Oregon State Hospital

STATE OF OREGON DHS - OFFICE OF MENTAL HEALTH AND ADDICTION SERVICES

Framework Master Plan
Phase II Report

KMD Architects
with New Heights Group

February 28, 2006

EXECUTIVE SUMMARY

The intent of the Oregon State Hospital Framework Master Plan Phase II Report is to build upon the conclusions and recommendations set forth in the May 2005 Phase I Framework Master Plan with the goal of providing guidance to the Department of Human Services (DHS), the Governor, and the Oregon Legislative Assembly in setting the future for the State's Mental Health System.

While the Phase I Master Plan focused on the physical conditions of the Oregon State Hospital's (OSH) Salem campus, it also noted that Oregon's system of publicly funded care for adults with severe and persistent mental illness (SPMI) needs significant improvement. This Phase II report recommends changes to the system, and clarifies the role and size of the Oregon State Hospital (OSH) within an improved community-based system.

PROCESS

As with the Phase I Framework Master Plan, the consultant team has worked closely with the project's Steering and Advisory Committees. The consultant team interviewed multiple regional and community-based mental health service providers, acute care hospital program directors, current and former consumers of State mental health services, OSH physicians and staff, DHS personnel, and developers of community housing. Included in this process were interviews with those who provide programs that serve as models for other communities and practitioners.

FINDINGS

Today, consumers of mental health services in Oregon are often kept longer than is clinically necessary in hospital and extended care community settings. The mental health system has been, and continues to be, under-funded. It is projected that Oregon's general population will grow by about 25% over the next 25 years. Similar growth in the number of Oregon's citizens with mental illness is anticipated.

By year 2030 there will be 935 individuals on a daily basis who will need significant mental health services best accommodated within the State Hospital environment. This would require a State Hospital of 1,100 beds based on an 85% occupancy rate. Further, it is also anticipated that by year 2030 there will be a need for approximately 2,630 residential program beds. This represents an additional 900 beds (beyond the current number) that will be required to serve residential mental health needs best provided in the community. If no new community residential services are, in fact, provided a substantial number of the individuals who would utilize these beds could default to OSH potentially ballooning the State Hospital average daily population to nearly 2,000 patients.

Oregon is in the process of shifting to a "Recovery Model" system of mental health care. This model encourages individuals with mental illness and caregivers within the mental health system to actively work toward individual consumers maximizing their ability to create the life they want for themselves. This model, with its focus on self-determination, challenges the "traditional medical" approach which has guided the treatment of mental illness in the past.

Integral to this care model is the concept that persons will progress better in their home communities, self-directing their lives with support from their family, friends and skilled professionals. There is evidence that most people with mental illness do recover and go on to live productive lives as integral members

of society, reducing demand on state and local resources and support. Implementation of the "Recovery Model" requires improvements and investments in affordable housing, community-based services, discharge planning, early intervention, among others, all of which work to improve the flow of patients through a system of more responsive and functional care.

The needed investments in community services proposed within this report, will allow Oregon to build a new State Hospital System that is more efficient and will provide a more integrated continuum of mental health care.

CONCLUSIONS AND RECOMMENDATIONS

The State Hospital population has grown steadily in recent years and will continue to increase whether or not there are any changes to the statewide system of care. However, with the changes proposed in this report – a focus on community based resources to facilitate more efficient and effective use of state hospital beds – the increase in the average daily population of the State Hospital could be limited to only 22% over the next 25 years. As stated above, during this same period of time there will be an estimated additional 900 individuals requiring significant community-based residential services. This fact emphasizes the need to enhance community-based resources concurrent with development of new state hospital facilities.

Therefore, to improve the statewide system of care for those with mental illness this report recommends that the State of Oregon implement the following:

- Replace the State Hospital with properly-sized and more efficient modern hospital facilities, designed to reflect and reinforce the "Recovery Model" of care;
- Locate the State Hospital System facilities near to the homes of the majority of patients;
- Continue the process of change already underway, embracing the "Recovery Model" of care and encouraging all communities and service venues to adopt this model's underlying philosophies and goals;
- Improve the movement of persons through the system by adequate state funding of enhancements to acute care and community-based programs;
- Improve access to family, friends and skilled professionals, thereby maximizing the opportunity for self-determination inherent in the "Recovery Model";
- Increase the available educational resources and information for the entire population, improving general awareness, knowledge and attitudes about mental illness and recovery.

Oregon State Hospital System Facilities Recommendations

Based on implementation of the community-based enhancements described in this report, the following are three viable options for State Hospital System facilities (these figures are based on opening new facilities by the year 2011 which incorporates projected bed capacity needs through 2021):

Option 1

One 980-bed facility encompassing all inpatient beds, located in the North Willamette Valley region, and two non-hospital level, 16-bed secure residential treatment settings placed strategically east of the Cascades. $297-307 million Project Costs.

Option 2

One 620-bed facility located in the North Willamette Valley region, one 360-bed facility located south of Linn County on the west side of the Cascades, and at least two non-hospital level, 16-bed secure residential treatment settings placed strategically east of the Cascades. $324-334 million Project Costs.

Option 3

One 600-bed facility located in the North Willamette Valley region, plus one 320-bed facility located south of Linn County on the west side of the Cascades, and one 60-bed forensic facility in Central Oregon. $326-337 million Project Costs.

Recommended Option

This Master Plan recommends that **Option 2** be funded to provide state hospital facilities located near the homes of approximately 93% of the inpatients, along with much-needed alternatives to hospital services for Eastern/Central Oregon. The historical utilization numbers for Eastern and Central Oregon do not support a medium or large state hospital in these regions.

This recommended option (along with Option 1) calls for the development of two secure intensive residential treatment settings located east of the Cascades. These two program settings will provide the flexibility that allows an individual patient to receive safe and secure, up-front services. In many cases this is all that is needed to stabilize an individual and eliminate the need for long-term State hospitalization. These programs also serve as a step-down treatment site that allows individuals to stay a shorter time in the State Hospital by virtue of having a secure, non-hospital residential setting for them to return to that is near their homes.

It is important to stress that, for any of these options to be successful, the community-based program enhancements outlined in this report need to be fully implemented.

Community-Based Enhancements Recommendations

Enhancing the breadth and depth of community-based services is a critical piece of the state hospital master plan. This report provides estimates of beds needed in community residential programs, as well as associated costs. Not part of this study, but equally as critical, are other community services such as supported employment, case management, crisis intervention, and respite. While more detail is provided later in this report, the recommendations include:

- More aggressive funding for 'front end' services that aid in the prevention and early intervention of those with mental illness. This master plan focuses on those services and settings that are needed when an illness has exacerbated to a point where no other care option exists. A greater emphasis on prevention and early intervention could contribute to further declines in state hospital needs, while aiding a greater number of those with mental illness. Some communities within the State currently

have treatment programs such as the EAST program. These programs effectively address the issues of early intensive intervention for adolescents and young adults who are experiencing their first severe mental health crisis.

- Continued financial support for the development and operation of community based residential programs to facilitate care in the least restrictive environment and promote a recovery orientation.

- Providing counties with the financial support necessary to oversee and monitor the expanded community based services as well as the increased numbers of individuals with mental illness residing in their communities.

It is important to note that some of the community cost estimates provided in this report can be accommodated in the current caseload growth factor within the OMHAS budgeting process.

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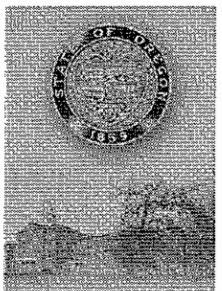

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Acknowledgments

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The consultant team of KMD Architects and Planners with New Heights Group, the mental health systems specialists, would like to thank the many stakeholders, groups and individuals who have assisted in the planning process.

We particularly appreciate the efforts and recommendations of the Governor's Mental Health Task Force in their 2004 Report. The Honorable Peter Courtney, Senate President, is recognized for his efforts and focus on the plight of those persons with mental illness in Oregon. The bipartisan Legislative effort to keep this issue before the citizens has been particularly effective in bringing this topic to public discussion.

We appreciated the patients and staff of the Oregon State Hospital for their openness and enthusiastic interest in the project. A special thanks goes to Mr. Norman Miller, Project Manager for OMHAS, for his absolute commitment to the mission, dedication to the effort, partnership in the implementation of this report, and wisdom.

We recognize that without the growing interest generated by these and others, Oregon's Public Mental Health System would continue to languish, out of the eye of the general public.

Stakeholders

Consumers, Peers, Survivors
Community Mental Health Providers and Program Directors
Consumer Advocates, Friends, Families, NAMI
OSH Staff

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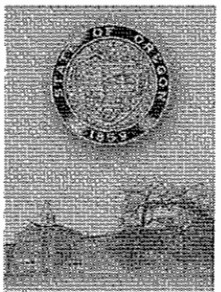

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INTRODUCTION

The conclusions of the May 16, 2005 Phase I Master Plan indicate that Oregon's current system of care for those adults with severe and persistent mental illness (SPMI), while in the process of becoming more systematically community-oriented, is complex and at times is operating more as an aggregate of treatment settings rather than as a truly integrated system of care. In addition the Phase I Master Plan notes that the existing facilities on the Salem campus of the Oregon State Hospital have physical limitations that cannot be remediated to provide safe and secure treatment environments.

Consequently, the primary objective of this Phase II Master Plan is to evaluate the role and size of the Oregon State Hospital (OSH) within an improved statewide system of care for persons with SPMI. This objective required that the consultant team review and evaluate inpatient and outpatient services throughout the State of Oregon and recommend appropriate changes and enhancements to the system.

Individual patient recovery, safety, and security are the primary goals of Oregon's Mental Health (MH) system. The options and recommendations that are proposed in this Phase II Master Plan are not intended to redesign the entire system, but build upon it. While the focus is on the Hospital, this report also describes improvements in community-resources that are needed to support the mission of the Hospital and to allow it to meet these overarching goals.

This report, by providing evidence-based information and insights, will assist the Governor and the Legislative Assembly as they formulate decisions about the future of Oregon's mental health services.

PROCESS

With the guidance of the Project Steering Committee and with review and input from the Advisory Committee, the planning process undertaken for projecting future OSH bed need and corresponding community resources included the following steps.

1. Review of available data provided by the State:

    - To understand historical utilization of OSH beds by program type, and to understand recent trends in admission patterns by county/region, length of stay, and wait lists for admission to and discharge from the State Hospital. Data for all campuses was included in this analysis.

    - The current inventory of community-based residential services by setting and region to understand current distribution of those non-hospital residential services..

2. Interviews with selected representatives of "best practice" providers, as identified by the Master Plan Steering Committee, to understand their programs, critical success factors, how experiences might be applied to other providers across the State, and future needs and challenges.

3. Facilitate five regional program meetings with provider and consumer representatives across the State to gather pertinent information and to understand area utilization challenges, delivery system needs, and their implications on OSH use.

4. Meet with and interview individuals and groups who are or have been patients at Oregon State Hospital and those who are family and friends of patients. These have included persons who now provide an advocacy role for those with mental illness.

5. Interviews with OSH physicians, staff and administrators to gather information relative to needs, current programs and implications of hospital size.

6. Interviews with representatives of local acute psychiatric inpatient units to understand both their challenges and their ideas regarding system enhancements. Acute psychiatric inpatient unit representatives were also invited to attend the regional program meetings.

7. Meet with the Psychiatric Security Review Board to gain their perspective on the assumptions used for the State Hospital forensic population.

The qualitative and quantitative information that was gathered through this process provides the basis for the planning projections. The initial assumptions developed within this interactive process were reviewed with OMHAS staff for additional input into trends, patterns and implications. The consultant team then assimilated the data and developed projections that are based on accepted forecasting methodologies. It is important to note that any projections for a 25 year time frame are, at best, estimations.

These Master Plan projections reflect 1) the future OSH bed need, and 2) the corresponding community residential and supporting program needs that are required to positively impact OSH patient admission and length of stay patterns.

Key Findings

KEY FINDINGS

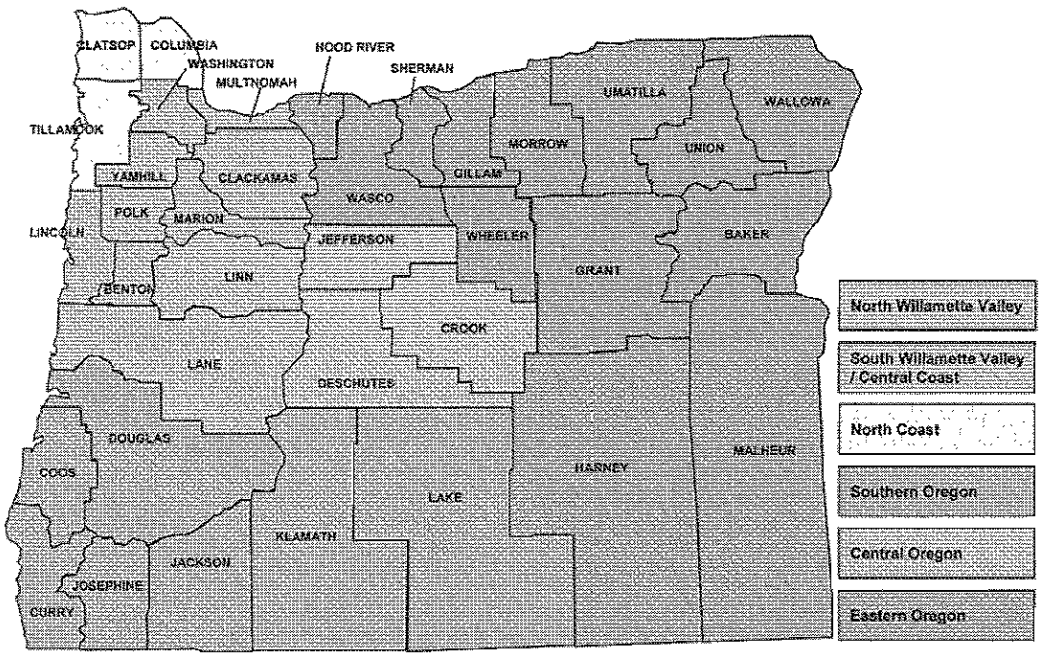
STATE HOSPITAL

The State Hospital provides long term care for those with severe and persistent mental illness (SPMI). There are three service areas: Adult Treatment Services (ATS), Neuropsychiatric Services, and Forensic Services.

Approach and Assumptions

Projections for state hospital beds are provided through year 2030 and address the need across the entire State that is now served by the three campuses – OSH Salem and Portland campuses, and Blue Mountain Recovery Center (Eastern Oregon Psychiatric Center, Pendleton).

Each county is placed in one of six regions to better address the variations in utilization noted in rural vs. urban areas. The regions are similar to those used in other state planning activities and are shown below:



OSH BED NEED PROJECTIONS

The projected need for OSH beds through 2030 is based on the following:

- Historical utilization patterns of OSH by county and region. Utilization data includes age-adjusted use rates (OSH admissions per 1,000 population), wait lists for admission and discharge, and length of stay by program type.
- Extensive feedback from multiple stakeholders across the State for improved understanding of the current system as well as opportunities for improvement. The input included:
  - Individual interviews with identified 'best practice providers' and consumers in the community;
  - Group meetings within each region to discuss historical utilization and future needs for both OSH and community based resources;

- Interviews with OSH clinical and support staff;
- Meetings with the Psychiatric Security Review Board (PSRB) to review assumptions; and
- Meeting with acute care hospital providers.

- Discussions focused on the following:
  - Regional variations in OSH utilization and rationale;
  - Existing community resources and the types and numbers of services needed to minimize reliance on OSH beds;
  - Best practice models of care in the communities; and
  - Barriers to developing a more integrated continuum of care among community and OSH settings.
- Population projections by county and region focused on those age groups that most closely reflect the program type:
  - Adult Civil (ATS): 20-64 year population segment
  - Neuropsychiatric: 65+ population
  - Forensic: 20+ population

  The process of focusing on the population segments most likely to use the services allowed the consultants to develop age-adjusted utilization rates and projections. Population projections were obtained from the Oregon Department of Administrative Services (DAS) Office of Economic Analysis.
- Projections were based on regional variations in use and regional demographic trends.

The following assumptions were made regarding the future need for OSH beds:

- **Adult Civil (ATS)**

  State Hospital services for adults who have been civilly committed for hospitalization. This population currently occupies about 25% of the State Hospital beds.

  - **Admissions to OSH**. Considerable variation in use of OSH beds exists across regions. Bed projections assume this regional variation will continue. Admission rates (admissions per 1,000 adult population) have declined in the past years. This trend is expected to continue upon the development of more community resources. Changes in admission rates were adjusted for each region to reflect the continued variation in utilization by region. Rates were applied against the projected adult population by county in order to estimate future admissions to OSH.

  - **Length of Stay.** OSH length of stay for ATS patients is anticipated to decrease from an average of 250 days to 175 days with the development of additional intensive case management and community residential programs. It is assumed that this length of stay decrease, and the community program development needed to facilitate earlier discharge, would occur by the year 2011 when new facilities open.

  - **Wait Lists for Admission and Discharge.** Through development of additional community residential programs, it is assumed that patients who would have been on a wait list will be accommodated in the appropriate setting when clinically necessary.

- **Neuroscience/Geriatrics**

  State Hospital services for those with medical conditions that cause or contribute to psychiatric disorders. This group currently occupies about 15% of State Hospital beds and is centralized at the Salem campus.

  - **Admissions to OSH.** Unlike adult civil patterns, the admissions per 1,000 population for the neuroscience/geriatric program have increased in recent years. For planning purposes it is assumed that this increase will continue as the incidence and prevalence of Alzheimer's disease, head injury, and other neurobehavioral diseases increases and as the current population of persons with SPMI ages. These increases in the admission rates were adjusted to reflect the continued variation in utilization by region. These rates are then applied against the projected population of the 65+ age group, which is the fastest growing population segment in Oregon.

  - **Length of Stay.** Length of stay at OSH, with considerable variations per patient, averages 461 days for the neuroscience/geriatric program. Much of this condition is due to the limited options available in communities for these patients. It is assumed that incentives will be provided to develop these community-based settings in the future, enabling a limited decline in length of stay at OSH from 461 days to 400. As with the adult civil population, it is assumed that the community program development needed to facilitate earlier discharge will occur by year 2011 when new facilities open.

  - **Wait Lists for Admission and Discharge.** Through development of additional community residential programs, it was assumed that patients who would have been on a wait list will be accommodated in the appropriate setting when clinically necessary.

- **Forensics**

  The forensic population is committed through the criminal courts and currently occupies nearly 60% of the current State Hospital population.

  The forensic population is the most rapidly growing population at OSH. Admission decisions to OSH for both Aid and Assist and PSRB programs are determined by the judicial system and, as such, are not driven solely by clinical needs, but also by public safety considerations. Anticipating future changes in OSH utilization projections is difficult. For purposes of this report, only modest changes in the forensic system are assumed because of judicial, clinical, and external non-clinical forces. Among others these non-clinical forces include community fears and reluctance by some to site community services for this population in their neighborhood. Without significant changes in the court and PSRB systems, the forensic patient population will continue to increase at dramatic rates.

  - **Admissions to OSH.** No decreases in the admission rate to OSH are projected for the forensic population. It was assumed that forensic admissions would follow the projected intake rate developed by the Department of Corrections.

  - **Length of Stay (PSRB).** With significant development of community residential programs, the PSRB length of stay at OSH will decline from almost 1,000 to 800 days due primarily to a decrease in waiting for discharge upon assignment to the conditional release planning

process. The planning projections assume treatment success as a result of developing considerable PSRB community beds. Without this change, the length of stay will likely remain closer to current levels. It is important to note that these community beds are often the most difficult to develop in light of resistance from local residents. Length of stay reductions should be met by 2011 (when the new hospital facilities open) to meet occupancy level projections.

- **Length of Stay (Aid and Assist).** The Aid and Assist length of stay will decrease from 165 days to 100. This decrease will be accomplished through enhanced evaluation techniques and improved linkages with the court system. Length of stay reductions should be met by 2011 (when the new hospital facilities open) to meet occupancy level projections.

In addition to the above program assumptions, the Department of Corrections (DOC) will contract for dedicated beds at OSH to help manage the growing population of persons with mental illness in the prisons. The DOC will maintain 20 beds at OSH in 2011 and 40 beds by the year 2030.

An 85% occupancy rate is assumed for all state hospital program areas and reflected in bed numbers and cost figures. This rate is a standard occupancy assumption for healthcare facility design. It provides the flexibility needed to manage census fluctuations as well as changes in patient acuity, gender, etc. OSH has operated above 100% occupancy in recent years. This reality has created issues regarding staff safety, staff to patient ratios, and general overcrowding. Estimates of state hospital bed need, development and operating costs are based on this 85% occupancy level.

Oregon State Hospital Bed Need

Given the above assumptions, beds needed for patient admission to OSH will be about 1,100 by year 2030. A total bed breakdown by program type follows:

Total State Hospital Bed Needs

Average Daily Population	2005	2011	2021	2030
ADULT CIVIL (ATS)	193[1]	111[6]	109	107
NEUROPSYCH[2]	114	99[6]	140	184
FORENSIC	434	525	575	613
BED NEED	741	735	824	904
BED NEED @ 85% OCCUPANCY[3]	***872[5]***	***865***	***969***	***1064***
DOC[4]	0	20	20	40
TOTAL	***872***	***885***	***989***	***1,104***

[1] *The 193 Adult Civil (ATS) patients include those at Blue Mountain Recovery Center (Eastern Oregon Psychiatric Center, Pendleton)*

[2] *Neuropsychiatric beds include medical beds for those with medical and psychiatric needs.*

[3] *Using the 85% occupancy rate, this is the number of beds that should be available. Note the methodology used for calculating occupancy is to divide the number of beds ("BED NEED") by 85%.*

[4] *These are beds in OSH facilities requested by the Oregon Department of Corrections (DOC).*

[5] *This number represents the current number of beds that SHOULD exist in the OSH system today to allow for a proper occupancy rate.*

[6] *The decreased 2011 bed needs for ATS and Neuropsych at the State Hospital are based on the development and implementation of significant new community-based services to accommodate an overall increase in these populations.*

The major factor attributed to the growth in the neuropsychiatric population is the rapid growth in the 65+ population in Oregon. Future bed need by region and program type, excluding DOC beds, is shown below. The projected regional bed need reflects differences in population growth and historical use of OSH and is presented as a population-based distribution of beds.

Total State Hospital Bed Needs by Region

REGION	2011			2021			2030		
	Adult (ATS)	Neuro-Psych	Forensic	Adult (ATS)	Neuro Psych	Forensic	Adult (ATS)	Neuro Psych	Forensic
North Willamette Valley	79	69	304	82	100	325	83	134	344
North Coast	5	1	15	4	2	16	4	2	16
South Willamette/Central Coast	16	21	138	16	29	162	16	36	175
Southern Oregon	15	19	120	12	25	128	10	31	136
Central Oregon	4	4	14	3	6	17	3	9	19
Eastern Oregon	11	3	27	11	3	28	11	4	30
TOTALS @ 85% Occupancy	**130**	**117**	**618**	**128**	**165**	**676**	**125**	**215**	**720**

The above chart excludes beds requested by the Oregon Department of Corrections (DOC).

The need for investment in community residential and other settings is pivotal to OSH projections. Without community residential investment, which will be described in the next section, the beds needed at OSH could exceed those projected, increasing the size and cost of replacement facilities. This increase in hospital beds would occur largely because of unnecessary admissions and longer lengths of stay, both caused by lack of enhanced community resources.

COMMUNITY BASED PROGRAMS

Greater investment in local and regional services is needed to support development of a community-based system of care. While this master plan focuses on the facility plan for the Oregon State Hospital, projections are also provided for the number of community residential program beds and the increased funding of community front-end services needed in order to achieve the desired reduction in OSH length of stay and admissions. **Without the enhanced community programming, demand for OSH beds will substantially exceed projections of size and cost.**

There are two components of the community-based programs that affect OSH utilization: community-based residential programs and critical "front-end" services.

Community Residential Programs

The community residential programs are a primary resource for diverting individuals who otherwise would go to OSH and for expediting the discharge of individuals from OSH. Thus, availability and access to these programs are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community.

Approach and Assumptions

As noted earlier, an inventory of existing programs by setting and region was developed from the OMHAS licensure database. In reviewing this inventory, it is clear that current beds are not distributed consistent with Oregon's population. This condition could contribute to difficulty in placing patients from OSH since patients often want to be discharged to their place of last residence.

Projections for future community residential program needs were based on the following:

- Developing an inventory of services by setting and location. Calculating the number of beds per 1,000 citizens for each setting and region.
- Determining the number of patients currently waiting to be admitted to, or discharged from OSH who could be served in community residential programs. The wait lists identify setting type needed. Wait list days are incorporated into the current distribution model.
- Incorporate the provider feedback obtained in interviews to adjust use-rates for community residential programs.

The planning projections thus reflect more effective use of community residential programs as well as a population-based distribution of beds.

The assumptions for community residential program development were:

- Changes in OSH utilization will be enabled by community residential program development. Limiting the size of the hospital and its associated capital investment cannot occur without proper investment in the community residential programs.

- Many patients in acute care hospitals today could be accommodated primarily in community-based intensive residential programs such as Post Acute Intermediate Treatment Service (PAITS) rather than going to OSH.

- Length of stay within community residential programs will decrease as housing and other front-end community services are further developed. This change will provide discharge placement options as well as services that could prevent need for state hospital admission. Expansion of housing, intensive care management, support employment and other programs is needed to achieve this.

- OSH wait list and length of stay adjustments and the corresponding community program development will occur by year 2011, before the opening of a new state hospital. This is an aggressive assumption, but necessary to achieve a more efficient operation and system of care.

- Intensive case management functions will be integrated between OSH and the communities to facilitate discharge planning across all settings. Patient-centered mental health services are best managed at the community level.

- Community residential programs will operate at 95% occupancy, consistent with current assumptions. This occupancy level allows the flexibility needed within residential programs to accommodate census fluctuations, privacy needs, and other adjustments needed to operate smoothly.

Projected Community Residential Program Needs

Given the planning assumptions above, a need for an estimated 2,633 community residential beds is projected in year 2030, up from a total of 1,729 today. The bed projections reflect a redistribution of beds based on Oregon's population. There will also be a shift in program type with a focus on developing beds in more secure settings for the patients who are more difficult to place; those individuals now have the longest stays at OSH.

Community residential beds by region are shown below:

REGION	2005[1]	2011	2030
North Willamette Valley	857	1,098	1,361
South Willamette/Central Coast	373	431	531
North Coast	30	62	69
Southern Oregon	290	317	370
Central Oregon	36	112	153
Eastern Oregon	121	128	149
Total	**1,729**	**2,148**	**2,633**

[1] *The 2005 numbers represent current distribution of beds.*

The above bed numbers for years 2011 and 2030 by region provide a population-based distribution of community residential beds that better enables consumers to remain in their home region. An estimate of community beds based on program type is shown below, although this could change with adjustments in patient needs and treatment approaches.

RESIDENTIAL BED PROGRAMS [1]	2005[3]	2011	2030
Adult Foster Home (AFH)	486	548	640
Residential Treatment Facility (RTF – including Secure (SRTF))	790	892	1,037
Residential Treatment Home (RTH – Including Secure (SRTH))	109	204	241
Supported Housing (SH) [2]	119	165	185
PAITS	22	27	27
Intensive Residential	-	48	58
Enhanced Care (EC)	140	178	303
Enhanced Care Outreach Services (ECOS)	63	86	142
Total	**1,729**	**2,148**	**2,633**

[1] *See Appendix G, Glossary, for definitions of Residential Program Types.*

[2] *Supported housing needs are based on current programs supported by OMHAS. Other supported housing units are unavailable; as such, the numbers may be understated.*

[3] *The 2005 numbers represent current distribution of beds.*

OPERATING AND DEVELOPMENT COSTS

The estimated costs of operating the future system of care, including both OSH and the community residential programs identified above, were based on the current average daily OMHAS cost by program type. All costs – operating and development – are in 2005 dollars, with no accounting for inflation. Costs shown below are annual costs, not biennial.

Operating Costs

Assumptions in estimating operating costs in both the State Hospital and community residential settings are described below.

- **State Hospital** – The OSH average cost per day will increase to a level more consistent with other state hospitals. Current budgets and client capacity suggest an average cost of $373 per day at OSH, 25% below comparable facilities for which data was available (see below). The average cost of $373 per patient per day includes the impact of the 30 additional staff members recently budgeted. The low cost per day could be due to continued understaffing, wages, older facilities, limited programming, or other factors.

Facility Location	Bed Capacity	Cost per Paitient per Day (year 2004)
Kansas	422	$ 429
Minnesota	247	$ 408
Nevada	150	$ 550
Washington	274	$ 531
Washington	776	$ 438
Average	*374*	*$ 471*
Oregon - 2005 (Salem and Portland campuses)	**681**	**$ 373**
Oregon - 2011 Projections	**885**	**$ 465**

The increase in daily costs will allow OSH to reach improved staff-to-patient ratios and enhanced programming. While it is understood that the cost for care in Adult and Neuropsychiatric programs is more expensive than in Forensic programs, the average cost per day is estimated to be about $465 per patient for year 2011.

- **Community Residential** – Operating costs for the community residential beds by region are provided below (all costs in 2005 dollars, not adjusted for inflation). The costs of operating the expanded community residential settings are based on the average 2005 OMHAS payments to these settings. Payments are based on occupied beds only, assuming community residential programs operate at a 95% occupancy rate.

  These estimates focus solely on the identified beds noted below and do not include costs for community case management, crisis, early intervention, housing and other front-end services. The State must assure, at a minimum, that ample and appropriate case management services are available for residents in these programs. Some of the support can be funded through case load growth.

Community Beds by Region	2005	2007 Est. Need	2007 Estimated Costs per Year	2009 Est. Need	2009 Estimated Costs per Year	2011 Est. Need	2011 Estimated Costs per Year
North Willamette	873	999	$67,323,662	1,049	$70,718,102	1,097	$73,771,756
South Willamette	379	395	$26,324,069	414	$27,369,486	431	$28,482,057
North Coast	30	57	$3,601,773	60	$3,894,049	62	$3,999,230
Southern Oregon	290	295	$19,737,241	306	$20,089,308	317	$20,665,572
Central Oregon	36	95	$5,900,263	104	$6,753,083	112	$7,167,681
Eastern Oregon	121	118	$7,593,027	123	$8,097,976	128	$8,451,546
Total Community Beds	**1,729**	**1,959**	**$130,480,035**	**2,056**	**$136,922,004**	**2,147**	**$142,537,842**

In addition to the above operating cost estimates for the direct provision of care, an estimated 10%, or $14 million, is needed for counties to provide the infrastructure to support the expanded community based programs. Without this support, the expansion of services at the local level will add undue burden to local county mental health agencies.

Estimated **annual** combined OSH and Community Residential operating costs for the next three biennia are shown below.

	2005		2007		2009		2011	
		Costs per Year	Est. Need	Estimated Costs per Year	Est. Need	Estimated Costs per Year	Est. Need	Estimated Costs per Year
Community Residential	1,729	$115,110,000	1,959	$130,480,000	2,056	$136,940,000	2,147	$142,570,000
OSH	741	$101,000,000	907	$131,510,000	888	$128,360,000	865	$124,600,000
Oregon Total	2,470	$216,110,00	2,866	$263,990,000	2,944	$265,300,000	3,012	$267,170,000

Costs have been rounded to the nearest $10,000

Costs reflect total State costs, without federal matching funds. Historically, Medicaid has contributed to some community-based settings through a federal match; the amount has varied by year. Recently, national efforts have occurred to minimize and/or eliminate this funding to state psychiatric services; this funding has not been included in these dollars. Accordingly, if Federal matching funds are available, State costs will be less.

Community-Based Residential Development Costs

Development costs for the community based residential services are based on recent historical experiences within OMHAS. These costs are applied against the number and type of projected new beds in each region. Costs reflect OMHAS funding only and may not reflect total costs to the providers. Average cost-per-bed assumptions include program start up, housing facility development, and changes necessary to accommodate recent fire safety standards for residential programs. In many instances, providers obtain additional funding from other state or private sources, but this has not been included in the cost estimates below.

The assumed average development start-up cost per bed by program type is shown below.

Community Residential Program Type	Development Cost per Bed
Adult Foster Home	$ 2,000
Supported Housing/ Case Management	$ 2,000
Enhanced Care	$ 35,250
Residential Treatment Facility	$ 13,250
Residential Treatment Home	$ 13,250
Secure Res. Treatment Facility	$ 35,250
Secure Res. Treatment Home	$ 37,600
Intensive Residential/Post Acute Intermediate Treatment (PAITS)	$ 37,250

The estimated costs to develop the community residential programs that will be needed by year 2011 are shown below by region and biennium. Much of these costs are allocated to urban areas where there is the highest need for additional beds, particularly of the higher acuity type. The costs below address the additional beds needed to develop a population-based system of care. They are based on 2005 costs and do not include estimates for inflation.

Estimated Development Costs – New Beds			
REGION	2007	2009	2011
North Willamette Valley	$3,467,100	$942,100	$854,000
South Willamette/Central Coast	$1,302,300	$337,250	$372,850
North Coast	$667,250	$85,750	$1,000
Southern Oregon	$2,491,350	$222,000	$222,000
Central Oregon	$903,450	$190,100	$172,500
Eastern Oregon	$688,950	$124,350	$51,500
TOTAL	**$9,520,400**	**$1,901,550**	**$1,673,850**

Most of the community development will need to occur over the next five years so that these services are in place before a new state hospital opens. This development is key to the assumptions in state hospital utilization and corresponding bed need. Without these community programs operating before a new state hospital is built the decreases in length of stay and changes in use rates will not be realized.

The large investment projected for community-based programs in the next biennium is required to begin decreasing the length of stay at OSH as well as to correct the current mal-distribution of community beds. It is important that shifts in the geographic distribution of beds occur as well as shifts in program types. In some areas an excess number of certain types of beds occur while in other areas a shortage of appropriate program beds is the result.

The OMHAS budgeting process incorporates projected caseload growth to account for those who have been through the civil or criminal commitment process. *The operating and development cost estimates in this report do not take into consideration current funding through the caseload growth budgeting process.* This may result in dollars already having been budgeted thereby potentially reducing the amount of new dollars needed for operating and development costs.

Development Challenges

Many of the beds needed in the future are for particularly hard-to-place clients, such as sex offenders, violent or aggressive individuals, etc., and others who will require secure settings. Many communities have been reluctant to develop programs for these more difficult patients and many remain at OSH beyond clinical necessity. Shifting case management and accountability to counties for patients in OSH may help develop these programs.

Incentives and resources for developing these facilities may need to be established for community providers. In some cases, with a lack of provider interest or capacity, development of these more challenging programs might require state ownership and operation. State operation could make these programs more expensive and could further disengage communities from accountability for these patients, but could ensure sustainability for these treatment settings. The provision by the State of infrastructure dollars to the counties may allow them to develop these complex programs.

COMMUNITY FRONT-END SERVICES

This report was commissioned to focus on the State Hospital. It quickly became clear that one could not address the State Hospital without also addressing community-based services, of which the residential component is very large. However, to only focus on "bed needs" minimizes the importance of early intervention and community supports. The "bed need" orientation focuses on the most expensive aspects of the System of Care and addresses the needs of only a relatively small portion of the mentally ill population (of the 100,000 individuals served in 2005 by the public mental health system in Oregon, less than 1,000 were admitted to one of the State Hospital campuses). Without more aggressive funding of services to recognize and treat people earlier in their illness, demands on the State Hospital and other more expensive settings will continue to grow. These services are referred to in this report as "up front" or "front end" services and include:

- **Crisis Intervention Services**: Provided in local communities these services provide early assistance to those undergoing a rapid exacerbation of their mental health condition.
  - With adequate crisis services, many consumers could be stabilized early and resume their previous function more quickly.
  - Without these important services, treatment can be delayed, the consumer gets sicker, and hospitalization becomes the only remaining option.
  - While crisis services are provided for Medicaid patients as part of the Medicaid MHO rates, funding has been limited for the non–Medicaid eligible population. The non-Medicaid eligible clients represented an estimated 45% of the 2005 population served by OMHAS (based on the 2005 mental health block grant report prepared by OMHAS).

- **Psychiatric Hold Rooms**: Support, development and staffing are needed for psychiatric hold rooms in acute medical hospitals. These hold rooms, often associated with emergency departments, are a critical safety net in many communities. They serve as the only location that can provide a safe environment in which to stabilize patients during a crisis episode. The State of Oregon provides funding to some counties and regions to help offset the costs of "psychiatric holds." By Oregon statute the "County of Residence" is responsible for compensating the hospital for the "hold" as payer of last resort. The hospital is responsible for seeking all other funding sources prior to billing the county. The funds provided by the State through the county may or may not cover the county's full responsibility for these "holds".

- Many hospitals, particularly in rural communities, do not have the mental health professional staff needed to effectively staff these services.
- Mental health patients using the hold rooms can cause considerable disruption in the emergency rooms, affecting emergency wait times and ultimately the treatment of others.
- Payments received by the hospital may not adequately cover the true costs of these hold services.

As a result of the above challenges, hospitals are feeling increasing pressure to close their hold rooms for mental health patients, cutting off a critical safety net for communities. Recognizing the role these services play in the full continuum of care, increased State support for these services is warranted.

- **Respite Care**: It is often the case that a person with SPMI needs an occasional opportunity to pull out of their current life situation and receive support in a safe environment. Respite care programs are relatively inexpensive to fund and are often all that is needed to prevent further decompensation, and potential hospitalization.

- **Respite Care for Caregivers**: Caregivers require a break in the day-in-and-day-out rigors of caring for those who need help caring for themselves. Evidence supports the need and benefit of providers receiving compensated time-off, but currently little funding is available for this. While respite beds can be incorporated into community residential program settings, it is made difficult under current licensure and payment practices.

- **Supported Housing and Affordable Housing** has been addressed in Appendix D of this report. This service remains a critical need that can have a powerful effect on the ultimate use of state hospital beds and state supported services. The lack of available housing causes a domino effect for persons with mental illness, limiting the ability to work, afford treatment for their mental illness, and resulting in a more frequent need for hospitalization.

- **Case Management Services** are needed for all persons with SPMI, the most frequent users of the state continuum of care. Case management services facilitate the use of the most effective and efficient levels of care, as well as help provide early intervention to prevent the need for more intensive care. Case management can contribute greatly to a lower cost system of care by ensuring individuals achieve the most appropriate care at the most appropriate time. While average case manager caseload sizes have slightly decreased in recent years, case management services are disproportionately distributed across the State. This condition results in excessive caseload sizes in some areas. There are also a significant number of low-income, non-Medicaid-eligible individuals who could benefit from these services, but funding for this is insufficient.

- **Medication Subsidies** are needed because of rising drug costs. Many consumers can manage their disease effectively with the appropriate medications and outpatient/case management services. Episodic exacerbations resulting in hospitalizations are often caused by a stoppage in medication due to affordability. Providing subsidies to assure that patients who have no drug benefits receive the needed medication can help prevent acute or long-term hospitalizations, and contribute to more productive lives.

- **Supported Employment and Supported Education** are needed to assist persons with SPMI in obtaining and maintaining employment to break the cycle of dependency on state support and facilitate recovery.

- **Training and Education** is needed for consumers, family members, and caregivers in new techniques of care, available resources, and support systems. Some of these resources are provided in a fragmented manner through advocacy organizations, providers, and other groups. The State is positioned to facilitate organizing these resources and disseminating the information to those who need the assistance.

These incentives are critical components of the continuum of care, but are not currently receiving adequate funding. These services may be less visible to the State, yet the lack of such services contributes greatly to the ultimate use of more expensive state resources. Greater investment in these services at the community level will facilitate more appropriate utilization at OSH and contribute to a more recovery-oriented model of care for those with mentally illness. A look at other states that have attempted to decrease use of state hospital beds without adequate funding of the community continuum of care shows that this approach can "backfire" resulting in an even higher reliance on state hospital services.

The costs of these services remain under review but will no doubt be substantial. However, the greater the investment in the community level of care, the less reliant the communities will be on the more expensive state hospital.

CONTINUUM OF CARE

Severe and persistent mental illness (SPMI) is a chronic but treatable condition, with patients utilizing the mental health system at multiple points along a mental health service continuum of services and settings. As such, any one component of the service continuum of care cannot be addressed without affecting the other settings and services.

The settings and services comprising the current continuum of care are provided in this report's appendices and include the following types of services:

- State Hospital – The State Hospital provides long term care for those with severe and persistent mental illness. There are three populations served by the State Hospital:
  - Adult treatment services focuses on adults who have been civilly committed and have severe and persistent mental illness.
  - Neuropsychiatric services include patients who have a medical condition contributing to their mental illness. This may include those with brain injuries, Alzheimer's, or other medical diagnoses.
  - Forensics services comprise the largest population within the State Hospital. These patients have been committed to the State Hospital for one of two reasons:
    > For determination – prior to trial – of their ability to aid and assist in their own defense (referred to as Aid/Assist patients), and
    > For being found guilty except by reason of insanity. These patients are then under the jurisdiction of the Psychiatric Security Review Board (referred to as PSRB patients).

- Acute Care Hospitals – Many of the acute care hospitals in the State provide a critical function in the continuum. The emergency rooms serve as a safety net provider for those undergoing an acute episode who may be of danger to themselves or others. Psychiatric hold rooms are often available in emergency rooms to manage these patients for a few days while awaiting commitment proceedings. In addition, several acute care hospitals operate psychiatric units to manage civil patients undergoing an acute episode. These units are designed for short-term care (less than 10 days); patients are typically discharged back to their communities or civilly committed to the State Hospital if continued long-term care is needed.

- Community based residential programs include adult foster homes, residential treatment facilities, and enhanced care services among others (see Appendix A). These programs take residents who are not yet able to live independently, and assist them in developing the skills necessary for independence. Residents typically stay for months or years in these programs that provide a critical link in the system of care.

- Community "front end" services include case management, crisis intervention, prevention, housing, supported employment, and respite care. These programs serve to maintain individuals with mental illness in the least restrictive setting, often helping them to live independently. These services are oriented less around long-term treatment, and more around prevention, early detection and intervention.

Successful investment in properly sized new state hospital facilities relies on investment in other aspects of the mental health service continuum. Gaps anywhere along the continuum – whether it is

the limited availability of OSH beds or the lack of crisis services – will foster unnecessary utilization and/or lack of capacity across other services and settings. With any community enhancements it is essential that counties be provided with sufficient infrastructure dollars (funds provided by the State to a county) for program development and management.

To work effectively, the service continuum must operate as an integrated and well-managed system. This Phase II report focuses on the master facility plan for OSH, yet outlines other system implications and opportunities that must be addressed for the OSH Master Plan to succeed.

Some of the key findings of the master planning process are the following:

- **Statewide System of Care**
  - Insufficient investment has taken place in community level initiatives that focus on prevention, early diagnosis and treatment (front-end services). The result is an over-reliance on more expensive services such as OSH, contributing to on-going capacity issues for the hospital. Greater investment in housing, respite, crisis services, supported employment, and other front-end services is needed to better manage utilization of OSH.
  - Initiatives at the national level indicate that the more successful programs are those that use a recovery model and/or consumer-driven models of care. While OMHAS has supported these approaches, more consistent definition and direction must be provided in how they should be applied in the continuum of clinical settings serving the mentally ill throughout Oregon. Considerable variability now exists in how these initiatives are currently implemented.
  - Some communities within the State currently have programs that effectively address the issue of early intensive intervention for adolescents and young adults who are experiencing their first severe mental health crisis. One such initiative is the EAST program. These types of programs have proven very effective.
  - Better integration of agencies serving the mentally ill is needed to promote a more seamless approach to care:
    > The efforts of OMHAS and the Psychiatric Security Review Board (PSRB) should be more coordinated in formulating improved placement criteria for the forensic population.
    > OMHAS and community agencies must be better integrated to foster the seamless flow of persons across treatment settings.
    > Acute care hospitals need to be better integrated with community-based programs, thereby eliminating discontinuity in the continuum.
  - The current service system is oriented around the case management of settings rather than consumers. Many community providers struggle to maintain involvement with their clients while they are at OSH. Case management, therefore, tends to be both limited and disjointed. Continuity is needed in a patient-specific case management system as it assists individuals moving through the entire continuum of care.

- **Community-Based Resources**
  - The geographic availability of community residential services varies considerably across the State. There are currently over 1,700 community beds serving adults across Oregon. This number is neither sufficient nor appropriately distributed across the State to allow patients who are ready for discharge to leave OSH in a timely manner thereby producing longer lengths of stay at OSH.

> Data and feedback from individual interviews and regional program groups indicate that a few community beds are underutilized. Some of this is due to the geographic mal-distribution of beds noted above.

> An overall lack of independent and supported housing opportunities for those persons with mental illness contributes to a longer stay in the residential program settings. The lack of affordable community-based housing delays individuals' ability to move from one level of treatment to another, thereby creating a backlog within the mental health system. Moreover, those with mental illness must compete with the general population for available housing. An adequate amount of affordable housing in appropriate settings with a geographical balance is critical to patient success as they move to independent or semi-independent living.

> Despite the defined roles of the different community residential programs supported by OMHAS, lack of consistency occurs in how residential services are actually used across counties. Further, few financial incentives are in place to move clients through the continuum of care. For example, most programs are paid the same, fixed daily rate irrespective of how long a resident has stayed. As a result, clients may stay longer than is clinically necessary in community-based treatment settings.

- While the State provides financial support to fund community based residential program development, there is little corresponding support provided to the counties for managing these programs and residents. This infrastructure support is needed for community mental health providers to foster program development, case management, technical assistance and regulatory monitoring of the community based programs.
- Individual community settings need to be adaptable to a particular community's changing needs, especially those serving smaller communities. Current licensure practices limit what community residential programs can and cannot do. Flexibility in how these settings are used provides a more efficient system of care.
  > For example, residential treatment facilities may be needed and appropriate to provide occasional respite care or crisis services. This could facilitate better utilization of these facilities as well as meet the needs of local communities.
- A more subacute level of care is needed to respond to a client's early episode, thereby either precluding or minimizing acute hospital care. This level of care may take the form of supported housing, intensive case management services, or a residential based program with professional staff to care for individuals who, in its absence, would otherwise need acute or OSH hospitalization. The Post Acute Intermediate Treatment Services (PAITS) program is an example of subacute residential care.
- The Oregon mental health system needs increased funding for supportive employment services. Gainful employment is a key factor in recovery.

- **Community Acute Care Psychiatric Units**
  - Hospitals are experiencing increased financial struggles and psychiatric units, in particular, are under greater scrutiny as hospitals are faced with difficult decisions regarding which services to keep and which to exit. The difficult financial situation for hospital psychiatric units has resulted in reductions in beds on some of those units and the closure of one psychiatric hospital. Acute care capacity in Oregon has been further reduced with the closure of two other hospitals related to poor clinical performance and overall hospital financial issues. This trend threatens a critical safety net and program setting for those with mental illness.

- The length of stay within these acute psychiatric units is driven somewhat by the lack of availability of non-acute community-based services or state hospital beds, depending upon patient needs. Without these state hospital and community services, or with extended wait periods for these services, patients are prone to stay longer than necessary in the acute hospital setting.

The above findings have implications for the State Hospital System:

- Admission rates to OSH would decrease with greater availability of front-end services and programs at the community level. Early intervention services such as housing, crisis and case management often prevent the need for hospitalization or decrease the length of stay in the hospital.

- Length of stay at OSH would be reduced if more community-based programs were provided to continue treatment upon discharge. Without residential placement options, patients stay longer at OSH, despite their clinical readiness for discharge.

- Data indicates an increase in the numbers of geriatric, neuropsychiatric, and dual diagnosis patients will occur in light of demographic shifts and the methamphetamine epidemic. The future OSH patient will be more medically complex than today, requiring greater health care resources and staffing levels.

- Federal budget proposals that result in any Medicaid or other entitlement program reductions or any rise in the State's indigent population could increase OSH utilization due to lack of other options. These unknown variables could not be factored into this analysis, yet are key issues to monitor and incorporate into any future planning.

Conclusions and Recommendations

CONCLUSIONS AND RECOMMENDATIONS

OREGON STATE HOSPITAL

Some states have attempted to eliminate the state mental hospital from their continuum of services. Many of these states have come to find that such facilities fill a vital role, providing focused care, recovery, education, and training in a safe environment. The consultant team recommends that Oregon continue to provide an array of mental health services through a state hospital system.

Challenges for Oregon's State Hospital

- Nationwide there is a shortage of qualified professional psychiatrists, psychologists, and nurses. Oregon needs to attract and retain the best physicians and professional staff.

- These professionals seek:
  - Professionally challenging work,
  - Competitive compensation and benefits,
  - Community amenities such as excellent schools, healthcare, recreation, arts, and social opportunities,
  - Opportunities for consultation with peers as well as continuing educational resources.

- Neuropsychiatric patients require specialists who are even less available.

- Oregon's demography places a majority of the population in one small region of the State. The remaining land mass is much less densely populated.

- To receive specialized care, including mental health services, citizens who live in remote areas are required to travel long distances.
  - Improvements to the community mental health services may mitigate some of the inconvenience of remote services.
  - Standards of living sought by the majority of the mental health professionals may not be found in rural and remote communities.

- Provide limited mental health services to the Department of Corrections (DOC) population. (See Appendix E - Agreement between DHS and DOC)

Underlying Functional Issues

Oregon is committed to a continued shift to a community-oriented, recovery model of care and education.

- A more decentralized delivery system will facilitate patient reintegration into their home communities.

- Oregon State Hospital plays an important role in the processes that lead to diagnosis, care and recovery but not everyone with a severe and persistent mental illness will need the higher level of services of the Hospital.

- Center of Excellence – Oregon State Hospital needs to take advantage of closer associations with colleges and universities which offer cutting edge advancements in the care and treatment of those with mental illness via the following and other programs:
  - Oregon Health Sciences University's Public Psychiatry program,
  - Portland State University's Social Services programs,
  - University of Oregon's Clinical Psychology programs,
  - Southern Oregon University's Applied Psychology programs,
  - Oregon's nursing schools.

- This Master Plan is based on an anticipated total hospital need of 1,100 beds by the year 2030.
  - If no new community residential services are provided, a substantial number of the individuals who would utilize those beds could increase the State Hospital average daily population to nearly 2,000 patients.

Existing Hospital Facility Issues

- As concluded in the Phase I Master Plan report, the current Salem campus facilities are not appropriate for long-term continued use for the care and treatment of those with mental illness.
  - Patient rooms are overcrowded and undersized relative to Oregon Administrative Rules (OAR).
  - Patients and staff spaces are not well designed for treatment, safety, or security.
  - Patient wards are overcrowded.
  - Structural conditions of many buildings housing patients do not comply with current seismic requirements.
  - Buildings do not comply with current building or energy codes for secure psychiatric facilities.

- The lease for the Portland Campus of OSH will end before 2015 with no guarantee of renewal. It is imperative that Oregon State Hospital should be located in facilities that are owned by the State of Oregon to achieve long-term stability.

Proposed Schedule for Hospital Replacement

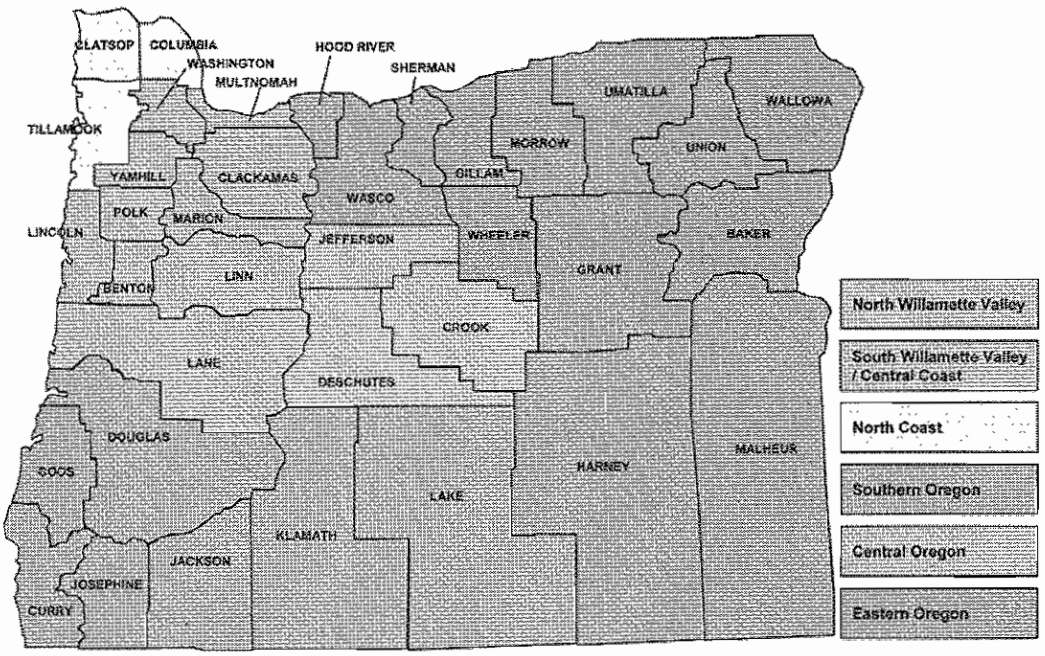
- Initial construction projections suggest that if programming and design begin in mid-2006, facilities could be operational by 2011.

- Rather than open facilities that would soon be overcrowded, it is important that the initial 2011 construction be sized to accommodate projected bed needs for ten years in the future (2021), with a support services infrastructure (kitchen, mechanical systems, utilities, electrical systems, etc.) capable of sustaining growth through the year 2030.

HOSPITAL LOCATION ANALYSIS

As previously stated relative to the recovery model of care, it is desirable that those with mental illness be treated through community-based services that are located as close to their homes as practical. This applies as well to patients during their stay at the State Hospital.

To facilitate the analysis of where hospital facilities might be located, the planning regions described in this report were used, combined with pertinent historical patient demographics. The regions were then analyzed relative to their perceived potential for accommodating a State Hospital.



Regional Location Considerations for a State Hospital

Hospitalized patients should be accessible to their friends and families. Data analysis confirms that the communities that contribute the largest numbers of patients to the hospital are those regions that have the largest populations. Incorporating growth projections across the State, for each of the next 25 years:

- 55% of the OSH patient population will come from the North Willamette Valley and North Coast Regions.
- 38% will come from the South Willamette Valley, Central Coast and Southern Oregon Regions.
- 7% will come from the Eastern and Central Oregon Regions.

Evaluation of Oregon's Planning Regions

Other factors in addition to population may affect the level of desirability of an area for possible placement of a State Hospital; however, most are directly related to population density.

- **North Willamette Valley**

  Advantages

  - Large population center is desirable for attracting and retaining qualified MH professionals.
  - Majority of MH professionals now reside in this area.
  - Major Healthcare facilities available.
  - OHSU and PSU readily available for research, innovative support, continuing education.
  - Region is the major source of patients (52%)
  - Readily accessible to interstate highway and regional transportation systems.
  - Patient access to community "lifestyle" activities and supportive services.
  - Close to the North Coast Counties.

  Disadvantages

  - Costs of living, land, and construction are high relative to some other areas in Oregon.
  - Metropolitan area is distant from southern and eastern communities.

- **North Coast**

  Advantages

  - Reasonably accessible to the North Willamette Valley.
  - Some communities would eagerly desire a state hospital as a boost to their economy.
  - 3% of patients are from this area.

  Disadvantages

  - Population base could not support a state hospital facility.
  - Attracting and retaining qualified MH professionals may be more difficult here than in North Willamette region.
  - "Not in my backyard" (NIMBY) issues may be stronger here than in North Willamette Valley.
  - Limited access to major highway and transportation systems.
  - Limited patient access to community "lifestyle" activities and supportive services.

- **South Willamette Valley/Central Coast**

  Advantages

  - Large population centers and major universities are desirable for attracting and retaining qualified MH professionals.
  - Major Healthcare facilities available.
  - Readily accessible to interstate highway and regional transportation systems.
  - Readily accessible from coastal, southern, and eastern Oregon communities.
  - Patient access to community "lifestyle" activities and supportive services.
  - Second largest source of OSH patients (21%).

  Disadvantages

  - Cost of living, land, construction is high relative to some other areas in Oregon.
  - NIMBY issues may be stronger here than in North Willamette Valley.
  - Attracting and retaining qualified MH professionals may be more difficult here than in North Willamette region.

- **Southern Oregon**

  Advantages
  - Growing communities may be desirable for attracting and retaining qualified MH professionals.
  - Readily accessible to interstate highway and regional transportation systems.
  - Third largest source of OSH patients (17%).

  Disadvantages
  - Cost of living, land, construction is high relative to some other areas in Oregon.
  - NIMBY issues may be stronger here than in North Willamette Valley.
  - Attracting and retaining qualified MH professionals may be more difficult here than in North Willamette region.

- **Central Oregon**

  Advantages
  - Rapidly growing area, reasonably central to populations east of the Cascades.
  - Some trained MH staff available.
  - Region may be desirable for attracting and retaining qualified MH professionals.
  - Some communities would eagerly desire a state hospital as a boost to their economy.
  - 3% of patients come from this area.

  Disadvantages
  - Population base could support a small state hospital facility, but only if combined with Eastern Oregon. There is some question as to whether or not it can be efficiently operated.
  - Cost of land and construction near population centers similar to North Willamette Valley.

- **Eastern Oregon**

  Advantages
  - Northern portion is readily accessible to interstate highway and regional transportation system.
  - Eastern Oregon Psychiatric Center (Pendleton) now provides state hospital services to northeastern part of State.
  - Some communities would eagerly desire a state hospital as a boost to their economy.
  - 4% of patients come from this area.

  Disadvantages
  - Population base could support a small state hospital facility, but only if combined with Central Oregon.
  - Extreme northeast and southeast areas are not convenient to the rest of the east side of the Cascades.
  - Attracting and retaining qualified MH professionals will be significantly more difficult here than in any other part of the State.
  - Limited patient access to community "lifestyle" activities and supportive services.

Facility Design Considerations

The following design parameters reflect the results of our meetings and the expressed desires of patients, physicians and staff as related to the Recovery Model of care.

- Designed for patient care, safety, and security:
  - Patients at various stages in their recovery may require protection from themselves and from real or perceived external hostilities.
  - Physical conditions may require readily available medical and continuing care.
  - Society may at times require protection from the patient.

- Progressive and therapeutic work environment:
  - Modern staff working conditions including communication and flexible security technologies.

- A place in which the patients can be treated, learn more about their condition, and focus on the process of developing the skills necessary to manage their recovery.

- An environment in which to heal:
  - At certain levels, it is a quiet, contemplative place;
  - At other levels it will provide space to teach and places for social interaction and sense of community.
  - It's a sanctuary, a recovery center.

- Patient living units are to be flexible in utilization:
  - Units based on a prototypical plan provide greater future flexibility than do units that are specifically designed to accommodate one fixed program.
  - Maximum Security and DOC Units will have similar hard security requirements, permitting flexibility in utilization between the two program types.
  - Shared functional program space between units offers space efficiency and program flexibility.
  - "Swing" rooms between units offer flexibility in unit and program sizes.

- Patients require a variety of experiences to promote recovery in a normative environment:
  - Facilitate integration back to their home community.
  - Vocational, Educational, Training, Transition Planning, Peer Supports.
  - Indoor and Outdoor recreational opportunities.
  - Spiritual Center, Library.
  - Coffee shop, store, barber, salon.
  - Recovery Mall, Fitness Center, Arts & Crafts.
  - Outdoor and off-campus community life encounters.

- Facility appearance or image to reflect a "recovery" environment that also responds to neighborhood character:
  - Low profile – one story preferred, however if the facility footprint becomes too large, it may become staffing inefficient.
  - Required security provided by electronics and "transparent" physical barriers in lieu of obvious "security" fencing.
  - Large, internal courtyards and recreation areas secured, as needed, by buildings.
  - Visual connections to variety of outdoor spaces and activities.

- Peer Mentoring Center:
  - Would facilitate patient recovery, liberty, and encourage a sense of "community".
  - Training center for Peer mentors.
  - Repository and center for creative arts, drama, writing projects for hospital patients.
  - Dual-diagnosis, cultural, and diversity sensitive self-help groups for persons transitioning into the community.
  - A resource for those peers, consumers, survivors living near the hospital(s).

- Peer-Run Store:
  - Retail for wares and crafts created by patients.
  - Provides opportunities for work experience by patients.

STATE HOSPITAL FACILITIES

OPTIONS FOR LOCATION AND CONFIGURATION

The following options for development and cost are based on occupancy by the year 2011 with capacity to meet patient needs through year 2021. This will create facilities to accommodate 980 beds.

- Growth potential and support infrastructure is provided to accommodate the year 2030 patient projections of 1,100 beds.

- Project costs consist of construction costs plus owner soft costs (see Appendix G, Glossary). All costs exclude purchases of land. For more detailed analysis of project costs see Appendix D.

- Each of the options includes a conceptual drawing to show general relationships among the various hospital program elements.
  - These images are intended to indicate one possible site configuration, relative size, and suggested amenities and are not intended to indicate all possible solutions.
  - A conceptual drawing is provided for a 20-bed patient living unit that was utilized as a module for programming and campus development.
  - No drawings are included for the two 16-bed secure, non-hospital, residential treatment facilities recommended in Options 1 and 2.

One may note that the estimated combined construction costs of Options 2 and 3 are greater than for Option 1 even though the number of total beds is the same. In addition the amount of land for each Option does not appear to be proportionate to the number of beds at a facility. The reasons for this are:

- Multiple campuses will require more space for staff, more service spaces, and more engineered systems due to duplication of functions.

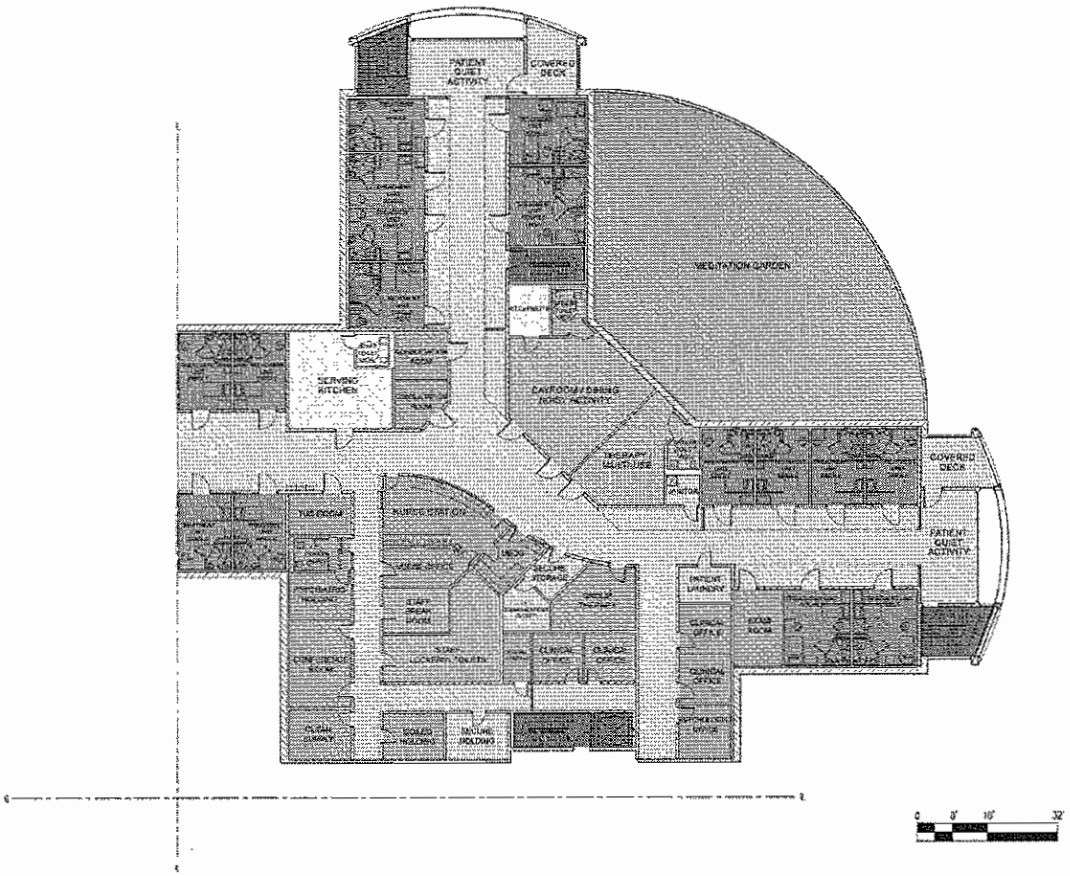
- To lessen the amount of land consumed in the larger facilities, the concept diagrams make some use of two-story elements, where a single story facility may be preferred operationally.

- It is assumed that the amount and variety of interior and exterior educational and recreational space will vary according to the number and types of patients anticipated at each campus.

- Additional land is suggested to accommodate growth, at least for year 2030.

Anticipated annual maintenance costs may be found in Appendix D.

OSH Patient Living Unit Planning Module



20-Bed Patient Unit Planning Module

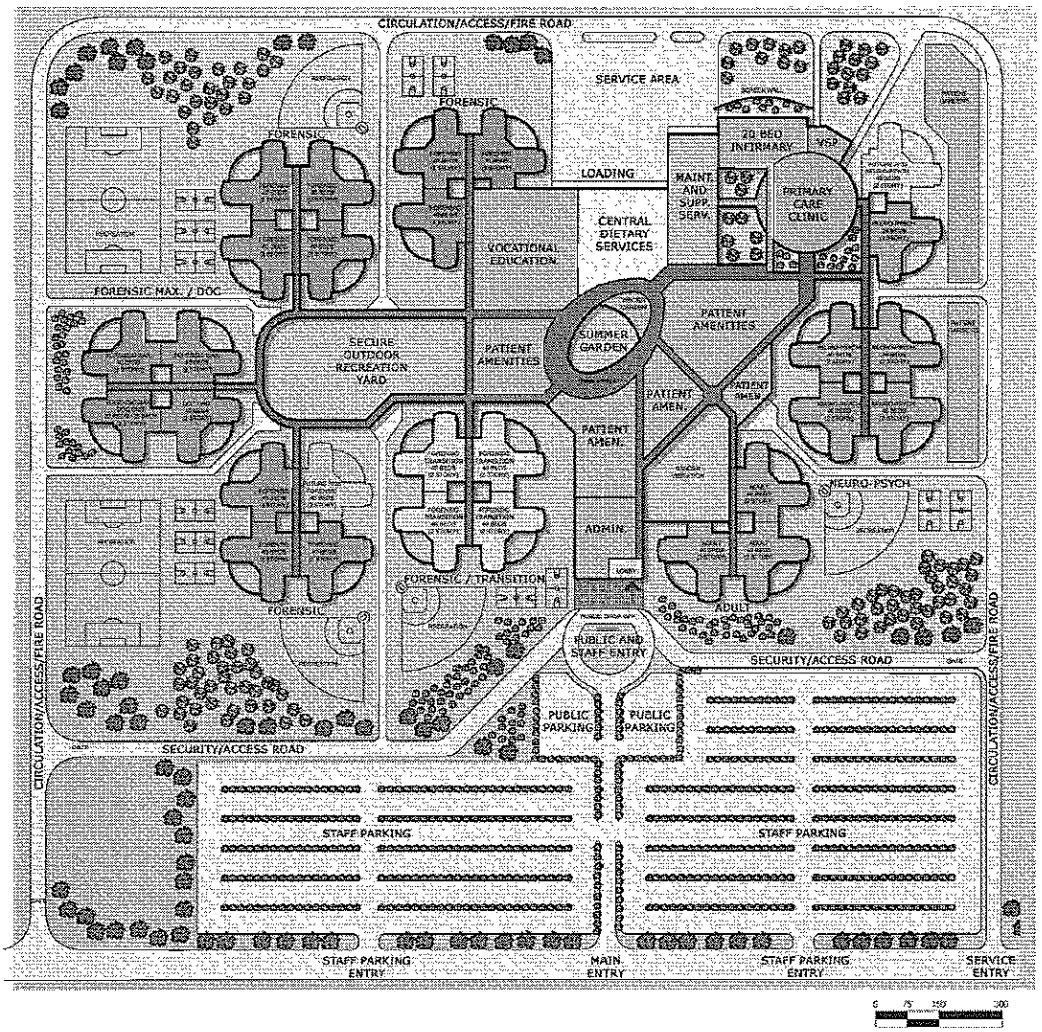
This 11,700 square foot planning module was utilized to facilitate development of an understanding of total hospital size and configuration that might be applicable to each of the following conceptual planning options for the new Oregon State Hospital.

While the design of the various patient units will need to accommodate specific patient classifications, group and staffing program needs, it is desirable to have functional and flexible patient living units that can adapt to new program needs over time:

- Maximum Security and DOC units will have similar requirements for "hardness" and security, permitting flexibility in those uses.
- Program spaces may be shared between units as designs are developed in the next phase.
- Secure outdoor activity space should be readily accessible.

OSH Option 1

One 980-bed facility encompassing all inpatient beds, located in the North Willamette Valley region, plus two non-hospital level, 16-bed secure residential treatment settings placed strategically east of the Cascades.



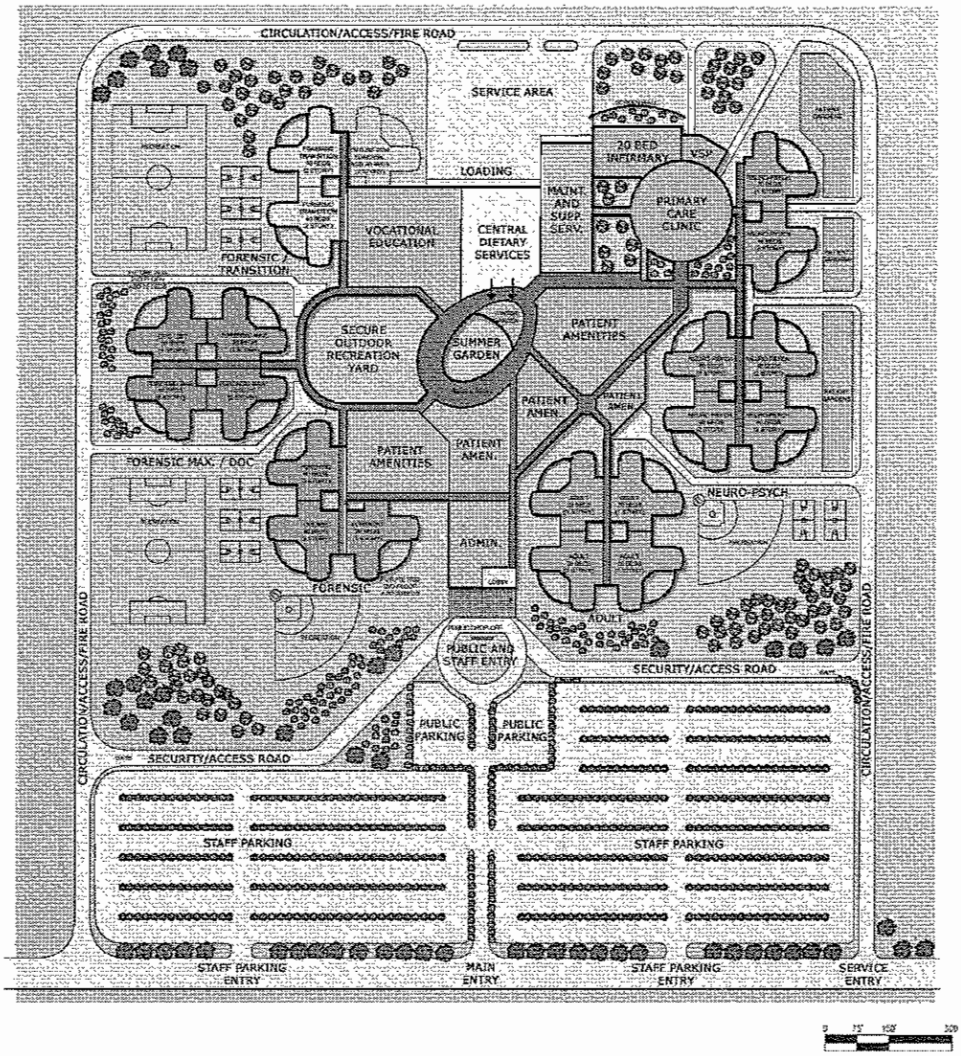
980 beds / 1,060,000 SF Hospital / 120 Acre Campus / $293-304 million estimate projects costs this campus / Estimated Project Costs: $297-307 million (including the two Residential Treatment Facilities)

- **Advantages**
  - Reasonably close to homes of 55% of the patient population (including the North Coast Region).
  - Ready availability of all levels of professional and support staff.
  - Most efficient for professional and support staff, minimizing duplication of positions.
  - Maximizes the amount of patient vocational and recreational opportunities.
  - Current state hospital campus contains sufficient acreage and infrastructure, and perhaps is the easiest place to site the new facility.

- **Disadvantages**
  - Inconvenient access for about 45% of the patient population.
  - Large two-story facility, necessitating use of elevators and stairs.
  - Possibly difficult to site outside of current Salem campus.
  - Centralizing the hospital could further disengage OSH from communities.

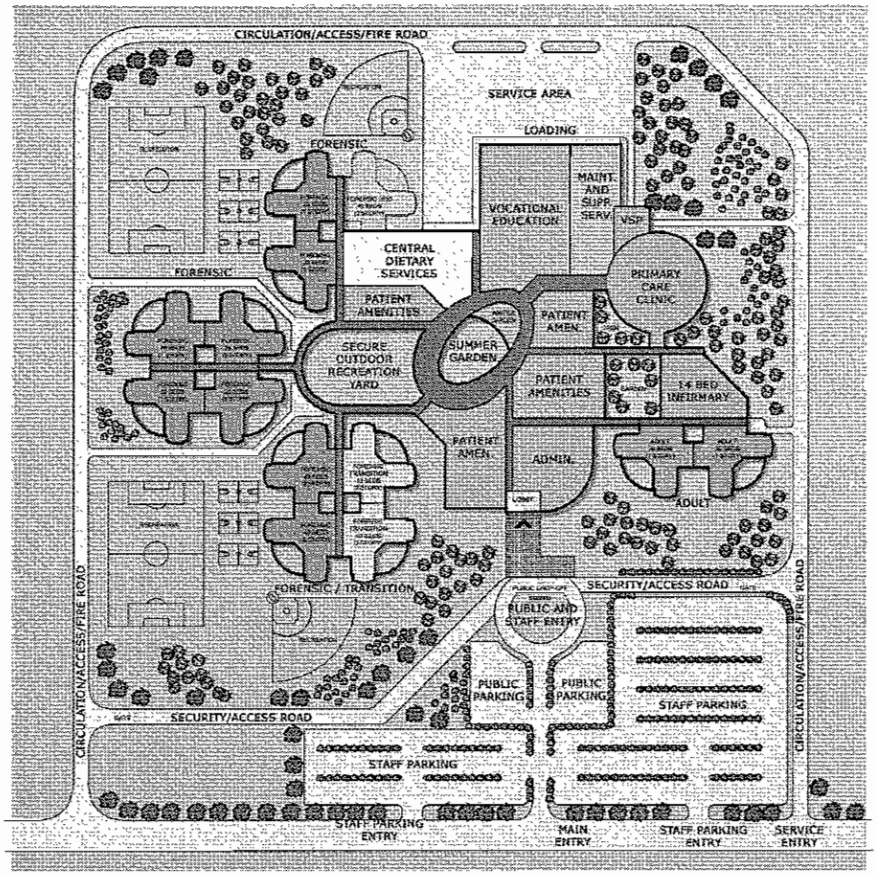
OSH Option 2

One 620-bed facility (2A) located in the North Willamette Valley region, one 360-bed facility (2B) located south of Linn County on the west side of the Cascades, plus two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.



Option 2 – Campus A

- 620 beds
- 758,000 SF Hospital
- 100 Acre Campus
- $204-208 million estimated project costs this campus



Option 2 – Campus B

- 360 beds
- 472,000 SF Hospital
- 78 Acre Campus
- $117-120 million estimated project costs this campus

Option 2 – Summary

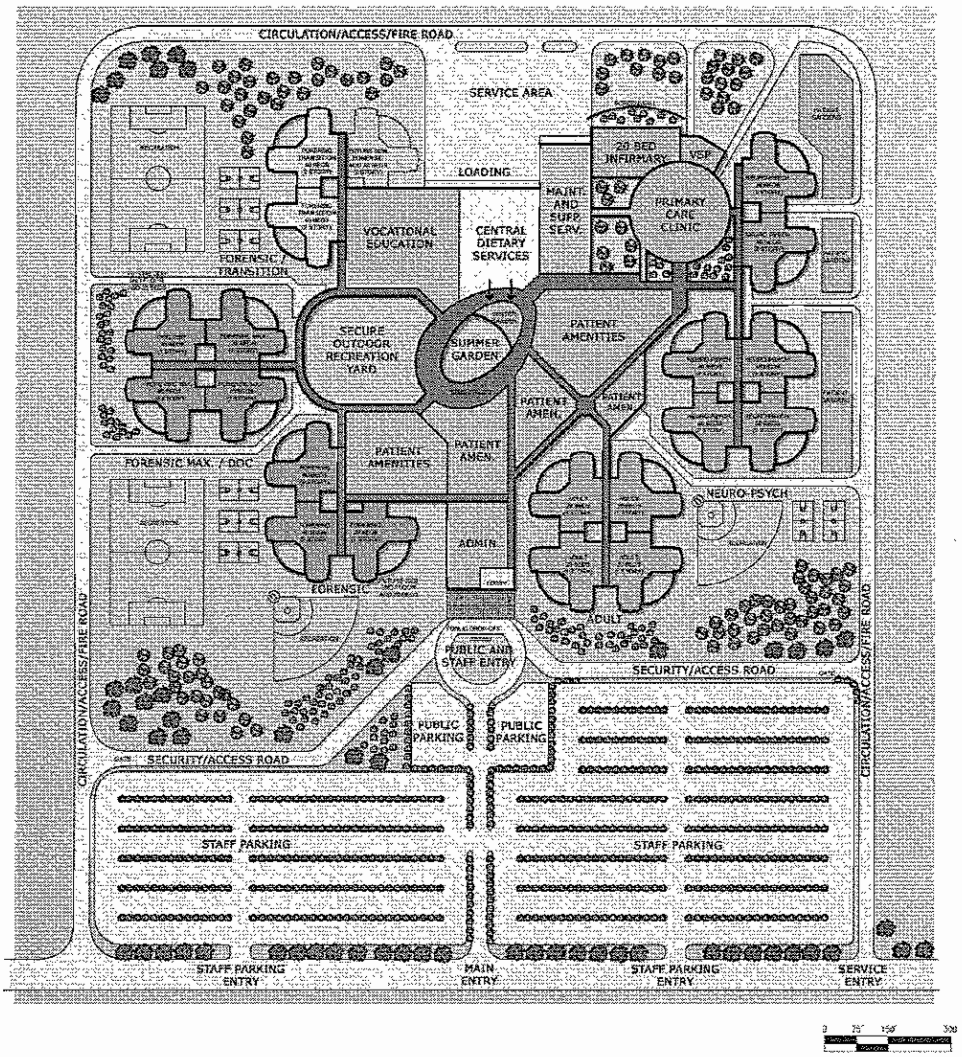
- Estimated Facility Size for Hospitals only: 758,000 SF Hospital A; 472,000 SF Hospital B
- Estimated Land Required for Hospital Campus only: 100 Acres, Campus A; 78 Acres, Campus B
- Estimated Project Costs: $324-334 million, including both campuses and the two Residential Treatment Facilities.

- **Advantages**
  - Two campuses provide 93% of the patient population with reasonable opportunity to be close to home while still providing for some centralized administration.
  - Assures preferred single-story design.
  - Smaller, single-story facilities more easily accommodated in some communities.
  - Ready availability of all levels of professional and support staff.
  - Maximizes the amount of patient vocational and recreational opportunities.
  - Current state hospital campus contains sufficient acreage and infrastructure, and perhaps is the easiest place to site one of the new facilities.
  - Two facilities are close enough to encourage interaction and coordination between staff.

- **Disadvantages**
  - Duplication of support services will increase construction, administrative and operational costs.
  - Land acquisition required for at least one of the facilities.
  - Possible NIMBY issues.

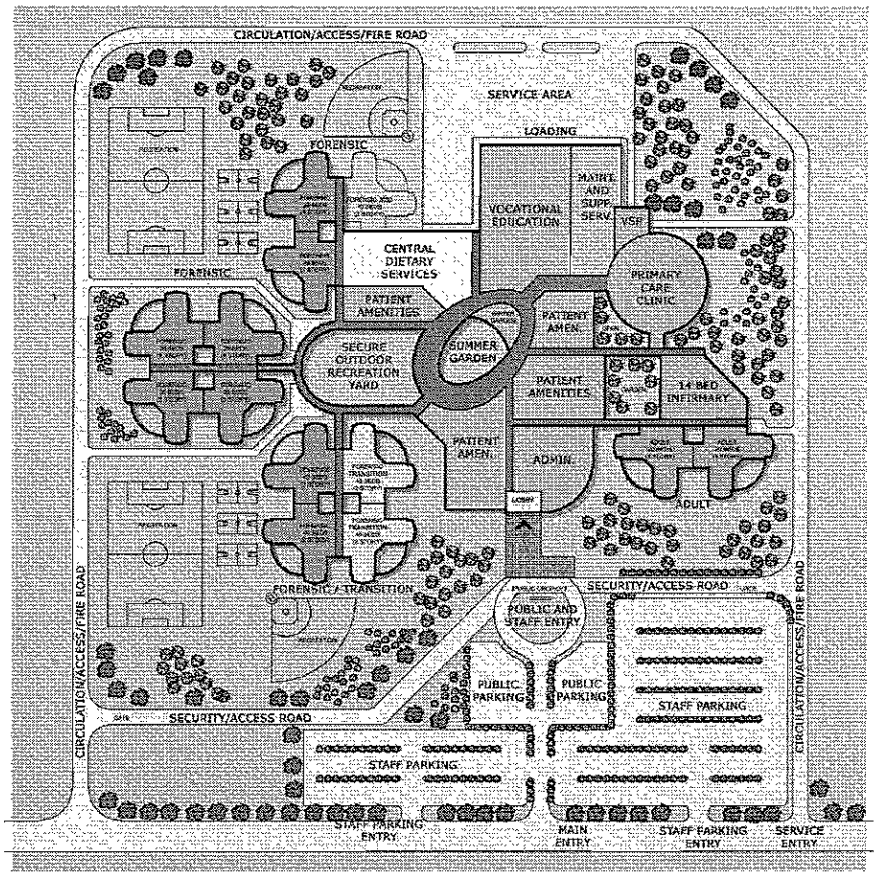
OSH Option 3

One 600-bed facility (3A) located in the North Willamette Valley region, plus one 320-bed facility (3B) located south of Linn County on the west side of the Cascades, and one 60-bed forensic facility (3C) located in Central or Eastern Oregon.



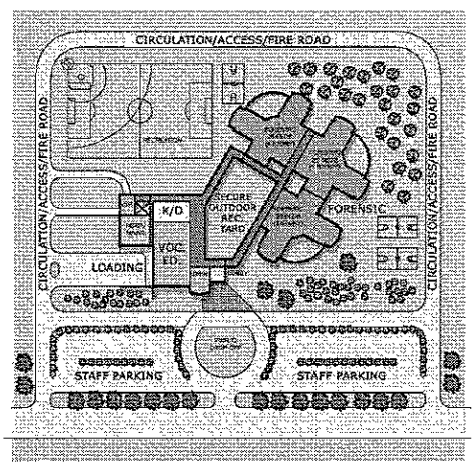
Option 3 – Campus A

- 600 beds
- 716,000 SF Hospital
- 100 Acre Campus
- $198-203 million estimated project costs this campus



Option 3 - Campus B

- 320 beds
- 406,000 BGSF Hospital
- 78 Acre Campus
- $106-109 million estimated project costs this campus



Option 3 - Campus C

- 60 beds
- 110,000 SF Hospital
- 22 Acre Campus
- $22-25 million estimated project costs this campus

Option 3 – Summary

- Estimated Facility Sizes: 717,000 SF Hospital A; 406,000 SF Hospital B; 110,000 SF Hospital C
- Estimated Land Required: 100 Acres, Campus A; 78 Acres, Campus B; 22 Acres, Campus C
- Estimated Project Costs: $326-337 million including all three campuses

- **Advantages**
  - Three campuses provide reasonable proximity to home communities for about 96% of the patient population.
  - Cost of housing and land may be less in some areas compared with the North Willamette Region.
  - Maintains a state hospital presence in the Eastern Regions.

- **Disadvantages**
  - Recruiting and retaining professionals is more difficult in Eastern region.
  - 60-bed facility is operationally inefficient.
  - Size of 60-bed facility precludes the ability to provide a full array of vocational and educational programs.
  - Duplication of support services will increase construction, administrative, and operational costs.

RECOMMENDATION

No matter which of the hospital development options is selected by the State, it must be understood that the full project along with the community enhancements need to be provided. Any major modification or deletion will undermine the viability of the plan.

KMD Architects and Planners with New Heights Group strongly recommend adoption of OSH Option 2. It is preferred for the following reasons:

- In keeping with the Recovery Model, this option would provide the State of Oregon with:
  - The opportunity for a significant majority (93%) of patients to have convenient access to their home communities, family and friends at the most reasonable cost.
  - The highest quality of care at the most efficient operational level.
  - 32 much needed, high-level, multi-use secure residential treatment beds in Central and/or Eastern Oregon. This will provide the flexibility that allows an individual to receive safe and secure up-front services.
- It would provide economic benefit to a greater segment of Oregon through development of multiple campuses, decentralizing the work force, and creating jobs in the community of location.
- It would provide better utilization of the statewide continuum of mental health care.

See Appendix D for additional information regarding OSH Options program size and projected costs.

CONCLUSIONS AND RECOMMENDATIONS:

COMMUNITY-BASED RESOURCES

Sufficient funds need to be made available to community caregivers to provide enhanced support services for individuals with severe and persistent mental illness. An additional 419 community residential beds are needed by 2011 to support the size and scope of the State Hospital described in this report. A significant number of these beds have already been budgeted, but continued support is needed.

In addition to the dollars needed to construct the new community residential programs, infrastructure funding to the counties is needed to allow them to administer and monitor these programs. An additional 10% of estimated operating costs has been identified to support infrastructure development.

In addition to the residential development by 2011, more aggressive prevention and early intervention services are needed to identify and manage those with mental illness early on. This is key to a recovery model and necessary to ensure more appropriate use of state hospital resources. More integrated, on-going case management is necessary so that those with mental illness can move smoothly across the system of care, accessing services as needed to maximize independence. Better integration among counties as well as between counties and the State Hospital is needed.

NEXT STEPS

The State of Oregon needs to consider the information provided in this report and set the direction for Oregon's Mental Health System by:

1. Selecting the Oregon State Hospital Development Option. We recommend this be accomplished by May 2006.

2. Securing the services of a qualified architectural/engineering consulting team by Summer 2006 to:
   a. Develop a program of spaces for the new hospital facilities, confirming site requirements.
   b. Identify the location and specific site for construction of new hospital facilities.
   c. Establish the design and construction processes that will lead to the opening of new hospital facilities by 2011 based on an approved program of spaces and the selected hospital site(s).

3. Funding development of the Community Services component. These need to be in place prior to opening a new State Hospital facility.

COMMUNITY-BASED RESIDENTIAL PROGRAM DEFINITIONS

Program Type	Capacity	Staffing	Description
Supported Housing (SH)	Site Specific	Occasional Drop-In. Staffing – not on site	Unlicensed facilities using staffing to assist individuals to live as independently as possible. These can be Site-Specific. Integrated, Transitional, Room and Board or Safe Haven.
Adult Foster Home (AFH)	Up to 5	Provider and an approved caregiver for occasional respite. (24 Hour Care) Provider awake until 11 p.m.	Adult Foster Homes are licensed by OHMAS, ODDS, or by the Senior and Disabled Services Office. Services provided include: training or assistance with personal care; activities of daily living; supervision of medications, behavior, crisis prevention; and management of diet and health care. Adult Foster Homes testing and Certification of Completion is required for Staff. Yearly License issued if in compliance.
Residential Treatment Home (RTH)	Up to 5	(24 Hour Awake Staff) Minimum Staff Required:* 0.5 Administrator One Direct Care Staff per 8-hour shift.	A program licensed by the OMHAS to serve 5 or fewer adults with mental illness. Services include medication monitoring, daily living skill training, and supportive services. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance.
Residential Treatment Facility (RTF)	6 to 16	(24 Hour Awake Staff) Minimum Staff Required:* 0.5 Administrator One Direct Care Staff per 8-hour shift.	A program licensed by OHMAS to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance.
Secure Residential Facility (SRTF) **Includes: Post-Acute Intermediate Treatment Services (PAITS)**	6 to 16	(24 Hour Awake Staff) Minimum Staff Required:* 0.5 Administrator Two Direct Care Staff and an RN per 8-hour shift.	A locked residential treatment facility licensed by the Office of Mental Health Services to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually. 2 yr license issued if in compliance.
		RESIDENTIAL SUPPORT PROGRAMS	
Enhanced Care Services (ECS)	Varies	Varies	Structured rehabilitative services and 24/7 Crisis intervention – see Appendix G – Glossary for additional information
Enhanced Care Outreach Services (ECOS)	Varies	Varies	Structured rehabilitative services and 24/7 Crisis intervention – see Appendix G – Glossary for additional information

COMMUNITY-BASED RESIDENTIAL DEVELOPMENT

SITE SELECTION CONSIDERATIONS

Consistent with national mental health care trends, OMHAS is committed to continuing its shift toward a community-oriented recovery model of care. To that end, increasing the number of available community-based patient beds in appropriate settings throughout the State is critical to reducing the length of stay and consequently the reducing the demand at OSH. In 1999, the U.S. Supreme Court's ruling in the Olmstead Decision noted that states cannot continue to hold people in institutions when they have maximally benefited and are clinically ready for community-based treatment.

To support changes in OSH utilization, a shift toward greater use of community-based settings (additional beds) will be needed at the local level. Currently within Oregon, a statewide imbalance exists in the geographic distribution of community beds. Future program development will correct this imbalance and will be based on population distribution that better reflects consumer need in local communities.

Within the next 25 years, an estimated 900 affordable community beds in local settings will be needed. Within the first 10 years of that period, 515 beds are projected in response to a shorter length of stay at a smaller state hospital. During the following 15 years, another 385 community beds are needed to accommodate population growth and to sustain a lowered length of stay in OSH.

Currently, a lack of affordable, independent housing delays patients moving from one level of treatment to another, thereby creating a patient backlog within the mental health system. Moreover, those with mental illness must compete with general population for housing. Providing affordable housing in appropriate settings with a geographical balance is critical to patient success at they move to independent or semi-dependent living.

Historical impediments to safe, available, affordable housing have been the following:

- Costs – many individuals with SPMI have very little money.
- Lack of adequate compensation or guarantees to housing providers.
- Lack of appropriate housing types.

COMMUNITY HOUSING SITE SELECTION CONSIDERATIONS

Selection of sites for residential treatment housing should consider the following factors in evaluating their suitability:

- **Statewide Need & Distribution**
  To better serve patients and their families, residential treatment programs should be distributed across all regions of the State.

- **Adjacent Land Uses**
  Community housing should be sited on new properties or existing settings that reduce or eliminate community concerns or reluctance. Adjacent land uses should be compatible uses.

- **Availability**
  Site selection should identify available parcels of publicly owned property or in private ownership.

- **Site**
  Specific parcels of property should be evaluated for the following:
  - Access: Convenient access via existing street system.
  - Size: Adequate square footage for designated treatment-housing type.
  - Configuration: Shape of property that allows flexible design options.
  - Topography: Slope or gradient of site that is not extreme or excessive and is suitable for functional design solutions.
  - Utility Infrastructure: Presence of necessary utility services for operation.
  - Expansion: Capability for future growth if required.

- **Public Support Services**
  Specific parcels of property should be evaluated for the following:
  - Medical: Availability of acceptable medical services.
  - Transportation: Convenient access to modes of public transportation for employment and other personal needs.
  - Recreation: Availability of a range of recreational opportunities.
  - Social: Access to a range settings or circumstances that encourage social interaction.
  - Shopping: Access to retail settings for meeting personal needs.
  - Employment: Availability of work opportunities in the community.

- **Safety & Security**
  For patients to respond to treatment and move toward independent or semi-independent living, residential treatment program sites must provide safe settings.

AVAILABLE HOUSING FUNDING SOURCES

In 2005, OMHAS commissioned an analysis of the availability of state housing resources for persons with chronic mental illness. The report's findings concluded that, currently in Oregon, funding for affordable and appropriate housing of individuals with serious mental illness is not distributed in proportion to population. A series of recommended actions were identified to remedy the funding imbalance through outreach to under-funded areas.

The following is a partial listing of federal, state, and local resources that are available to assist in funding housing for community-based residential settings:

Federal or National

- US Department of Housing and Rural Development Programs
- US Department of Agriculture Rural Development Housing Programs
- Federal Home Loan Bank Affordable Housing Program
- Corporation for Supportive Housing

State of Oregon

Grants

- Alcohol and Drug Free Housing Fund
- Alcohol and Drug Free Housing Assistance Services

- Community Development Block Grant
- Community Mental Health Housing Fund (OMHAS)
- Community Services Block Grant
- Farmworker Housing Development Account
- HELP Program
- HOME Investment Partnerships Program
- Housing Development Grant (Trust Fund)
- Low Income Weatherization Program
- Mental Health Housing Fund (OMHAS)
- Real Choice Housing Assistance Fund (OMHAS)

Loans

- Elderly & Disabled Loan Program
- Lease Guarantee Program
- Loan Guarantee Program
- Manufactured Dwelling Park Purchase Program
- Oregon Recovery Homes (OMHAS)
- Oregon Rural Rehabilitation Loan Program
- Pass-Through Revenue Bond Financing Program (Conduit)
- Risk Sharing Loan Program
- Seed Money Advance Loan Program

Tax Credits

- Farm Worker
- Housing Tax Credit Program
- Low Income Housing Tax Credit Program
- Oregon Affordable Housing Tax Credit Program

Local Communities

- Community Engagement Program - City of Portland

Total Number of Adults Served and Residents by Housing Type

	County Mental Health Program	Adults Served 2002-03	% of Adult Population Served	Total Number of Housing Units by Type* Structured/ Specialized Capacity (# of residents)	Structured/ Specialized County % of total	Supportive Housing Capacity (# of residents)	Supportive Housing County % of total	Total Capacity (# of residents)	Total County % of total
North Willamette Valley	Clackamas	2,933	5.2%	53	3.9%	241	9.6%	294	7.6%
	Marion	5,637	10.1%	127	9.3%	110	4.4%	237	6.1%
	Multnomah	14,350	25.6%	298	21.8%	853	33.9%	1,151	29.7%
	Washington	3,914	7.0%	93	6.8%	252	10.0%	345	8.9%
		26,834	47.9%	571	41.8%	1,456	57.9%	2,027	52.2%
South Willamette / Central Coast	Benton	878	1.6%	40	2.9%	21	0.8%	61	1.6%
	Lane	5,606	10.0%	193	14.1%	239	9.5%	432	11.1%
	Lincoln	1,140	2.0%	4	0.3%	36	1.4%	40	1.0%
	Linn	1,892	3.4%	3	0.2%	12	0.5%	15	0.4%
	Polk	658	1.2%	80	5.9%	0	0.0%	80	2.1%
	Yamhill	1,219	2.2%	25	1.8%	123	4.9%	148	3.8%
		11,393	20.3%	345	20.3%	431	20.3%	776	20.3%
North Coast	Clatsop	940	1.7%	0	0.0%	57	2.3%	57	1.5%
	Columbia	621	1.1%	20	1.5%	61	2.4%	81	2.1%
	Tillamook	555	1.0%	5	0.4%	30	1.2%	35	0.9%
		2,116	3.8%	25	3.8%	148	3.8%	173	3.8%
Southern Oregon	Coos	1,382	2.5%	45	3.3%	31	1.2%	76	2.0%
	Curry	444	0.8%	2	0.1%	12	0.5%	14	0.4%
	Douglas	1,666	3.0%	36	2.6%	10	0.4%	46	1.2%
	Jackson	2,348	4.2%	131	9.6%	128	5.1%	259	6.7%
	Josephine	1,959	3.5%	47	3.4%	100	4.0%	147	3.8%
	Klamath	1,324	2.4%	25	1.8%	58	2.3%	83	2.1%
	Lake	76	0.1%	3	0.2%	1	0.0%	4	0.1%
		9,199	16.4%	289	16.4%	340	16.4%	629	16.4%
Central Oregon	Crook	448	0.8%	0	0.0%	0	0.0%	0	0.0%
	Deschutes	2,062	3.7%	6	0.4%	11	0.4%	17	0.4%
	Jefferson	351	0.6%	11	0.8%	0	0.0%	11	0.3%
		2,861	5.1%	17	5.1%	11	5.1%	28	5.1%
Eastern Oregon	Baker	402	0.7%	0	0.0%	10	0.4%	10	0.3%
	Grant	161	0.3%	0	0.0%	0	0.0%	0	0.0%
	Harney	143	0.3%	15	1.1%	0	0.0%	15	0.4%
	HR/Was/Sh	767	1.4%	24	1.8%	29	1.2%	53	1.4%
	Malheur	477	0.9%	22	1.6%	17	0.7%	39	1.0%
	Mor/Wh/Gil	114	0.2%	0	0.0%	0	0.0%	0	0.0%
	Umatilla	866	1.5%	14	1.0%	19	0.8%	33	0.9%
	Union	517	0.9%	17	1.2%	48	1.9%	65	1.7%
	Wallow a	168	0.3%	26	1.9%	6	0.2%	32	0.8%
		3,615	6.5%	118	6.5%	129	6.5%	247	6.5%
Total		55,018	100.0%	1,365	100.0%	2,515	100.0%	3,880	100.0%

April 2004 Source - OMHAS

Based on data collected in Fall 2000 Mental Health Housing Survey

- Specialized/Structured Residential Services means residential programs that are generally licensed by the state and provide 24-hour supervision. They include residential treatment facilities, residential treatment homes, adult foster homes and enhanced care services program.
- Supportive Housing – means supported independent living and other minimally structured settings where services and housing are made available to person with mental illness. They include site-specific supported housing, integrated supported housing, transitional housing, room and board settings, and safe havens.

* Includes adult individuals served in FY 2002-2003 in public mental health services and excludes individuals whose residence was indicated as out-of-state, transient or unknown per OMHAS CPMS data. Capacity based on data from Fall 2000 Survey.

Unique Mental Health Adult Clients

who were homeless at anytime during the time period

(Based on enrollment data for state-funded community MH treatment)

(* indicates 3 or fewer)

OMHAS May 2005

County	Fiscal Year 97/98	98/99	99/00	00/01	01/02	02/03	03/04	Co % of 03/04Total	7 year Average	Co % of Total
CLACKAMAS	66	58	63	68	80	72	69	2.0%	68	2.0%
MARION	407	342	330	372	470	513	499	14.8%	419	12.5%
MULTNOMAH	1,087	1,061	1,198	1,175	1,375	1,093	1,233	36.5%	1,175	35.2%
WASHINGTON	91	83	141	175	185	170	151	4.5%	142	4.3%
North Willamette Valley								**57.8%**	**1,804**	**54.0%**
BENTON	64	67	72	62	65	70	71	2.1%	67	2.0%
LANE	589	598	663	600	664	604	390	11.6%	587	17.6%
LINCOLN	40	52	71	73	82	64	73	2.2%	65	1.9%
LINN	48	41	65	60	67	76	100	3.0%	65	2.0%
POLK	9	11	7	19	20	20	14	0.4%	14	0.4%
YAMHILL	21	32	30	47	57	36	46	1.4%	38	1.2%
South Willamette / Central Coast								**20.6%**	**837**	**25.1%**
CLATSOP	46	43	42	61	63	46	49	1.5%	50	1.5%
COLUMBIA	5	12	11	11	6	14	6	0.2%	9	0.3%
TILLAMOOK	10	12	8	18	17	16	18	0.5%	14	0.4%
North Coast								**2.2%**	**73**	**2.2%**
COOS	54	50	63	70	79	81	58	1.7%	65	1.9%
CURRY	26	16	17	9	11	18	17	0.5%	16	0.5%
DOUGLAS	137	128	126	137	128	109	114	3.4%	126	3.8%
JACKSON	79	130	132	151	168	141	95	2.8%	128	3.8%
JOSEPHINE	49	59	37	45	83	99	117	3.5%	70	2.1%
KLAMATH	24	25	33	56	69	52	49	1.5%	44	1.3%
LAKE	*	*					*	0.1%	0	0.0%
Southern Oregon								**13.4%**	**449**	**13.5%**
CROOK	5	*	4	7	9	8	6	0.2%	6	0.2%
DESCHUTES	41	33	72	93	134	132	110	3.3%	88	2.6%
JEFFERSON	*	*	*	*	4	6	12	0.4%	3	0.1%
Central Oregon								**3.8%**	**97**	**2.9%**
BAKER							*	0.0%	0	0.0%
GRANT						*	*	0.1%	0	0.0%
HARNEY	*	10	8	*	*	5	*	0.0%	3	0.1%
MALHEUR	21	14	15	13	28	19	9	0.3%	17	0.5%
MID-COLUMBIA	25	23	18	15	19	22	29	0.9%	22	0.6%
MORROW	*	4	6	4	*	4	*	0.1%	3	0.1%
OTHER		6	4	*	6	7	*	0.0%	3	0.1%
UMATILLA	14	8	9	13	18	36	26	0.8%	18	0.5%
UNION	9	13	6	5	*	*	4	0.1%	5	0.2%
WALLOWA	*	*		*	*	4	*	0.0%	1	0.0%
WARM SPRINGS	*	*		*	*	*		0.0%	-	0.0%
Eastern Oregon								**2.3%**	**72**	**2.2%**
TOTAL	2,979	2,940	3,253	3,369	3,916	3,542	3,376	100.0%	3,339	100.0%

Appendix C

DISPOSITION OF CURRENT OSH SALEM CAMPUS FACILITIES

RECOMMENDATIONS

OSH Framework Master Plan Phase I developed an assessment of existing conditions for the OHS Salem campus facilities. The assessment focused on the physical condition of buildings and infrastructure and their operational effectiveness for administering contemporary mental health treatment programs in a safe and secure setting. Based on the findings of Phase I investigation, OSH Master Plan Phase II provides recommendations for the disposition of Salem campus facilities.

During Phase I, the KMD master planning team developed and employed an assessment methodology to review current conditions of the physical plant with regard to existing building and site systems. The assessment methodology included interviews with staff, review of relevant documents, and visual observations of architectural, structural, electrical, mechanical, and environmental systems. The historical significance of campus buildings was also evaluated for potential preservation considerations. Specific attention was given to buildings designated for patient care. Assessment investigations also included review of compliance with current state and national codes requirements, accessibility, Oregon Administrative Rules for psychiatric hospitals, and relevant guidelines and criteria for contemporary treatment programs for mental illness.

The overall findings of Phase I conclude that the majority of current Salem campus buildings are inadequate to provide effective treatment of hospital patients according to prevailing mental health treatment criteria. The Salem campus was built incrementally over a 120-year period, beginning in 1883. In general, buildings and site systems are dated and have not been upgraded sufficiently or adequately maintained. Buildings have been allowed to deteriorate through deferred maintenance, have had stopgap measures applied for temporary repairs, or have had retrofit system modifications. Numerous buildings are non-compliant with currently adopted building codes and ADA accessibility requirements. Significant seismic deficiencies were noted for building performance in a major seismic event. Environmental hazards are present in a large number of buildings. A detailed documentation of assessment findings can be found in Master Plan Phase I.

The physical condition of buildings used for long-term patient treatment programs does not comply with contemporary mental health building design standards for treatment and security. A number of structures are in such an advanced state of deterioration that they should be demolished for life safety concerns and the prohibitive costs to upgrade for continued use. Most specifically, continued use of 'J' Complex buildings and the Rehabilitation Facility pose a danger to both patients and staff due to structural and fire and life safety deficiencies.

Some of the campus buildings could continue to be utilized through building systems upgrade and remodeling, but such improvements will be expensive. Although costly, these buildings could be upgraded and continue operating with current hospital uses or could be leased or sold to other potential non-hospital tenants. Upgrades in site infrastructure systems will be impacted by decisions regarding retention or demolition of campus buildings and require appropriate modifications to address any new circumstances.

The disposition of the Salem campus buildings are distributed among four categories:

1. Upgrade and Remodel
2. Sustained Operation
3. Historic Rehabilitation
4. Demolition

1. Upgrade and Remodel

This category includes buildings deemed worthy of remodeling and upgrading for use by OHS or alternative occupancy by tenants within public or private sectors. This collection of buildings is more recent in date of construction, circa early 1950s. Upgrade and remodel costs for these buildings will be substantial to meeting currently adopted codes and criteria. Further feasibility analyses are warranted in undertaking individual building renovations to establish more specific detail on program uses, necessary improvements, and associated capital construction budgets.

- Siskiyou Hall - Building 29, (Administration) 1950
- Yaquina Hall - Building 33 (Administration) ca. 1950s
- Santiam Hall - Building 34 (Patient Wards/x-Ray Department) 1951
- Breitenbush Hall - Building 35 (Patient Wards/Pharmacy/Med Lab) 1948
- McKenzie Hall - Building 40 (Patient Wards/Offices) 1948
- Eola Hall - Building 50 (Patient Wards) 1955
- Recreation Center - Building 77 (Recreation Activities) 1956

2. Sustained Operation

This category includes buildings that could continue to be used in current functions with minimal investment in capital construction funds. These buildings are in reasonably good condition and deficiency issues regarding code compliance can be corrected.

- Lumber Mill - Building 58
- Shelter Workshops - Building 93
- Residential Cottages (Residences/Offices)

3. Historic Rehabilitation for Adaptive Reuse

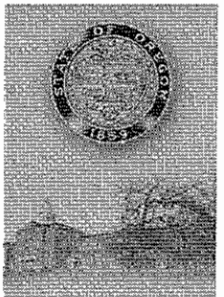
This category includes buildings that are deemed historically significant and worthy of preservation and adapted to alternative uses. While the City of Salem Historic Commission lists both structures as significant, neither has received designation on federal historic registry. Rehabilitating these two buildings would require further preservation analysis and design to address the myriad of non-compliance code items for future occupancy, and to develop associated construction cost estimates.

- Cascade Hall - Building 30 (Offices/Gymnasium) 1883
- Dome Building - Building 36, (Dental Services/DOC) 1912

4. Demolition

This category includes buildings that are recommended for demolition. These buildings have seriously deteriorated and present potential danger to occupants due to structural, environmental, and operational deficiencies with continued use. Several of these buildings such as the 'J' Complex are very dated and upgrading them would require significant financial investment to comply with current building codes and program criteria. In all cases, remodeling is considered cost-prohibitive and would provide questionable return on financial investment of capital funds.

- Kitchen - Building 31 (Kitchen/Food Service Administrative Offices) 1926



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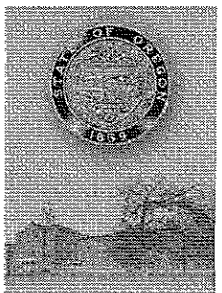
APPENDIX C-2

- J-Complex - Buildings 41, 42, 43, 44, 45, 46, 47, 48 (Patient Wards) 1883 – circa 1920
- Rehabilitation Facility - Building 49 (Patient Rehabilitation) Pre-1920
- Boiler Building - Building 51 (Mechanical Systems) 1951
- Vehicle Garage - Building 53 (Maintenance/Offices) Pre-1940
- Central Storage - Building 59 (Central Storage) 1909
- Outdoor Program - Building 60 (Outdoor Program Office) 1896
- Physical Plant - Building 63 (Physical Plant/Storage) 1929
- Physical Plant Storage - Building 75 (Storage) Date Unknown
- Physical Plant Storage - Building 76 (Large Equipment Storage) Date Unknown



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APPENDIX C-3

OREGON STATE HOSPITAL DEVELOPMENT OPTIONS

Basis for Estimation of Costs

The methodology used to develop the estimated magnitude of cost for the initial year 2011 increment of construction for each of the OSH Development Options included the following:

- Establishing the projected conceptual architectural space requirements for each anticipated component of the project.

- Assigned information obtained from a professional cost estimator, applying that expertise to similar facilities based on a cost per square foot adjusted for the metropolitan Oregon area.

- Estimated site development costs assume suitable soil and geotechnical conditions for building foundations, adequate utility infrastructure supporting the project, and site security appropriate to the facility type. These site costs are incorporated into the cost per square foot noted above.

- Applying an escalation factor that adjusts the estimated construction cost to the projected date for the start of construction. Currently this includes a 5% escalation to 2007 plus a 3.5% escalation from 2007 to 2008.

- Start of construction is estimated to be mid 2008 with facilities being operational in year 2011 – a projected construction time of 30 months.

- Estimated project costs add the owner's project-related "soft costs" to the estimated construction costs.
  - "Soft costs" include, but are not limited to: design fees, permits, inspections, surveys, off-site utilities development, geotechnical analysis, owner's project management, construction contingencies, furnishings, telecommunications/data systems, equipment, system development charges, legal fees, etc.
  - These costs vary significantly with each project depending on location, local conditions, and other project-specific factors. For the purposes of this Master Plan, these costs are estimated at 30% of the construction costs. This represents an average range of owner's soft costs for other, similar projects that have been constructed.

- Land acquisition, off-site roadway construction, and off-site utility development beyond normal connections are excluded from all project costs.

OSH Development Option 1

One 980-bed facility encompassing all inpatient beds, located in the North Willamette Valley region, plus two non-hospital level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

980 BED CENTRAL FACILITY, WILLAMETTE VALLEY						
Space Designation	**Beds/ Unit**	**Units**	**Total Beds**	**DGSF / Unit**	**Total Area**	**Estimated Costs**
Patient Treatment Units						
Adult Treatment	20	6	120	11,700	70,200	$ 16,146,000
Neuro-Psych	20	9	180	11,700	105,300	$ 24,219,000
Forensic - Transition	20	8	160	11,700	93,600	$ 21,528,000
Forensic-	20	20	400	11,700	234,000	$ 53,820,000
Forensic - MAX	20	5	100	11,700	58,500	$ 16,087,500
DOC Unit (Separate)	20	1	20	11,700	11,700	$ 3,217,500
		49	980		573,300	$ 135,018,000
Support Facilities & Services						
Campus Clinical Services						
20-bed Infirmary					8,768	$ 2,630,250
Primary Care Clinic					20,061	$ 4,614,030
Public / Administration						
Public Lobby / Reception / Security					2,691	$ 538,200
Hospital Administration					11,185	$ 1,901,408
Central Dietary Services					19,260	$ 3,852,000
Mainenance & Support Services					21,450	$ 4,397,250
Centralized Vocation / Recreation					70,817	$ 9,914,380
Total Support Facilities					154,231	$ 27,847,518
Departmental Gross Square Footage					727,531	$ 162,865,518
Departmental to Building Area Multiplier						1.25
Building Gross Square Footage					909,414	$ 203,581,897
Patient Unit Exterior Yards					83,300	$ 2,082,500
Secure Vehicle Sallyport					2,000	$ 70,000
Dietary Covered Service Dock					650	$ 71,500
Maintenance/Supply Covered Dock					1,000	$ 110,000
Exterior Recreation - Basketball / Baseball / Etc.					64,000	$ 1,600,000
Building Gross Square Footage					1,060,364	
Estimated Construction Costs						$ 207,515,897
Escalate Const. Cost (5%) to 2007						$ 217,891,692
Escalate Const. Cost (3.5%) to 2008 Start						$ 225,517,901
Project Cost Multiplier					30%	$ 67,655,370
Estimated HOSPITAL Project Costs						$ 293,173,271
Estimated SRTF (2 each) Project Costs						$ 4,600,000

PROBABLE PROJECT COST RANGE - Campus 1 **$297 to $307 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

Maintenance Cost & Schedule			Option 1
General System	**Unit Cost in Current $**	**Years to Replace**	909,414 SF **Cost per Year**
Interior Finishes	$ 22.00 /SF	7	$ 2,858,158
Roof Systems	$ 9.00 /SF	15	$ 545,648
HVAC	$ 44.50 /SF	30	$ 1,348,864
Electrical	$ 18.50 /SF	30	$ 560,805
Security Electronics	$ 9.50 /SF	10	$ 863,943
Doors & Locking Systems	$ 9.00 /SF	15	$ 545,648
Equipment & Furnishings	$ 3.00 /SF	10	$ 272,824
Contingency @ 14%			$ 979,439
	$ 115.50 /SF		
			$ 7,975,431

Annual Set-Aside $$ for Future Replacement Option 1 **$7,975,431**

OSH Development Option 2

One 620-bed facility located in the North Willamette Valley region, one 360-bed facility located south of Linn County on the west side of the Cascades, plus at least two non-hospital-level, 16-bed secure residential treatment settings placed strategically east of the Cascades.

CAMPUS 2A

620 BED CENTRAL FACILITY, WILLAMETTE VALLEY

Space Designation	Beds/ Unit	Units	Total Beds	DGSF / Unit	Total Area		Estimated Costs
Patient Treatment Units							
Adult Treatment	20	4	80	11,700	46,800	$	10,764,000
Neuro-Psych	20	9	180	11,700	105,300	$	24,219,000
Forensic - Transition	20	4	80	11,700	46,800	$	10,764,000
Forensic-	20	8	160	11,700	93,600	$	21,528,000
Forensic - MAX	20	5	100	11,700	58,500	$	16,087,500
DOC Unit (Separate)	20	1	20	11,700	11,700	$	3,217,500
		31	620		362,700	$	86,580,000
Support Facilities & Services							
Campus Clinical Services							
14-bed Infirmary					6,878	$	2,063,250
Primary Care Clinic					19,386	$	4,458,780
Public / Administration							
Public Lobby / Reception / Security					2,366	$	473,200
Hospital Administration					11,185	$	1,901,408
Central Dietary Services					17,100	$	3,420,000
Mainenance & Support Services					21,450	$	4,397,250
Centralized Vocation / Recreation					68,345	$	9,568,230
			Total Support Facilities		146,709	$	26,282,118
			Departmental Gross Square Footage		509,409	$	112,862,118
			Departmental to Building Area Multiplier				1.25
			Building Gross Square Footage		636,761	$	141,077,647
Patient Unit Exterior Yards					52,700	$	1,317,500
Secure Vehicle Sallyport					2,000	$	70,000
Dietary Covered Service Dock					650	$	71,500
Maintenance/Supply Covered Dock					1,000	$	110,000
Exterior Recreation - Basketball / Baseball / Etc.					64,000	$	1,600,000
			Building Gross Square Footage		757,111		
			Estimated Construction Costs			**$**	**144,246,647**
			Escalate Const. Cost (5%) to 2007			$	151,458,979
			Escalate Const. Cost (3.5%) to 2008 Start			$	156,760,043
			Project Cost Multiplier		30%	$	47,028,013
			Estimated HOSPITAL Project Costs			**$**	**203,788,057**
			Estimated SRTF (2 each) Project Costs			$	4,600,000

PROBABLE PROJECT COST RANGE - Campus 2A **$204 to $211 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

OSH Development Option 2
(continued)

CAMPUS 2B

360 BED FACILITY WEST of the CASCADES

Space Designation	Beds/ Unit	Units	Total Beds	DGSF / Unit	Total Area	Estimated Costs
Patient Treatment Units						
Adult Treatment	20	2	40	11,700	23,400	$ 5,382,000
Neuro-Psych						
Forensic - Transition	20	4	80	11,700	46,800	$ 10,764,000
Forensic-	20	12	240	11,700	140,400	$ 32,292,000
Forensic - MAX						
DOC Unit (Separate)						
		18	360		210,600	$ 48,438,000
Support Facilities & Services						
Campus Clinical Services						
10-bed Infirmary					5,640	$ 1,692,000
Primary Care Clinic					9,531	$ 2,192,130
Public / Administration						
Public Lobby / Reception / Security					1,879	$ 375,700
Hospital Administration					6,845	$ 1,163,565
Central Dietary Services					7,680	$ 1,536,000
Mainenance & Support Services					12,760	$ 2,615,800
Centralized Vocation / Recreation					43,677	$ 6,114,780
Total Support Facilities					88,011	$ 15,689,975
Departmental Gross Square Footage					298,611	$ 64,127,975
Departmental to Building Area Multiplier						1.25
Building Gross Square Footage					373,264	$ 80,159,969
Patient Unit Exterior Yards					30,600	$ 765,000
Secure Vehicle Sallyport					2,000	$ 70,000
Dietary Covered Service Dock					650	$ 71,500
Maintenance/Supply Covered Dock					1,000	$ 110,000
Exterior Recreation - Basketball / Baseball / Etc.					64,000	$ 1,600,000
Building Gross Square Footage					471,514	
Estimated Construction Costs						**$ 82,776,469**
Escalate Const. Cost (5%) to 2007						$ 86,915,292
Escalate Const. Cost (3.5%) to 2008 Start						$ 89,957,327
Project Cost Multiplier					30%	$ 26,987,198
Estimated HOSPITAL Project Costs						**$ 116,944,526**

PROBABLE PROJECT COST RANGE - Campus 2B **$117 to $120 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

Maintenance Cost & Schedule			Option 2A	Option 2B
General System	Unit Cost in Current $	Years to Replace	636,761 SF Cost per Year	373,264 SF Cost per Year
Interior Finishes	$ 22.00 /SF	7	$ 2,001,249	$ 1,173,115
Roof Systems	$ 9.00 /SF	15	$ 382,057	$ 223,958
HVAC	$ 44.50 /SF	30	$ 944,529	$ 553,675
Electrical	$ 18.50 /SF	30	$ 392,669	$ 230,179
Security Electronics	$ 9.50 /SF	10	$ 604,923	$ 354,601
Doors & Locking Systems	$ 9.00 /SF	15	$ 382,057	$ 223,958
Equipment & Furnishings	$ 3.00 /SF	10	$ 191,028	$ 111,979
Contingency @ 14%			$ 685,792	$ 402,005
	$ 115.50 /SF			
			$ 5,584,302	**$ 3,273,470**

Annual Set-Aside $$ for Future Replacement Option 2 **$8,857,772**

OSH Development Option 3

One 600-bed facility located in the North Willamette Valley region, one 320-bed facility located south of Linn County on the west side of the Cascades, and one 60-bed forensic facility located in Central or Eastern Oregon.

CAMPUS 3A
600 BED CENTRAL FACILITY, WILLAMETTE VALLEY

Space Designation	Beds/ Unit	Units	Total Beds	DGSF / Unit	Total Area		Estimated Costs
Patient Treatment Units							
Adult Treatment	20	4	80	11,700	46,800	$	10,764,000
Neuro-Psych	20	11	220	11,700	128,700	$	29,601,000
Forensic - Transition	20	4	80	11,700	46,800	$	10,764,000
Forensic-	20	5	100	11,700	58,500	$	13,455,000
Forensic - MAX	20	5	100	11,700	58,500	$	16,087,500
DOC Unit (Separate)	20	1	20	11,700	11,700	$	3,217,500
		30	600		351,000	$	83,889,000
Support Facilities & Services							
Campus Clinical Services							
14-bed Infirmary					6,878	$	2,063,250
Primary Care Clinic					19,386	$	4,458,780
Public / Administration							
Public Lobby / Reception / Security					2,366	$	473,200
Hospital Administration					11,185	$	1,901,408
Central Dietary Services					17,100	$	3,420,000
Mainenance & Support Services					21,450	$	4,397,250
Centralized Vocation / Recreation					68,345	$	9,568,230
			Total Support Facilities		146,709	$	26,282,118
			Departmental Gross Square Footage		497,709	$	110,171,118
			Departmental to Building Area Multiplier				1.25
			Building Gross Square Footage		622,136	$	137,713,897
Patient Unit Exterior Yards					51,000	$	1,275,000
Secure Vehicle Sallyport					1,500	$	52,500
Dietary Covered Service Dock					650	$	71,500
Maintenance/Supply Covered Dock					1,000	$	110,000
Exterior Recreation - Basketball / Baseball / Etc.					40,000	$	1,000,000
			Building Gross Square Footage		716,286		
			Estimated Construction Costs			**$**	**140,222,897**
			Escalate Const. Cost (5%) to 2007			$	147,234,042
			Escalate Const. Cost (3.5%) to 2008 Start			$	152,387,233
			Project Cost Multiplier		30%	$	45,716,170
			Estimated HOSPITAL Project Costs			**$**	**198,103,403**

PROBABLE PROJECT COST RANGE - Campus 3A **$198 to $203 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

OSH Development Option 3
(continued)

CAMPUS 3B
320 BED FACILITY WEST of the CASCADES

Space Designation	Beds/ Unit	Units	Total Beds	DGSF / Unit	Total Area		Estimated Costs
Patient Treatment Units							
Adult Treatment	20	2	40	11,700	23,400	$	5,382,000
Neuro-Psych							
Forensic - Transition	20	4	80	11,700	46,800	$	10,764,000
Forensic-	20	10	200	11,700	117,000	$	26,910,000
Forensic - MAX							
DOC Unit (Separate)							
		16	320		187,200	$	43,056,000
Support Facilities & Services							
Campus Clinical Services							
10-bed Infirmary					5,640	$	1,692,000
Primary Care Clinic					9,531	$	2,192,130
Public / Administration							
Public Lobby / Reception / Security					1,879	$	375,700
Hospital Administration					6,845	$	1,163,565
Central Dietary Services					7,680	$	1,536,000
Mainenance & Support Services					12,760	$	2,615,800
Centralized Vocation / Recreation					43,677	$	6,114,780
			Total Support Facilities		88,011	$	15,689,975
			Departmental Gross Square Footage		275,211	$	58,745,975
			Departmental to Building Area Multiplier				1.25
			Building Gross Square Footage		344,014	$	73,432,469
Patient Unit Exterior Yards					27,200	$	680,000
Secure Vehicle Sallyport					2,000	$	70,000
Dietary Covered Service Dock					650	$	71,500
Maintenance/Supply Covered Dock					-	$	-
Exterior Recreation - Basketball / Baseball / Etc.					32,000	$	800,000
			Building Gross Square Footage		405,864		
			Estimated Construction Costs			**$**	**75,053,969**
			Escalate Const. Cost (5%) to 2007			$	78,806,667
			Escalate Const. Cost (3.5%) to 2008 Start			$	81,564,901
			Project Cost Multiplier		30%	$	24,469,470
			Estimated HOSPITAL Project Costs			**$**	**106,034,371**

PROBABLE PROJECT COST RANGE - Campus 3B **$106 to $109 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

OSH Development Option 3
(continued)

CAMPUS 3C
60 BED FACILITY IN CENTRAL OR EASTERN OREGON

Space Designation	Beds/ Unit	Units	Total Beds	DGSF / Unit	Total Area		Estimated Costs
Patient Treatment Units							
Adult Treatment Neuro-Psych Forensic - Transition Forensic- Forensic - MAX DOC Unit (Separate)	20	3	60	11,700	35,100	$	8,073,000
		3	60		35,100	$	8,073,000
Support Facilities & Services							
Campus Clinical Services							
No Infirmary							
Primary Care Clinic					500	$	114,885
Public / Administration							
Public Lobby / Reception / Security					897	$	179,400
Hospital Administration					2,660	$	452,115
Central Dietary Services					3,540	$	708,000
Mainenance & Support Services					4,279	$	877,195
Centralized Vocation / Recreation					9,741	$	1,363,670
Total Support Facilities					21,616	$	3,695,265
Departmental Gross Square Footage					56,716	$	11,768,265
Departmental to Building Area Multiplier							1.25
Building Gross Square Footage					70,894	$	14,710,331
Patient Unit Exterior Yards					5,100	$	127,500
Secure Vehicle Sallyport					1,500	$	52,500
Dietary Covered Service Dock					400	$	44,000
Maintenance/Supply Covered Dock							
Exterior Recreation - Basketball / Baseball / Etc.					32,000	$	800,000
Building Gross Square Footage					109,894		
Estimated Construction Costs						**$**	**15,734,331**
Escalate Const. Cost (5%) to 2007						$	16,521,048
Escalate Const. Cost (3.5%) to 2008 Start						$	17,099,284
Project Cost Multiplier					30%	$	5,129,785
Estimated HOSPITAL Project Costs						**$**	**22,229,070**

PROBABLE PROJECT COST RANGE - Campus 3C **$22 to $25 M**

This program anticipates opening new hospital by 2011, with bed units sized for next 10 years (2021). However, the core facility, Infirmary, dietary, etc. are sized for 25-year (2030) goal. The purchase of land is excluded from these figures.

Maintenance Cost & Schedule			Option 3A	Option 3B	Option 3C
General System	Unit Cost in Current $	Years to Replace	622,136 SF Cost per Year	344,014 SF Cost per Year	70,894 SF Cost per Year
Interior Finishes	$ 22.00 /SF	7	$ 1,955,284	$ 1,081,186	$ 222,811
Roof Systems	$ 9.00 /SF	15	$ 373,282	$ 206,408	$ 42,537
HVAC	$ 44.50 /SF	30	$ 922,835	$ 510,287	$ 105,160
Electrical	$ 18.50 /SF	30	$ 383,650	$ 212,142	$ 43,718
Security Electronics	$ 9.50 /SF	10	$ 591,029	$ 326,813	$ 67,350
Doors & Locking Systems	$ 9.00 /SF	15	$ 373,282	$ 206,408	$ 42,537
Equipment & Furnishings	$ 3.00 /SF	10	$ 186,641	$ 103,204	$ 21,268
Contingency @ 14%			$ 670,040	$ 370,503	$ 76,353
	$ 115.50 /SF				
			$ 5,456,043	**$ 3,016,951**	**$ 621,734**

Annual Set-Aside $$ for Future Replacement Option 3 **$9,094,728**

DHS AND DOC LETTER OF AGREEMENT

State of Oregon
Department of Corrections
Projects Office

MEMORANDUM UPDATE

To: Max Williams, Director **Date:** January 5, 2006

From: DOC OSH Single Facility Exploration Workgroup

Subject: Amendment to July 27, 2005 Recommendation

Findings:
Following the request of Governor Ted Kulongoski to evaluate and make recommendations concerning possible advantages of collaborative efforts by the Department of Corrections (DOC) and the Department of Human Services (DHS) in the provision of services to persons with mental disorders, the agencies convened a workgroup to identify the statutory, legal, and structural issues associated with such an effort. (See attached memorandum dated July 27, 2005.) Subsequently, both Departments met to discuss the issues identified and to review those issues in light of additional information obtained regarding similar models around the country. The Departments' findings resulting from those meetings are enumerated below.

1. The statutory impediments to joint programming are numerous and would be difficult to overcome. This is primarily due to the differing legal status of inmates and hospital patients, including those under the jurisdiction of the Psychiatric Security Review Board (PSRB). Oregon has a system of managing those persons found guilty except for insanity that is substantially different from most other states. In these circumstances, it greatly adds to the complexity of multi-jurisdictional operations.
2. The small population size of Oregon largely prevents the economies of scale and operational efficiencies that have driven attempts at joint facilities in other states. In addition, several states that previously attempted to provide co-managed mental health services have subsequently abandoned those efforts, often due to management and bargaining unit complexity that is integral to such endeavors.
3. Mental health advocates, especially those associated with family support groups, have expressed concern and in some cases strong opposition about cooperative ventures between DOC and DHS. Those concerns are primarily driven by the fact that there remains a profound disparity in public perception between inmates and hospital forensic patients, despite the similar mental health issues facing targeted populations in both systems. This is especially true in regards to expectations in the level of care provided in a hospital as opposed to a prison, and the intensity of post-discharge follow-up care.
4. Even without a shared facility approach, progress toward improved quality of care for DOC inmates and Oregon Youth Authority detainees with severe and persistent mental health needs is being made through increasing cooperation between the two agencies. HB 2141 (2005) amends Oregon law to allow DOC inmates and OYA detainees to be temporarily transferred to Oregon State Hospital custody for stabilization of severe mental health episodes.

Recommendation:
For these reasons, both Departmentss agree that a joint facility or campus is not a reasonable option for the State to consider consideration at this time. Although initially it appeared that a shared facility could be advantageous both in terms of inmate/patient care and operational efficiencies, the Departments now agree that further development of a shared facility proposal would not advance those objectives.

However, these discussions have allowed both Departments to recommend an alternative means for achieving those objectives through the Phase 2 Master Planning process scheduled to be completed in February 2006. To that end, DHS and DOC recommend that the new State Hospital system be designed to serve an allocated capacity of 20 DOC inmate patients, with an annual ability to serve 70 patients. This will allow DOC to provide hospital-level mental health programs without creating duplicate services on prison campuses. In addition, it is expected that the increased funding proposed for community mental health services by the OSH Master Plan will have the long term effect of stabilizing and perhaps decreasing of the number of inmates in DOC custody in need of hospital level of care.

cc: Bruce Goldberg, Director, Department of Human Services
Robert E. Nikkel, M.S.W., Assistant Director, Office of Mental Health and Addiction Services
Erinn Kelley-Siel, Health and Human Services Policy Advisor, Office of the Governor

PROJECT ASSUMPTIONS

Assumptions for State Hospital

User Rates – State Hospital Discharges per 1,000 Population

	2005			2011			2030		
Region	ATS	Neuro	Forensic	ATS	Neuro	Forensic	ATS	Neuro	Forensic
North Willamette	0.13	0.17	0.17	0.13	0.18	0.17	0.10	0.19	0.18
South Willamette/ Central Coast	0.06	0.15	0.18	0.05	0.15	0.20	0.04	0.15	0.24
North Coast	0.12	0.13	0.14	0.10	0.13	0.15	0.07	0.14	0.17
Southern Oregon	0.07	0.16	0.22	0.06	0.17	0.23	0.03	0.18	0.27
Central Oregon	0.10	0.13	0.07	0.08	0.13	0.07	0.04	0.14	0.08
Eastern Oregon	0.13	0.17	0.12	0.13	0.18	0.13	0.11	0.19	0.15
TOTAL	*0.10*	*0.16*	*0.17*	*0.10*	*0.17*	*0.18*	*0.08*	*0.17*	*0.20*

Use rate assumptions:

a) ATS and Forensic services based on adult (20+) population. Neuropsychiatric services based on adult (65+) populations.

b) ATS use rates will decline due to increased use of community based settings as alternatives to civil commitment at OSH.

c) Forensic use rates increased based on increased projected for prison intake population.

d) Neuropsychiatric rates increased assuming an increase in brain injured and elderly patients with psychiatric disorders.

e) Regional variations in OSH use currently exist; these variations will continue, accounting for differences across settings.

Average Length of Stay (ALOS) by Program Type (achieved by decreases in wait list and earlier discharge to community settings)

Length of Stay Assumptions:

a) Adult Treatment Services (ATS) length of stay will decline from an average of 249 days in 2005 to 175 days by year 2011. This length of stay will continue. Length of stay decline will be supported by community residential program development, facilitating easier and earlier discharge.

b) Neuropsychiatric length of stay will decline from an average of 462 days to 400 days by 2011. Length of stay decline will be supported by community residential program development, in particular Enhanced Care Services (ECS).

c) Forensic Aid and Assist length of stay will decrease from 165 days to 100 days by year 2011. Forensic PSRB length of stay will decrease from almost 1,000 days in 2005 to 800 days by year 2011. For both forensic populations served in the forensics program, the decline will be due to a greater availability and use of community based programs.

d) The distribution of PSRB vs. Aid and Assist patients is projected by OMHAS to remain as it has been in recent years.

Average Length of Stay by Program Type (in days)

	2005	2011	2030
ATS	249	175	175
Neuropsychiatric/Geriatric	462	400	400
Forensic			
PSRB	988	905	800
Aid/Assist	165	156	100

Percent Distribution of Forensic Admissions

PSRB (60%) vs. Aid and Assist (40%)

Occupancy Levels (average percent of beds occupied)

2005	2011	2030
100%+	85%	85%

- The 85% occupancy level is standard for health care facilities and enables flexibility for census fluctuations, gender needs, acuity needs, and other shifts that occur in patient care. In the charts within this report, when the 85% occupancy rate has been utilized, the occupancy number is divided by 85%.
- The current 100% occupancy is not recommended for any facility programming as it leaves no room for changes in patient type, staffing needs or other operations.

Operating Costs (per patient per day)

	2005	2011	2030
Rate per patient day (filled beds only)	$ 373	$ 465	$ 465

Operating costs based on review of five state hospitals (for which data was available). OSH current costs fall significantly below these levels and projected rate.

Assumptions for Community Program

Community Residential Programs

Beds per 1,000 adult population (age 20+) – all residential settings combined

REGION	*2005*	*2011*	*2030*
North Willamette	0.65	0.75	0.72
South Willamette/Central Coast	0.71	0.74	0.72
North Coast	0.37	0.73	0.69
Southern Oregon	0.72	0.73	0.70
Central Oregon	0.27	0.71	0.67
Eastern Oregon	0.73	0.72	0.70
TOTAL	**0.65**	**0.74**	**0.71**

Use Rate Increase Assumptions:

a) Length of stay at state hospital will decrease; use rates by region were adjusted to accommodate the length of stay decrease (patient days transferred from OSH to community beds).
b) Use of community-based settings will increase as these settings used more as an alternative to OSH.
c) Greater us of Post Acute Intermediate Treatment Services (PAITS) as a post-acute care discharge alternative.
d) All regions will build a more population-based distribution of services, decreasing the variations is use rates now seen among counties/regions.

Operating Costs by Setting (Costs not adjusted for inflation)

	2005	2011	2030
Supported Housing	$ 13	$ 13	$ 13
Adult Foster Home	$ 53	$ 53	$ 53
Residential Treatment Facility	$ 290	$ 290	$ 290
Residential Treatment Home	$ 200	$ 200	$ 200
Secure Residential Treatment Facility	$ 300	$ 300	$ 300
SRTF Converted to intensive residential	$ 600	$ 600	$ 600
Secure Residential Treatment Home (PSRB)	$ 600	$ 600	$ 600
SRTH converted to intensive residential	$ 600	$ 600	$ 600
PAITS/ Intensive residential	$ 460	$ 460	$ 460
Enhanced Care	$ 93	$ 93	$ 93
Enhanced Care Outreach	$ 63	$ 63	$ 63

a) Operating costs provided by OMHAS and reflect the most current contracting assumptions.
b) Operating costs reflect the costs of programs to OMHAS, what OMHAS pays, not the actual cost incurred by each program.

GLOSSARY OF TERMINOLOGY

Acute Care Hospital	For the purposes of this report, these are local community medical hospitals that have an acute care psychiatric unit or component.
ADA	Americans with Disabilities Act
AFSCME	American Federation of State, County and Municipal Employees
Aid and Assist	Individuals whose mental condition is being evaluated and treated so as to allow them to participate in their own defense.
ALOS/LOS	"Average Length of Stay" or "Length of Stay" of a patient in a hospital or other facility or program, from admission to discharge
AOCMHP	Association of Oregon Community Mental Health Programs
ATS	Adult Treatment Services – adults who have been civilly committed for hospitalization.
BGSF	Building Gross Square Footage: This includes all space within the building footprint
BMRC	Blue Mountain Recovery Center - formerly Eastern Oregon Psychiatric Center, located in Pendleton, Oregon, with about 60 patients
Consumer	A person who receives mental health services. The term is sometimes used more generically to refer to anyone who has a diagnosis of mental illness. Not all persons with mental illness accept this terminology. Some prefer to be known simply as clients of the facilities where they receive services. People who feel they have been abused by the system or who reject traditional mental health services may prefer a term such as "survivor."
DAS	Oregon Department of Administrative Services
DGSF	Department Gross Square Footage: This includes all area within a department or service area of a facility. It excludes shafts, structure, corridors, and stairs, exterior walls, etc., that are not within the confines of the department.
DHS	Oregon Department of Human Services
DOC	Oregon Department of Corrections
Dual Diagnosis	Generally used to describe the condition of those individuals with mental illness who are also addicted to a mind-altering drug.

EAST	The Early Assessment and Support Team is an initiative project that targets individuals between the ages of 15 and 30 who are experiencing their first psychosis or who experienced a first psychosis within the last twelve months. The goals are to increase recovery potential, decrease the effects of mental illness on the individual and family through early diagnosis and intervention, thus reducing reliance on the mental health system.
ECS	Enhanced Care Services - Structured rehabilitative services and 24/7 crisis services delivered to individuals residing in specified residential treatment facilities. Services include a client-appropriate mix of assessment, medication management, individual, group and activity therapy components; oriented toward reducing symptoms, promoting community integration, and transitioning the individual to a more integrated setting. This service is provided by treatment teams to individuals living in 16-bed residential facilities or OSH.
ECOS	Enhanced Care Outreach Services - Structured development or rehabilitative programs designed to improve an individual's basic functioning in daily and community living. Programs include a mixture of assessment, individual, group and activity therapy components, medication management and consultation with healthcare providers. Programs are oriented toward developing positive approaches to understand and respond to behaviors, promoting meaningful vocational and recreational interests and skills, and improving interpersonal functioning. Services include the availability of 24/7 crisis intervention. These services may be delivered to the individual at their place of residence, within day treatment programs, and/or in community settings where it meets the individual's needs and preferences.
EOPC	Eastern Oregon Psychiatric Center – see BMRC
FEMA	Federal Emergency Management Agency
GERO	Geriatric
GERO-PSYCH	Geropsychiatric: see Neuropsychiatric
Housing Types	See Appendix B for definitions of Community-Based Residential
HVAC	Heating Ventilating Air-Conditioning – part of building systems
Infrastructure Dollars	Funds provided by the State to a county for program development and management
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KMD	KMD Architects and Planners, PC, Portland and San Francisco
Mental Health Client	A person with whom mental health professionals have a clinical relationship
Mental Health Consumer	A person who is receiving mental health services

Mental Health Survivor	A person who has survived the mental health system and/or mental illness
Mental Illness	Refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning.
NAMI	National Alliance for the Mentally Ill
NARA	Native American Rehabilitation Association
Neuro-Psych	Those with Neuro-psychiatric disorders such as Alzheimer's disease, stroke, epilepsy, multiple sclerosis (MS), brain tumors, Parkinson's disease, etc.
NHG	New Heights Group, Mental Health consultants in New Mexico and North Carolina
NIMBY	"Not In My Back Yard"; an acronym referencing attitudes by individuals, groups, neighborhoods, communities or organizations that attempt to prohibit or draw attention to real or potential situations, events or persons that are deemed as undesirable.
OAR	Oregon Administrative Rules. The rules written to enforce laws in the State of Oregon. As it applies to this project, OSH is a psychiatric facility licensed by the State of Oregon, the design of a State Hospital must conform to the OAR psychiatric hospital rules.
ODDS	Office of Developmental Disabilities Services
Olmstead Decision	The 1999 U.S. Supreme Court ruling, requires states to treat disabled residents in their home communities, opening up the potential for lawsuits against states that kept large numbers of patients institutionalized.
OMHAS	Office of Mental Health and Addiction Services, a division of the Oregon Department of Human Services
OSH	Oregon State Hospital is currently located on two sites – the Salem campus has over 600 patients, and the Portland campus with about 68 patients
Peer Service	Generically, a reference to any service that is provided by a consumer
PSRB	Psychiatric Security Review Board. This Board oversees individuals who have been found guilty of a crime, except for reason of insanity.
Psychotropic Medications	Prescription drugs that address psychiatric symptoms, usually given to reduce anxiety, depression or other consequences of mental illness.
Recovery Model	A set of values or perspectives that recognizes that recovery is a highly personal process and one that continues throughout a person's life. This includes but is not confined to the following elements: • Hope and Faith • Self-management and autonomy

- Restoration and personal growth
- Tolerance and forgiveness
- Adaptability and capacity to change
- Personal responsibility and productivity
- Peer support and community life
- Dignity and self-respect
- Acceptance and self awareness
- Universal applicability

Recovery Model vs. Medical Model	Attitudes and philosophies that are the core of treating those with mental illness. The medical model tends to define recovery in terms of symptoms and complaints that need to be eliminated and disorders that need to be cured or removed. The recovery model tends to focus on the persons themselves who are the objects of recovery efforts. Focusing on recovery may appear to discount the seriousness of a mental illness. For those with severe mental illness the conditions are likely to indefinitely persist, at least in some form. So how does one recover from an incurable illness? The way out of this dilemma is by realizing that, whereas the illness is the object of curative treatment efforts, it is the persons themselves who are the objects of recovery efforts. *(Adapted from The American Association of Community Psychiatrists)*
SEIU	Service Employees International Union
Soft Costs	Part of the overall costs of a project, "soft costs" include, but are not limited to: design fees, permits, inspections, surveys, off-site utilities development, geotechnical analysis, owner's project management, construction contingencies, furnishings, telecommunications/data systems, equipment, system development charges, legal fees, etc. These costs vary significantly with each project depending on location, local conditions, and other project-specific factors. For the purposes of this Master Plan, these costs are estimated at 30% of the construction costs. This represents an average range of owner's soft costs for other, similar projects that have been constructed.
SPD	Seniors and People with Disabilities (a division of DHS)
SPMI	Severe and Persistent Mental Illness
Stakeholders	Those interested in the services for those with mental illness
Supported Employment	On-job training to assist persons with severe or significant disabilities in obtaining and maintaining community integrated competitive employment through specifically planned supports. *It is an attempt to meet the specific needs of individuals with severe disabilities and is based on fundamentally different principles and assumptions. The supported work model assumes that all individuals, regardless of the nature or extent of their disabilities, should have the opportunity and support to work in the community. There are no pre-requisite skills needed for community job success. The task, therefore, is not to identify and place "work ready" individuals, but rather to locate and/or modify meaningful jobs in the community and provide training and supports at the job site.*

Oregon State Insane Asylum, 1892
Oregon State Archives,
Oregon Board of Architect Examiners, OAE0013

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