begin discharge planning to more integrated settings as soon as an Individual is admitted to OSH, SRTF, RTF settings.

E. Make referrals to the most integrated settings appropriate for the Individual's assessed needs and level of care.

F. Assist in identification of financial alternatives for Individuals who are over resourced for Medicaid.

viii. Participate in OSH interdisciplinary meetings for each Individual within the County's Service area to update the discharge plan and to coordinate appropriate community-based Services.

ix. For Individuals receiving community restoration services, County shall coordinate the Individual's Behavioral Health and medical treatment in the community:

A. Attempt to conduct an individualized assessment of the Individual and develop a treatment Service plan in coordination with the Individual's Provider and consistent with any court-ordered conditions;

If the Individual does not participate in the initial assessment, continued efforts should be made to engage with the Individual to complete the assessment and develop a treatment Service plan;

B. Monitor the care, custody, and treatment of the Individual while on community restoration;

C. Monitor the Individual's progress in their treatment Service plan, and identify when the Individual may receive Services in a lower level of care and report that to the court;

D. Ensure treatment Service planning continues throughout the Individual's receipt of Services with the goal of the Individual receiving Services in the lowest level of care that will maintain their mental and physical health long term;

E. Provide care coordination to facilitate ongoing communication and collaboration to meet the Individual's needs, such as:

- **I.** Facilitating communication between natural supports, community resources, Providers, agencies (if eligible for APD or I/DD Services) and CCOs (if an enrolled member);
- **II.** Organizing, facilitating and participating in client staffing meetings;
- **III.** Providing for continuity of care by creating linkages to and managing transitions between levels of care;
- **IV.** Coordinating or providing transportation to and from the forensic evaluations and court appearances in this case; and
- **V.** Communication of court ordered requirements, limitations, and court dates to the defendant.

F. Provide coordination and consultation to the jurisdictional court or other designated agencies within the criminal justice system and OSH while the Individual is residing in the community and in

the process of being returned to fitness. Services include, but are not limited to:

I. Coordination of the periodic assessments of the Individual's fitness to proceed;

II. Collaboration and coordination with community corrections;

III. Consultation to the county mental health court, if mental health court is available in the Service area;

IV. Participation in mental health and law enforcement collaboration meetings; and

V. Communication of court ordered requirements, limitations, and court dates.

G. Provide monthly status reports to the appropriate court on the Individual's:

I. Compliance or non-compliance with their conditional release requirements; and

II. Progress in gaining or regaining fitness to proceed;

H. Notify the court if the Individual gains or regains fitness to proceed, and develop a transitional treatment Service plan for that Individual;

I. Provide interim quarterly reports for the purpose of communicating current status of Individuals to OHA and the court of jurisdiction; and

J. Provide community restoration Services, which are necessary to safely allow the Individual to gain or regain fitness to proceed in the community.

x. When appropriate, County shall attempt to enter into a Memoranda of Understanding (MOU) between law enforcement agencies, jails, circuit and municipal courts, local mental health providers, and other parties involved in the referral and treatment of Individuals receiving aid & assist Services, that outline:

A. Roles of each entity;

B. Sequence and protocols of forensic diversion model including referral process;

C. Data sharing agreements;

D. Communication and reporting;

E. Confidentiality agreements; and
F. Individual rights while receiving diversion Services.

(d) Other Allowable Services (Subject to Availability of Funds): County may coordinate the transition from forensic services for Individuals described in Subsection 2.b(1) of Exhibit B.

(e) Required Metrics. County shall be in Substantial Compliance with the following requirements:

i. Individuals under aid & assist orders or transitioning from OSH or jails are referred to community navigator services.

ii. Individuals under aid & assist commitment orders on the OSH waitlist are screened for forensic diversion services.

iii. Individuals under aid & assist orders at OSH who have been found ready to place will have a completed community transition plan by the time the community consult is sent to the court.

iv. All reports associated with aid & assist populations are completed and returned to OHA as required in OAR Chapter 309 Division 88.

(2) Monitoring, Security and Supervision Services for Individuals Under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board (PSRB & JPSRB)

(a) Description: Monitoring, security, and supervision Services delivered in accordance with OAR 309-019-0160.

(b) Population: Individuals who are described in Subsection 2.a(2) of Exhibit B.

(c) Required Services: County shall:

i. Complete requests for evaluation order as required by OAR 309-019-0160;

ii. Provide supervision and urinalysis drug screen consistent with the requirements of the PSRB or JPSRB Conditional Release Order;

iii. Coordinate with OSH and OHA (e.g. Civil, ECMU, aid & assist), a hospital, or facility designated by OHA on transition activities related to conditional release of an Individual to the community;

iv. Provide intensive case management for identified programs at approved budgeted rates;

v. Complete administrative activities related to the monitoring services described above, including but not limited to:

A. Reporting of the Individual's compliance with the conditional release requirements, as identified in the order for conditional release, through monthly progress notes to the PSRB or JPSRB;

B. Providing interim reports for the purpose of communicating the current status of an Individual to the PSRB or JPSRB;

C. Submitting requests for modifications of conditional release orders to the PSRB or JPSRB;

D. Implementing board-approved modifications of conditional release orders;

E. Implementing revocations of conditional release due to violation(s) of conditional release orders and facilitating readmission to OSH or facility designated by OHA;

F. Contacting the Individual when County is notified by the law enforcement data system that the Individual under the jurisdiction of PSRB or JPSRB has had an encounter with a law enforcement agency; and

G. Completion of the annual comprehensive review of supervision and treatment services to determine if significant modifications to the conditional release order should be requested from the PSRB or JPSRB.

H. Utilize an OHA approved risk assessment tool for the purposes of providing structured risk feedback to the PSRB or JPSRB, inclusion in the annual comprehensive review, and in determining security payment rates; and

I. Report to OHA in writing to the GEI Coordinator at oha.gei.coordinator@odhsoha.oregon.gov the

next business day, when there is concern that the County cannot provide the appropriate care and supervision that is needed for an Individual as stated in the conditional release plan. This concern and the communication with OHA must be documented in the Individual's Service record.

vi. Providing expert witness testimony to the PSRB or JPSRB from both the case monitor and a licensed medical professional who can speak to the Individual's current treatment regimen, including psychotropic medications;

vii. Completion of evaluation reports and the summary of conditions of release plan, if the Individual is accepted to a placement, as required by OAR 309-019-0160;

viii. Completion of monthly reports as required by OAR 309-019-0160;

ix. Completion of annual comprehensive reviews as required by OAR 309-019-0160; and

x. Coordinating transition from forensic services for Individuals ending jurisdiction under the PSRB within six months of termination.

(d) **Required Metrics:** County shall be in Substantial Compliance with the following requirements:

i. Conditional release evaluations for GEIs are completed and submitted within 30 calendar days of receiving the orders.

ii. PSRB monthly reports are submitted to PSRB as required by OAR 309-019-0160;

iii. Comprehensive annual reviews are submitted to OHA as required by OAR 309-019-0160;

iv. Treatment plans are reviewed and updated within 364 calendar days of the previous plan.

v. OHA approved risk assessments are updated within 180 calendar days of the previous assessment.

(3) **Civil Commitment Services**

(a) **Description:** Civil commitment services include pre-commitment services, placement and post-commitment activities, and outreach and stabilization activities.

(b) **Population:** Individuals who are described in Subsection

2.a(3) of Exhibit B.

(c) Required Services: County shall:

i. Provide pre-commitment services including:

A. Providing notice as required under ORS 426.070, ORS 426.233, ORS 426.234, and ORS 426.235;

B. Notifying and directing approved persons or peace officers to take custody and transport Individuals when appropriate;

C. Completing reporting and filing requirements relevant to authorized involuntary Services pursuant to ORS Chapter 426 such as custody, admission to nonhospital facilities, and Notices of Mental Illness;

D. Receiving Notices of Mental Illness submitted from the community under ORS 426.070 and from the circuit courts under ORS 426.070 and ORS 426.234;

E. Overseeing the placement and transfer of Individuals during the pre-hearing period of detention, including providing or arranging for transportation;

F. Having a certified mental health investigator initiate and conduct a prehearing investigation, within applicable statutory timeframes, pursuant to ORS 426.070, ORS 426.074, ORS 426.180, ORS 426.200 and OAR 309-033-0920 through OAR 309-033-0940;

G. Filing a certificate of intensive treatment with the court pursuant to ORS 426.237 for Individuals eligible for a 14-day diversion. Monitor the Individual's cooperation with the provider's treatment plan throughout and move for a hearing, as appropriate, if the Individual disengages or requests to discharge.

H. Writing and submitting an investigation report as required under ORS 426.070, including a recommendation to the court to pursue or not pursue a civil commitment hearing, or to pursue a hearing for AOT;

I. Developing a person-centered treatment plan that is in the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices, and strengths, and addresses risk and protective factors;

J. Monitoring the person's progress in completing the treatment plan and provide regular and as-requested updates to the court, including making requests for the appointment of a guardian ad litem when indicated; and

K. Provide linkage to Services that enhance Individuals' life skills abilities including money management, nutrition, hygiene and personal care, shopping, social skills, and cooking.

ii. Provide placement and post-commitment Services including:

A. In providing recommendations, County shall ensure Individuals:

I. Are recommended for Services in the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs;

II. Are certified for diversion or recommended for AOT whenever appropriate and feasible;

III. Are diverted from placement in OSH, community hospitals or SRTFs whenever possible; and

IV. Are considered for alternatives to inpatient placement such as voluntary treatment, conditional release, outpatient commitment, and, if already in an inpatient setting, trial visit;

B. Ensure that transition planning begins with intake and that the Individual is considered for initial outpatient commitment placement whenever appropriate;

C. Ensure the placement of Individuals with an appropriate provider in the least restrictive, most

integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices and strengths;

D. Issue a written placement order immediately upon the civil commitment of the Individual and as required by OAR 309-033-0290 thereafter. Submit completed placement orders to OHA as required by OAR 309-033-0290;

E. Monitor the Individual's progress in their placement, and identify when the Individual may benefit from a more integrated, less restrictive level of care, up to and including independent living, attributable to symptom improvement; discharging from a facility and accessing more integrated community-based resources and treatment; or discharging from civil commitment because the Individual is no longer a person with mental illness or the Individual's best interest is to transfer to a voluntary status;

F. Monitor the Individual's progress while placed in an inpatient setting and assess for readiness to step-down on a trial visit or discharge from civil commitment;

G. Monitor Individual's progress while placed on outpatient commitment and assess for readiness to discharge for civil commitment;

H. Establish conditions of placement prior to placement on outpatient commitment or trial visit in accordance with ORS 426.127, ORS 426.273, and ORS 426.278;

I. Support the Individual in adhering to the conditions of placement and completing the court requirements associated with the order for treatment if the Individual is placed in the community. This may include modifying conditions of placement as indicated in accordance with ORS 426.273(5) and ORS 426.275(3);

J. Provide notice to the court when the Individual is

not adhering to the conditions of placement and when a revocation hearing is being requested. Complete revocation processes as indicated in ORS 426.275 and OAR 309-033-0320;

K. Facilitate communication between and collaborate with the Individual, family, natural supports, community resources, providers, ODHS if eligible for Aging and People with Disabilities (APD) or Intellectual and Developmental Disabilities (I/DD) Services and the courts (when applicable); and

L. If discharging the Individual from civil commitment prior to the expiration date of the civil commitment order, file a written certificate discharging the Individual early from civil commitment pursuant to ORS 426.300 with the last committing court and the court in the county of residence.

(d) Other Allowable Services (Subject to Availability of Funds). The County may provide outreach and stabilization services, which include:

i. Establishing practices and procedures to identify Individuals within the Service area who are eligible for outreach and stabilization services in order to prevent or divert from civil commitment Services;

ii. Providing community-based supportive engagement with Individuals with aim of establishing rapport, identifying chronic needs resulting in multiple custodies, detentions, or holds; and proactively engaging in low barrier Services to reduce crisis episodes, access longer term benefits, and prevent civil commitments.

iii. Facilitating communication between and collaborate with the Individual, family, natural supports, community resources, providers, ODHS if eligible for APD or I/DD services and the courts (when applicable);

iv. Supporting Individuals access to and assistance in completing a Declaration for Mental Health Treatment (DMHT) including coordinating with providers to have the DMHT made part of the medical record; and

v. Removing barriers to support the life skills development

needed for the Individual to live as independently as possible in the community, including but not limited to providing assistance in navigating communities safely, managing prescriptions and health-related needs, shopping, hobbies and social engagement, housekeeping, laundry, and paying bills.

(e) Required Metrics: County shall be in Substantial Compliance with the following requirements:

i. Individuals transitioning from OSH are referred to community navigator services.

ii. Individuals under civil commitment will be provided a blank DMHT and offered the opportunity to complete one within 30 calendar days of being transferred to County's supervision.

iii. All reports associated with civil populations are completed and returned to OHA as required in OAR Chapter 309 Division 33.

(4) Forensic Diversion Services

(a) Description: Services designed to address Behavioral Health Disorders contributing to criminal behavioral and reduce unnecessary criminal justice involvement.

(b) Population: Notwithstanding Section 2 of Exhibit B, the County shall prioritize providing forensic diversion services to:

i. Individuals described in Subsections 2.a and 2.b in Exhibit B;

ii. Individuals on the OSH aid & assist waitlist;

iii. Individuals the court has ordered to be evaluated under ORS 161.365 or ORS 161.370 and are in jail; and

iv. Individuals who the court has determined lack trial competency under ORS 161.370 at least twice in the preceding 24 months.

(c) Required Services: County shall:

i. Provide Behavioral Health treatment Services in accordance with ORS 430.450, ORS 430.490-430.515, and ORS 430.630;

ii. Designate a forensic jail liaison(s) to coordinate with the jail, court and health care delivery system to screen defendants who may be suitable for diversion from jail

and OSH. The liaison shall:

A. Attempt to complete a Behavioral Health screening and, if the screening indicates further referrals, assessment and treatment are necessary, then attempt to coordinate them;

B. Identify jail and OSH diversion resources, including but not limited to:

I. Community-based placement resources;

II. Outpatient Behavioral Health services; and

III. Other basic needs and supports.

C. Identify those Individuals who a certified forensic evaluator has determined does not need hospital level of care or the CMHP has determined may be appropriate for community placement, and attempt to develop a community transition plan;

D. Facilitate communication with the court to discuss all potential actions such as: dismissal, commitment, community restoration, referral to OSH for each case;

E. Coordinate rapid forensic evaluations; and

F. Coordinate with other programs such as aid and assist, civil commitment, PSRB/JPSRB, and crisis services.

iii. Use the "Sequential Intercept Model" (SIM) to identify and intervene upon "points of interception" or opportunities for interventions to prevent Individuals from entering or penetrating deeper into the criminal legal system. Regardless of the intervention point, forensic diversion treatment Services include:

A. Providing voluntary, person-centered case planning;

B. Coordinating access to outpatient behavioral health treatment, housing, vocational, educational, and other Services;

C. Providing support Services to prevent or curtail relapses and other crises;

D. Supporting Individuals in their criminal justice obligations and navigating the court and legal system, which may include liaising with attorneys

if applicable; and

E. Promoting peer support and the social inclusion of Individuals with or in recovery from Behavioral Health Disorders in the community.

iv. Facilitate communication between and collaborate with the Individual, family, natural supports, community resources, providers, ODHS if eligible for APD or I/DD services and the courts (when applicable).

(d) Required Metrics: County shall be in Substantial Compliance with the following requirements:

i. Attempt to contact and complete a Behavioral Health screening for Individuals who are described above in Subsection (4)(b) of this Exhibit B:

A. Within 7 business days of the applicable court order; or

B. Within 7 business days of the court, CMHP, a party, or OHA identifying the Individual as someone who the court determined lacked trial competency under ORS 161.370 at least twice in the preceding 24 months; and

ii. Develop a transition plan for Individuals, who a certified forensic evaluator has determined does not need hospital level of care or the CMHP has determined may be appropriate for community placement, within 14 calendar days of that determination. The transition plan must align with the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices, and strengths, and addresses risk and protective factors.

d. Outpatient & Community-Based Support Services

(1) General Outpatient & Community-Based Support Services

(a) Description: A range of Services necessary to ensure that Individuals receive the appropriate level of care in the most integrated setting, based on their needs, to facilitate recovery and enhance overall well-being.

(b) Population: Individuals with a Mental or Emotional Disturbance or a Substance Use Disorder, subject to the prioritization described in Section 2. of Exhibit B.

(c) Required Services: County shall provide or ensure provision of:

i. **Early Assessment and Support Alliance (EASA).**

A. Provide EASA services, delivered in accordance with the fidelity standards located at https://easacommunity.org/pro-resource/practice-guidelines/, for Individuals ages 12 through 30 years of age whom:

I. Have not had a diagnosable psychotic disorder other than psychosis-risk syndrome, identified by the structured interview for psychosis risk syndrome or other EASA Center for Excellence approved formal assessment, for a period longer than 12 months; and

II. Have psychotic symptoms not known to be caused by the temporary effects of substance intoxication, major depression, or attributable to a known medical condition.

B. Upon referral to EASA, contact shall be made within two (2) business days of the referral by EASA staff with the referent, the Individual, and the Individual's family in a location that best suits the Individual. Individuals are enrolled in EASA once they are determined to have met the eligibility criteria. The referent and/or the Individual and their family are provided crisis resources and tailored psychoeducation upon first contact;

C. Ensure that EASA Services are rendered based on the needs of the Individual and their family as frequently as needed to optimize the EASA program's support and impact on short- and long-term outcomes; and

D. Provide access to crisis Services for Individuals enrolled in EASA and their family and primary supports.

ii. **Outpatient Programs:** Ongoing treatment delivered in a community setting including, but not limited to:

A. Individual therapy;

B. Group therapy;

C. Medication management;

D. Skills training; and
E. Case management.

iii. Intensive Outpatient Programs: Structured programs that provide more frequent and intensive therapy while allowing Individuals to live at home. Typically, these programs involve several hours of treatment per week. Intensive outpatient programs may include, but are not limited to, Services such as assertive community treatment (ACT) delivered in accordance with OAR 309-019-0225 through 309-019-0255.

iv. Aftercare and Recovery Support: Ongoing support Services to help Individuals maintain their recovery and reintegrate into the community including, but not limited to:
A. Educational and vocational supports;
B. Recovery coaching; and
C. Relapse prevention programs.

v. Services to Remove Barriers to Community-Based Care: Financial Assistance made on behalf of an Individual with a Behavioral Health Disorder which may include, but is not limited to:
A. Phone or internet bills;
B. Transportation;
C. Interpreter services;
D. Medical services and medications; and
E. Costs associated with obtaining or continuing representative payee or guardianship services.

(d) Other Allowable Services (Subject to Availability of Funds): County may provide:

i. Early Intervention: Services that identify and address mental health or substance use issues at an early stage, often involving screening and brief interventions.

ii. Partial Hospitalization Programs/Day Treatment: A step between inpatient care and outpatient treatment, providing a higher level of care with daily programming while allowing Individuals to return home in the evenings.

iii. Peer Delivered Services: Community-based Services provided by peer support specialists, peer wellness

specialists, family support specialists, and recovery mentors to Individuals or family members with similar lived experience. These Services are intended to support Individuals and families to engage Individuals in ongoing treatment and to live successfully in the community.

iv. **Care Coordination:** A process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs including facilitating communication between natural supports, community resources, and involved providers and agencies; organizing, facilitating, and participating in client staffing meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care.

v. **Case Management:** Services to assist Individuals to connect to and gain access to needed Services outlined in an Individual intervention plan; Substance Use Disorder treatment, health care, housing, employment and training, childcare and other applicable Services.

vi. **IPS Supported Employment** delivered in accordance with OAR 309-019-0270 through 309-019-0295 or other evidence-based vocational supports.

vii. **Supported Education** delivered in accordance with SAMHSA's Best Practices available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma11-4654-buildingyourprogram-sed.pdf.

(e) Required Metrics: County shall be in Substantial Compliance with the following requirements:

i. Individuals are offered an appointment with a licensed medical provider within seven (7) business days of enrollment in EASA.

ii. Individuals enrolled in EASA are offered supported employment or supported education services to 100% of.

iii. Individuals enrolled in EASA and their families will have access to structured family psychoeducational groups.

iv. Adults with mental illness enrolled in Services are

screened for potential home and community-based services eligibility and are referred when indicated.

v. New mental illness or Substance Use Disorder diagnoses are followed-up by treatment with in 14 calendar days of initial diagnosis.

vi. New mental illness or Substance Use Disorder diagnoses are followed-up by two engagement visits or medication treatments within 30 calendar days of initial treatment.

vii. A letter of acceptance and entry is sent to Individuals deemed eligible for Assertive Community Treatment as required by OAR 309-019-0248.

(2) Gero-Specialist Services:

(a) Description: Specialized geriatric Services.

(b) Population: Older or disabled adults subject to the prioritization described in Section 2. of Exhibit B.

(c) Required Services: County shall:

i. Provide direct care Services that are either supervised or delivered by a QMHP as defined in OAR 309-019-0105, including, but not limited to:

A. Medication management;

B. Quarterly interagency staffing;

C. Follow-up Services after treatment in local or state inpatient psychiatric hospitals; and

D. Screening and referrals.

ii. Collaborate and coordinate with APD, ODHS's Aging and Disabilities Resource Connection, ODHS's Adult Protective Services, CCOs, CMHPs, acute care hospitals, OSH, caregivers, community partners, family members, and any other appropriate participants in an Individual's care.

iii. Provide at least one workforce development training in geriatric Behavioral Health competencies each quarter. Trainings must include a competency confirmation verified by the gero-specialist including, but not limited to a certificate of attendance; and must be provided to a wide cross section of professionals, paraprofessionals, and volunteers using a variety of modalities such as:

A. Virtual webinars developed by OHA;

B. Team meetings,
C. Seminars, conferences, or symposiums;
D. Community of practice or learning collaboratives; or
E. Other community training forums.

iv. Provide complex case consultation and system navigation whether planned through a multidisciplinary team that meets regularly, ad hoc or crisis, or having regular office hours with APD/AAA to provide consultation to their case management staff; and

v. Provide consultation to key teams within the CMHP including, but not limited to, ACT, forensic services, SUD services, and crisis services. Regular complex care consultation meetings should include short didactic learning sessions on key Behavioral Health competencies.

(d) Other Allowable Services (Subject to Availability of Funds): County may provide indirect care Services including, but not limited to:

i. Consultation;
ii. Assistance working with multiple systems;
iii. Case coordination and planning;
iv. Supporting interagency collaboration; and
v. Education and training to agencies and caregivers who provide Services that may affect older and disabled adults with mental illness or Substance Use Disorder.

(e) Required Metrics: County shall be in Substantial Compliance with the following requirement: Older or disabled adults receiving Services are screened for potential home and community-based services eligibility and are referred when indicated.

e. Residential & Housing Support Services

(1) Description: Services to ensure that Individuals with Behavioral Health Disorders are served in the most integrated, least restrictive setting possible based on their individualized needs and strengths.

(2) Population: Individuals in need of residential Behavioral Health treatment subject to the prioritization described in Section 2. of Exhibit B.

(3) Required Services: County shall:

(a) Ensure that a Service plan is in place for each Individual in the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices, and strengths;

(b) Identify an appropriate residential services Provider that is able to meet the Individual's Behavioral Health needs and willing to provide that care, treatment, and Services to the Individual;

(c) Ensure that Services are provided in the least restrictive and most integrated setting appropriate to meet the Individual's Behavioral Health needs;

(d) Divert the Individual from placement at a state hospital, community hospital, or secure residential treatment facility, whenever possible;

(e) Obtain any necessary approvals from the Provider to allow admission, if it is a residential or state hospital placement;

(f) Continue to send referrals to Providers until the Individual is placed at or is no longer in need of residential Services;

(g) Monitor the Individual's progress in their Service plan while in a residential placement and identify when the Individual may be transferred to a lower level of care; and

(h) Ensure that discharge planning is conducted throughout the Individual's placement in a hospital or residential placement with the goal of moving the Individual to the lowest level of care that will maintain their mental and physical health.

(i) Provide care coordination to facilitate the Individual's access to Services in the least restrictive, most integrated setting appropriate to meet the Individual's Behavioral Health needs, preferences, choices and strengths, including:

i. Facilitate communication between the Individual, family, natural supports, community resources, Providers, and ODHS (if eligible for APD or I/DD Services);

ii. Identify Providers that can provide Behavioral Health Treatment Services consistent with the Individual's treatment Service plan, whether it is provided on an inpatient, residential or outpatient basis;

iii. Organize, facilitate and participate in interdisciplinary team meetings with the Individual, Providers, and CCO care coordinators (if the Individual is a CCO member);

iv. Facilitate access to community-based rehabilitative Behavioral Health treatment services that are recovery-oriented, culturally responsive, and geographically accessible;

v. Facilitate access to peer delivered services; and

vi. Collaborate with the ODHS, APD and I/DD divisions to support the Behavioral Health treatment needs of Individuals determined service-eligible for APD or I/DD.

(j) Within the limits of the Part A funds awarded in this Agreement, County shall provide the following housing support services, as clinically indicated, for Individuals who qualify under Subsection 2.a of Exhibit B:

i. **Rental Assistance:** Financial Assistance made on behalf of an Individual and their family, when applicable, that covers payment to landlords, property management companies, housing providers, property owners, or specific vendors for all or a portion of the monthly rent, or payment to specific vendors for resident utility expenses. Individuals who receive assistance may be living with other family members (e.g., where a parent is re-assuming custody of one or more children).

ii. **Housing Coordination Services:** Staff to support and assist Individuals to locate and secure safe, suitable housing, and provide referrals to other resources.

iii. **Services to Remove Barriers to Community-Based Care:** Financial Assistance made on behalf of an Individual may include, but is not limited to:

A. Room and board payments;

B. Utility deposits and fees including past due utility bills;

C. Phone or internet bills;

D. Moving and storage costs;

E. Household goods and supplies;

F. Cleaning or pest management Services; and

G. Interpreter Services.

(4) **Other Allowable Services (Subject to Availability of Funds):** County may provide:

(a) Peer Delivered Services: Services provided by peer support

specialists, peer wellness specialists, family support specialists, and recovery mentors to Individuals or family members with similar lived experience. These Services are intended to support Individuals and families to engage Individuals in ongoing treatment and to live successfully in the community.

(b) Respite Services: Short-term residential services (less than 30 calendar days) for Individuals who require 24-hour observation and support but do not require acute psychiatric hospitalization. Services include access to multidisciplinary treatment including therapeutic supports and may include treatment with medications.

(c) Housing support services, as clinically indicated, for Individuals who meet second, third, or fourth priority criteria outlined in Section 2. above:

i. **Rental Assistance:** Financial Assistance made on behalf of an Individual and their family, when applicable, that covers payment to landlords, property management companies, housing providers, property owners, or specific vendors for all or a portion of the monthly rent, or payment to specific vendors for resident utility expenses. Individuals who receive assistance may be living with other family members (e.g., where a parent is re-assuming custody of one or more children).

ii. **Housing Coordination Services:** Staff to support and assist Individuals to locate and secure safe, suitable housing, and provide referrals to other resources.

iii. **Services to Remove Barriers to Community-Based Care:** Financial assistance made on behalf of an Individual may include, but is not limited to:

- **A.** Room and board payments;
- **B.** Utility deposits and fees including past due utility bills;
- **C.** Phone or internet bills;
- **D.** Moving and storage costs;
- **E.** Household goods and supplies;
- **F.** Cleaning or pest management services; and
- **G.** Interpreter services.

(5) Required Metrics: County shall be in Substantial Compliance with the following requirements:

(a) Individuals who need residential treatment services are screened for potential home and community-based services eligibility and are referred when indicated.

(b) Individuals who receive housing support services are screened for potential home and community-based services eligibility and are referred when indicated.

(c) Individuals receiving residential Behavioral Health treatment are offered Services to assist with their transition to outpatient Services prior to discharge from residential treatment.

(d) Individuals enrolled in Behavioral Health treatment services establish or maintain housing prior to completion of treatment.

(e) Lengths of stay in all forms of residential treatment are less than 180 calendar days.

f. Behavioral Health Promotion & Prevention

(1) Description: Strategies aimed at improving mental health or preventing mental illness or Substance Use Disorders before they occur.

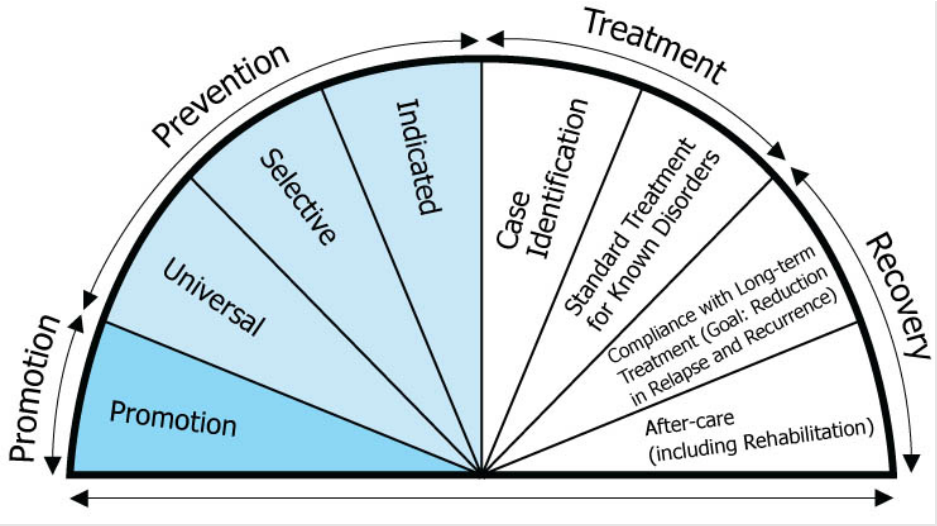
(2) Population: Individuals with or at risk of developing a Mental or Emotional Disturbance or a Substance Use Disorder, subject to the prioritization described in Section 2 of Exhibit B.

(3) Required Services: Using a framework, such as the Institute of Medicine's Continuum of Care Model (see graphic below) or other Behavioral Health Promotion and Prevention framework or strategy, the County shall:

(a) Create and implement an evidence-based continuum of activities, strategies, and supports that align with existing local prevention and promotion strategies;

(b) Provide preventive mental health Services for children and adolescents, including primary prevention efforts, early identification and early intervention Services as described in ORS 430.630(3)(L); and

(c) Preventive mental health Services for older adults, including primary prevention efforts, early identification and early intervention Services as described in ORS 430.630(3)(m).



(4) Other Allowable Services (Subject to Availability of Funds): County may:

(a) Develop and implement strategies and/or activities that prioritize the following determinants of Behavioral Health wellness across the life span.

(b) Develop and implement strategies to maintain healthy communities: Strategies and/or activities may include but are not limited to, community safety promotion, violence reduction, bullying prevention, social connectivity, and resource dissemination activities;

(c) Individual skill development: Strategies and/or activities may include but are not limited to, skill-building programs in schools, community and senior centers, assisted living facilities, and other community-based settings that emphasize social connection, problem solving and development of self-regulation; and

(d) Social emotional competence: Strategies and/or activities may include but are not limited to developing or sustaining community infrastructure, parenting/grandparenting education, stress reduction classes, communication skills classes, programs that address social isolation and loneliness, grief and other post distress supports, divorce and other losses, and community-based activities.

(5) Required Metrics: County shall be in Substantial Compliance with the following requirements:

(a) Individuals receiving Behavioral Health Prevention and Promotion Services report an increased understanding of mental health, substance use prevention, and available resources.

(b) Individuals receiving Behavioral Health Prevention and

Promotion Services report a change in attitude toward mental health, substance use, or coping strategies.

(c) Individuals receiving Behavioral Health Prevention and Promotion Services report an increased likelihood of engaging in behavior change such as accessing counseling Services or delaying or decreasing use of alcohol and other drugs.

g. Block Grant Funded Services:

(1) Description: Activities and Services to address the complex needs of Individuals, families, and communities impacted by mental illness and Substance Use Disorders and associated problems paid for, in whole or in part, by Substance Use, Prevention, Treatment, and Recovery Services Block Grant ("**SUPTRS BG**") or Community Mental Health Services Block Grant ("**MHBG**") funds awarded in this Agreement.

(2) Definitions: For use in this section:

(a) "Serious Mental Illness" or **"(SMI)"** means an Individual 18 years of age or older who, within the past year, has had a diagnosable mental, behavioral, or emotional disorder that substantially interferes with their life and ability to function.

(b) "Serious Emotional Disturbance" or **"(SED)"** means an Individual under the age of 18 who, within the past year, has had a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

(3) Population:

(a) County shall ensure that MHBG funds awarded through this Agreement are used to support Services for the MHBG Priority Populations:

i. Children with Serious Emotional Disturbance;

ii. Adults with Serious Mental Illness including Older Adults; and

iii. Individuals with SMI or SED in rural areas and who are experiencing homelessness.

(b) County shall ensure that SUPTRS BG funds awarded through this Agreement are used to support Services for the SUPTRS BG Priority Populations:

i. Pregnant women with dependent children;

ii. Persons who inject drugs;

iii. Persons in need of recovery support Services for Substance Use Disorder;

iv. Individuals with a co-occurring mental illness and Substance Use Disorder;

v. Persons experiencing homelessness;

vi. Services for persons with SUD who have or are at risk of:

A. HIV/AIDS, designated states per CDC only; or

B. Tuberculosis; and

vii. Services for Individuals in need of substance use primary prevention.

(4) Required Services: County shall:

(a) Comply, and as indicated, require all Providers to comply with the Required Federal Terms and Conditions for Services funded in whole or in part by MHBG or SUPTRS BG funds;

(b) Allocate and expend no less than the minimum MHBG amount indicated in the Financial Assistance Award for Crisis Services;

(c) Allocate and expend no less than the minimum MHBG amount indicated in the Financial Assistance Award for EASA Services; and

(d) County shall ensure that MHBG or SUPTRS BG funds be directed toward the following purposes:

i. To fund priority treatment and support Services for Individuals without insurance or who cycle in and out of health insurance coverage;

ii. To fund those priority treatment and support Services not covered by Medicaid, Medicare or private insurance and that demonstrate success in improving outcomes and/or supporting recovery;

iii. To fund universal, selective, and targeted prevention activities and Services;

iv. To collect performance and outcome data to determine the ongoing effectiveness of Behavioral Health prevention, treatment, and recovery support Services and to plan the implementation of new Services on a nationwide basis. Additionally, SAMHSA strongly supports that states provide additional recovery support Services with SUPTRS BG funds beyond the scope of treatment programs currently available in most communities across the nation;

v. To ensure Oregonians have access to a comprehensive, integrated physical and Behavioral Health Service array statewide that is inclusive and

where Individuals can choose providers that best fit their needs and cultural preferences within their community;

vi. To ensure that Individuals transitioning from a hospital level of care, including OSH, to community-based settings will be fully supported through care coordination, and inclusive Services and support;

vii. To ensure that older adults who live in rural areas of Oregon receive accessible and affordable Services;

viii. To ensure that Individuals have access to necessary Services and eliminate disparities in accessing care;

ix. To foster healthy families and environments through integrated care that promotes equitable health and well-being, for pregnant and post-partum persons;

x. To provide peer support services for Individuals transitioning between levels of care;

xi. To promote and provide activities that support physical health, substance use treatment, and mental health Services for young adults 18-25; or

xii. To increase prevention efforts including overdose, crisis response, and chronic disease prevention.

(5) Other Allowable Services (Subject to Availability of Funds): County may**:**

(a) Promote participation by Individuals with SMI, SED, or Substance Use Disorders in shared decision making and self-direction of their Services;

(b) Ensure access to effective culturally and linguistically appropriate Services for underserved populations including Tribes, racial and ethnic minorities, and LGBTQI+ Individuals;

(c) Promote recovery, resiliency, and community integration for adults with SMI and children with SED and their families;

(d) Prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications;

(e) Conduct outreach to encourage Individuals injecting or using illicit and/or licit drugs to seek and receive treatment;

(f) Provide early intervention Services for HIV at the sites at which Individuals receive Substance Use Disorder treatment Services;

(g) Coordinate Behavioral Health Prevention, early identification, treatment and recovery support services with other health and social services;

(h) Increase accountability for prevention, early identification, treatment, and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services;

(i) Ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as Behavioral Health services; and

(j) Provide continuing education regarding substance abuse prevention and Substance Use Disorder treatment services to any facility or program receiving amounts from the SUPTRS BG for such activities or Services.

(6) Required Metrics: County shall be in Substantial Compliance with the following requirements:

(a) Reduce the rate at which Individuals with a Mental or Emotional Disturbance or a Substance Use Disorder are admitted to the emergency room.

(b) SUD treatment Services are made available to Individuals who are pregnant or post-partum and request such Services.

(c) Ensure Individuals have a culturally responsive healthcare provider.

h. Invoiced Services

(1) Description: Services eligible for reimbursement through Part C funds identified in Exhibit C.

(2) Invoiceable Services: County may invoice OHA for:

(a) Mental Health Residential Services:

i. Daily Service rate for mental health residential treatment Services provided to adults age 18 years old or older in a secure residential treatment facility, residential treatment facility, or residential treatment home licensed under OAR Chapter 309 Division 35, who:

A. Are uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid Services, including those who meet the criteria for Citizen Alien Waived Medical Program; or

B. Have been ordered by a court or PSRB to receive Services in a level of care for which the Individual does not meet medical necessity.

ii. Daily Service rate for mental health residential treatment Services provided to young adults in

transition (YAT) age 17 through 25 years old in a YAT residential treatment home licensed under OAR Chapter 309 Division 35 who:

A. Are uninsured, underinsured, not eligible for Medicaid, or have exhausted Medicaid Services, including those who meet the criteria for citizen alien waived medical program; or

B. Have been ordered by a court to receive Services in a level of care for which the Individual does not meet medical necessity.

(b) Room and board for:

i. Adults age 18 years old or older with limited or no income residing in a secure residential treatment facility, residential treatment facility, or residential treatment home licensed under OAR Chapter 309 Division 35; and

ii. YAT age 17 through 25 years old with limited or no income residing in a YAT residential treatment home licensed under OAR Chapter 309 Division 35.

(c) Personal Incidental Funds for:

i. Adults age 18 years old or older with limited or no income residing in a secure residential treatment facility, residential treatment facility, or residential treatment home licensed under OAR Chapter 309 Division 35; and

ii. YAT age 17 through 25 years old with limited or no income in a YAT residential treatment home licensed under OAR Chapter 309 Division 35.

(d) PSRB Security and Supervision Services

i. Security services as identified in the PSRB or JPSRB conditional release order, which are not medically necessary Services but are required for the safety of the Individual and the public, and are covered at a rate based on a determination of the risk and care needs identified in the security services matrix below:

Security Services Matrix (Community)	Low Risk	Med Risk	High Risk
High Care	Rate 1	Rate 2	Rate 3
Med Care	Rate 2	Rate 3	Rate 4
Low Care	Rate 3	Rate 4	Rate 5

ii. Supervision services are non-medically necessary Services that are necessary for an Individual to maintain compliance with terms set by a court or other supervising authority including, but not limited to:

A. Assessment;

B. Evaluation (including evaluations ordered beyond typical monitoring required by the PSRB);

C. Outpatient treatment; and

D. Polygraph if such expenses are needed to maintain compliance with the terms of a conditional release and not covered by some other mechanism.

(e) **Pre-admission Screening and Resident Review (PASRR) Services for Individuals not Covered by Medicaid**. Evaluation services delivered by a QMHP or a licensed medical practitioner as defined in OAR 309-019-0105 to Individuals who are entering a nursing facility where a PASRR level I screen has indicated that they may have a Mental or Emotional Disturbance to determine if:

A. Individuals have a Mental or Emotional Disturbance; and

B. If those determined to have a Mental or Emotional Disturbance are appropriately placed in a nursing facility or need inpatient psychiatric hospitalization.

(3) **Invoice Requirements:** Invoices must be submitted by email to BHD.Contracts@oha.oregon.gov using the BHD's forms and procedures available at http://www.oregon.gov/OHA/HSD/AMH/Pages/Reporting-Requirements.aspx.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Behavioral Health Division at BHD.Contracts@oha.oregon.gov or 503-945-5772. We accept all relay calls.

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