

Oregon Health Authority Report  
to the United States Department of Justice

*Report Regarding July 2015 Data*

This is the fourth report to the United State Department of Justice (USDOJ) based on the July 2014 data matrix. This reporting period is for the fourth quarter of 2014. The data from the previous quarters is included in this report and begins to illustrate the impact of the Medicaid expansion under the Affordable Care Act and the new investments in the community mental health system. The Medicaid expansion took effect on January 1, 2014, and many of the services funded by the new investments began in the second quarter of 2014. Additional data has been provided for several measures through April or May 2015.

This report is submitted under the 2012 collaborative agreement between the United States Department of Justice and the State of Oregon. The agreement outlines a process of data collection, analysis and the establishment of performance measures for the behavioral health system. The purpose of this process is to guide Oregon towards improved services and supports for individuals with a Severe and Persistent Mental Illness (SPMI) to help them live a full life in the most integrated setting in the community.

This report outlines the data collection methodology and findings with discussion and summary. The narrative report section highlights key elements of the data collected. The complete comprehensive data tables are in appendices following the narrative.

### **Data Collection Methodology**

Most of the data was collected from the Medicaid Management Information System (MMIS). The other significant data sources are surveys completed by Community Mental Health Programs (CMHP) for services and supports not captured in MMIS.

As noted above, this report currently relies on surveys completed by CMHPs for the non-Medicaid data. The Oregon Health Authority Division (OHA) worked closely with the CMHPs to craft the survey to improve the validity and reliability of the reporting across the CMHPs. The quality of the data has significantly improved, but there are limitations that are inherent in any survey process. OHA has implemented a new data system called the Measures and Outcomes Tracking

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System (MOTS). This new system requires providers to input encounter-like data, as well as, status data. The MOTS data system will enable OHA to gather most of the data currently captured in surveys.

The MOTS application replaces a 30-year old mainframe system and went live late in 2013. Initially the adoption was slow, especially for those behavioral health providers that were submitting MOTS data electronically from their existing electronic health record (EHR). These providers had to make significant changes to their own systems to meet the MOTS reporting requirements. Incentives to help cover the cost of these system changes helped to ensure data compliance. By spring of 2014, with the exception of one CMHP, all CMHPs and their subcontractors had submitted MOTS data, and data for that CMHP was subsequently submitted. As of June 15, 2015, over 148,000 unique clients had been entered into MOTS by publicly funded treatment programs across the state. Data is collected at intake and status updates are required at least every 90 days. MOTS has both status and services data, so it will be possible to analyze which services lead to improved outcomes, including the costs associated with those services. Outcomes associated with improvements in employment, education and housing will be monitored.

There is a high degree of confidence that most individuals receiving publicly funded behavioral health services have been entered into the system by the end of 2014. OHA is analyzing the integrity of the data and the reliability that status data is being entered. This is being done through a multi-pronged approach:

1. Anomaly reports are reviewed daily and OHA data technicians contact providers with questionable data to make sure it's corrected;
2. Data Quality Consultation visits are occurring with all CMHPs to review their data, ensure that OHA is receiving all necessary data, and discuss improvements that can be made with the MOTS system;
3. Email notifications will begin to go out in July to notify providers and CMHPs of gaps in data submission; and
4. On Demand Reports will be available to providers beginning in July.

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OHA has identified gaps in the data in MOTS when compared to survey data and will continue to work with providers on their MOTS submissions.

**State Hospital Utilization**

The Oregon State Hospital (OSH) is an important part of the continuum of care for people in need of longer term care for psychiatric illness. In this section, the referral, length of stay and admissions to the hospital are examined.

When individuals who are civilly committed meet the criteria for admission to OSH, they are put on a waiting list and remain in acute care until a bed at OSH becomes available. For this reporting period, OHA elected to compile the data regarding the number of individuals waiting in an acute care hospital while they wait for admission to OSH. OHA is developing strategies to decrease the number of individuals on the waitlist for OSH admission.

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Figure 1(a) shows the number of individuals on the waitlist at the beginning of each week from December 2014 through May 2015.

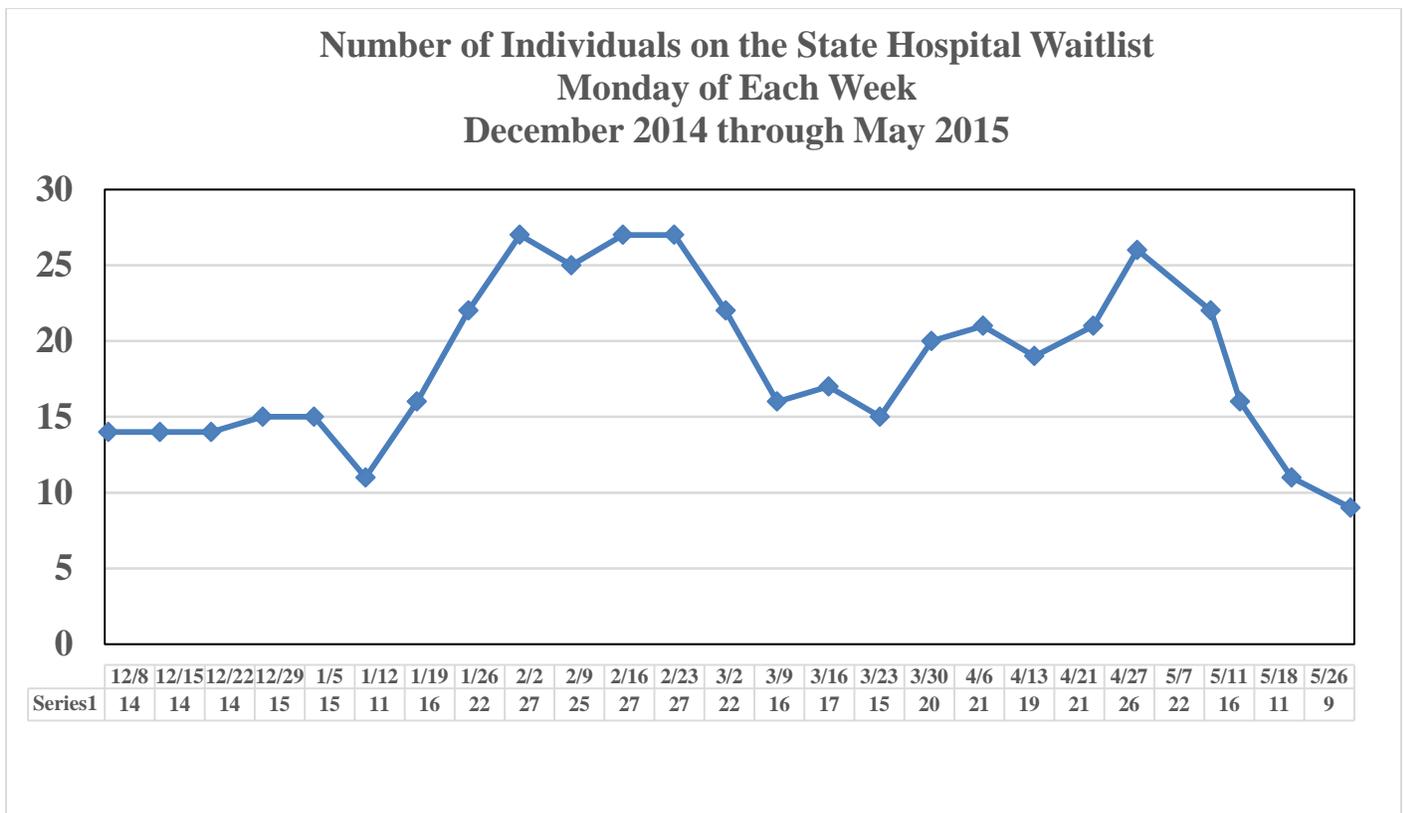


Figure 1(a)

After achieving a low in the second week of January 2015, the waitlist began to climb again. Historically, the number of individuals on the waitlist is higher in early spring. The waitlist began to steadily decrease beginning in April 2015 and this continued through May 2015. OHA is engaged in efforts to increase the flow of individuals in the system, and these efforts should facilitate a more rapid discharge to the community from OSH and decrease wait time in acute care.

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Figure 1(b) shows all admissions to OSH for six quarters by legal status.

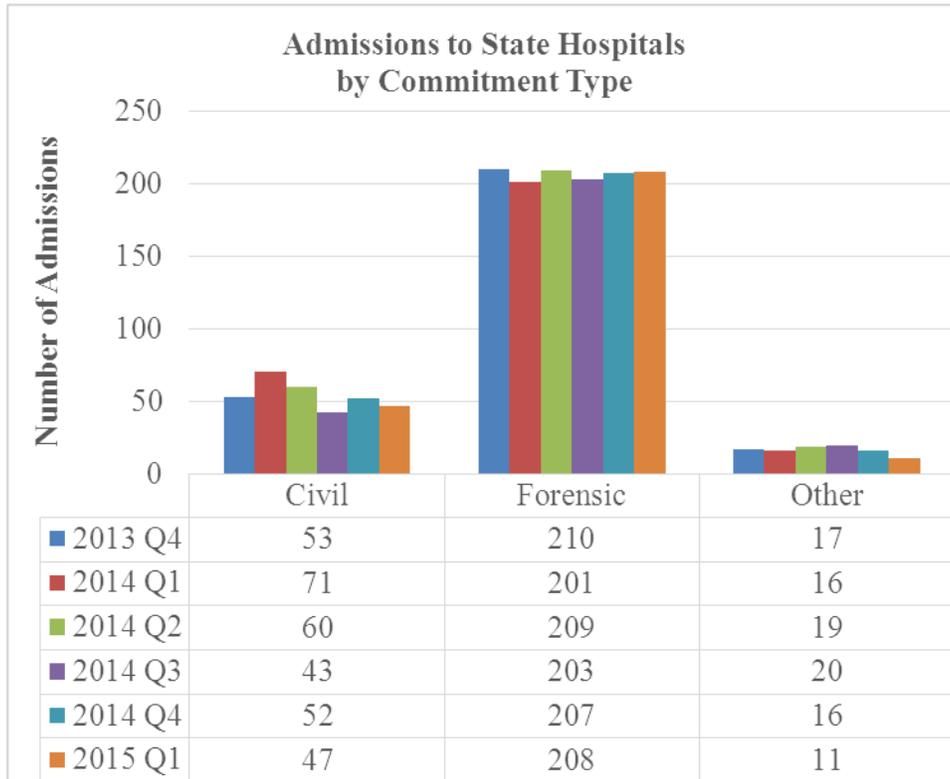


Figure 1(b)

Note: “Other” category primarily consists of neuro-geriatric patients on a guardianship.

There is variability in the data across the six quarters, without any trends emerging. Within each quarter, the number of civilly committed, forensic and other patients appears to be similar. These data are consistent with the overall percentages of the forensic and civil commitment populations at OSH.

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Figure 1(c) shows the average daily population for the past 12 years by legal status. The 2014 data is through December 31, 2014.

**Annual Average Daily Population at Oregon State Hospitals  
By Legal Status  
Including Total**

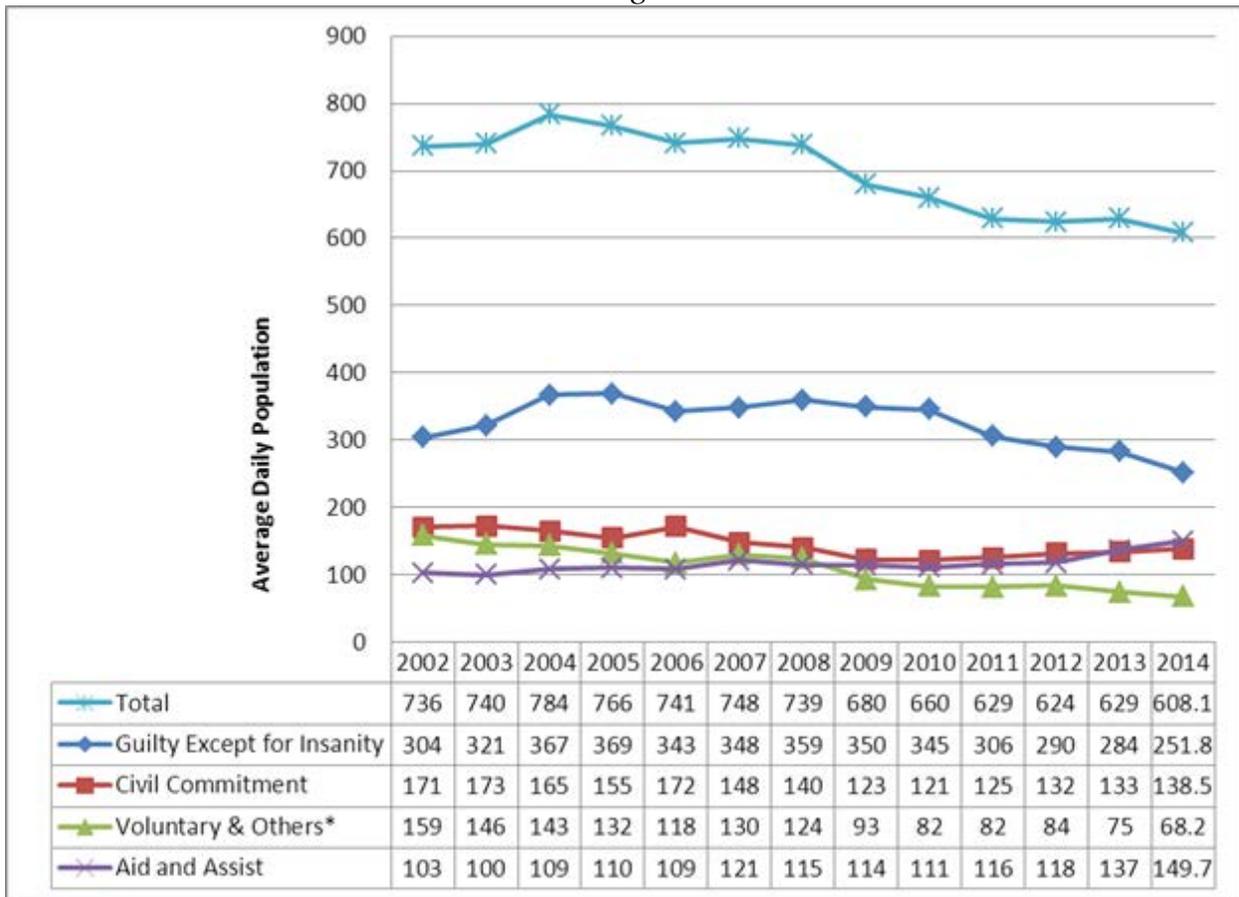


Figure 1(c)

\* “Voluntary & Others” category primarily consists of neuro-geriatric psychiatric patients on a guardianship.

These data show that the total annual average daily population in the state hospitals decreased from a high of 784 in 2004, to a twelve year low of 608.1 in 2014. The

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number of people in the ‘Guilty Except for Insanity’ category has declined while the number of people in the ‘Aid and Assist’ category continues to rise. These individuals are remanded to the OSH for competency restoration following arrest.

Figure 1(d) differs from Figure 1(c) only in that it does not include the total population across all categories. Because of the change in scale used in Figure 1(d), it is easier to see the decrease in persons at the hospitals in the guilty except for insanity and voluntary categories, and the slight increase in civil and aid and assist categories. OHA anticipates these rates will begin to decrease as new investments in community treatment and new legislation such as HB 2420 take effect, providing increased opportunities for community-based treatment.

**Annual Average Daily Population  
By Legal Status  
*Excluding Total***

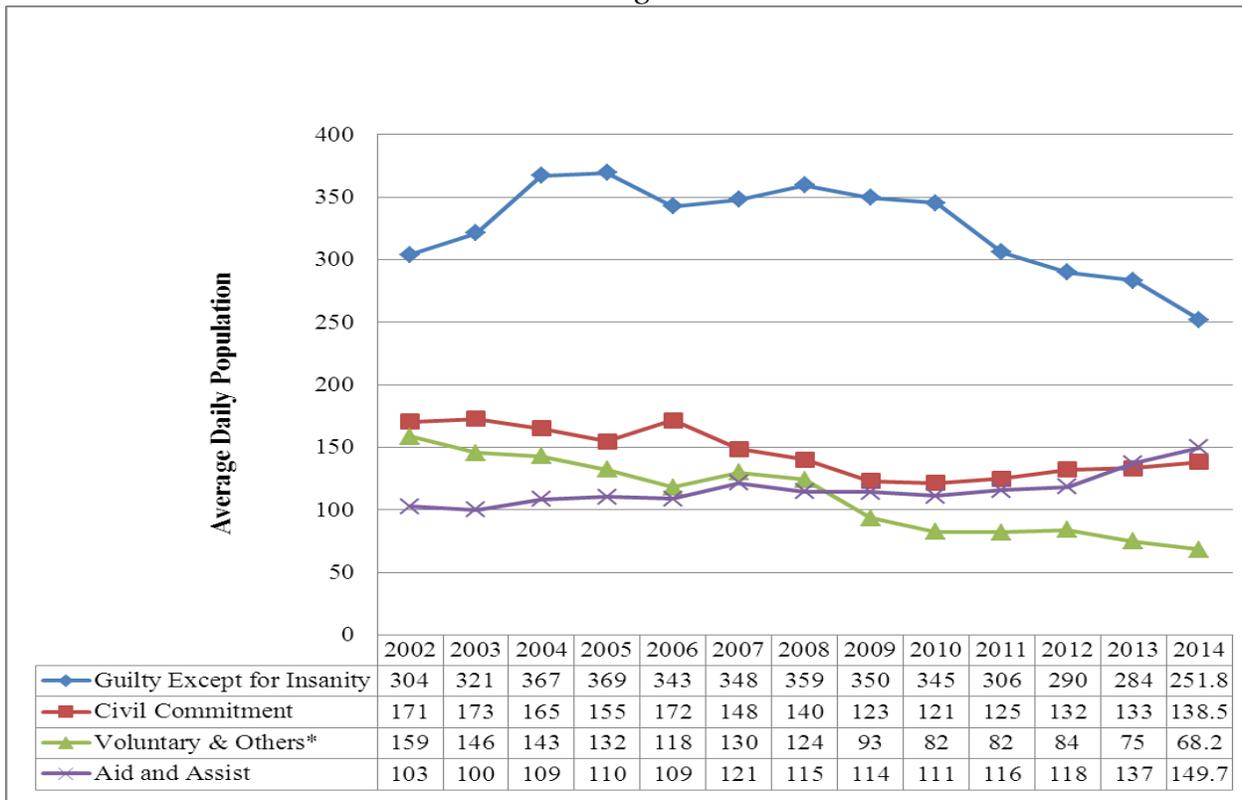


Figure 1(d)

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\* “Voluntary & Others” category primarily consists of neuro-geriatric psychiatric patients on a guardianship.

Figure 1(e) is the average and median length of stay for individuals on civil commitment at OSH.

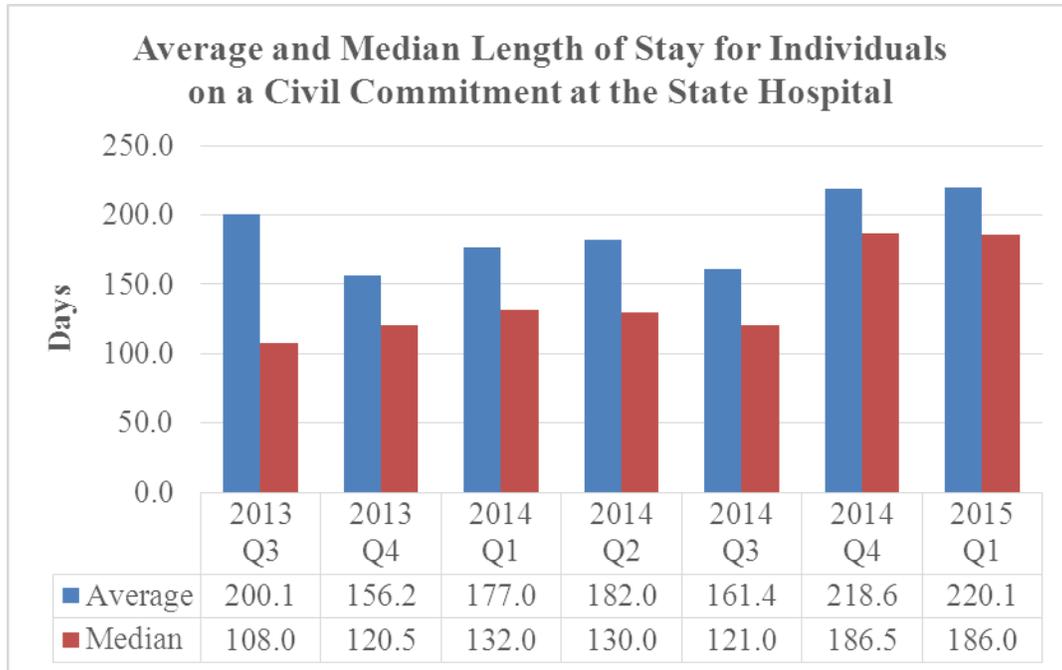


Figure 1(e)

For the most recent period (2015 Q1) the median length of stay remained virtually stable, while the average length of stay rose slightly. As in the last report, this was due primarily to discharges of patients with exceptional barriers to treatment.

**Discussion**

HB 2420 was passed during the week of March 30, 2015. This bill provides for increased community restoration opportunities for individuals deemed to lack capacity to participate in criminal proceedings. Passage of this bill should result in a decrease in Aid and Assist admissions to the state hospital.

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Figure 1(f) is the percentage of individuals on civil commitment who were readmitted to OSH within 180 days of discharge. The 30-day readmission rate is not shown, because individuals receive acute care in the community and are not readmitted to OSH within 30 days. The rate will always be zero.

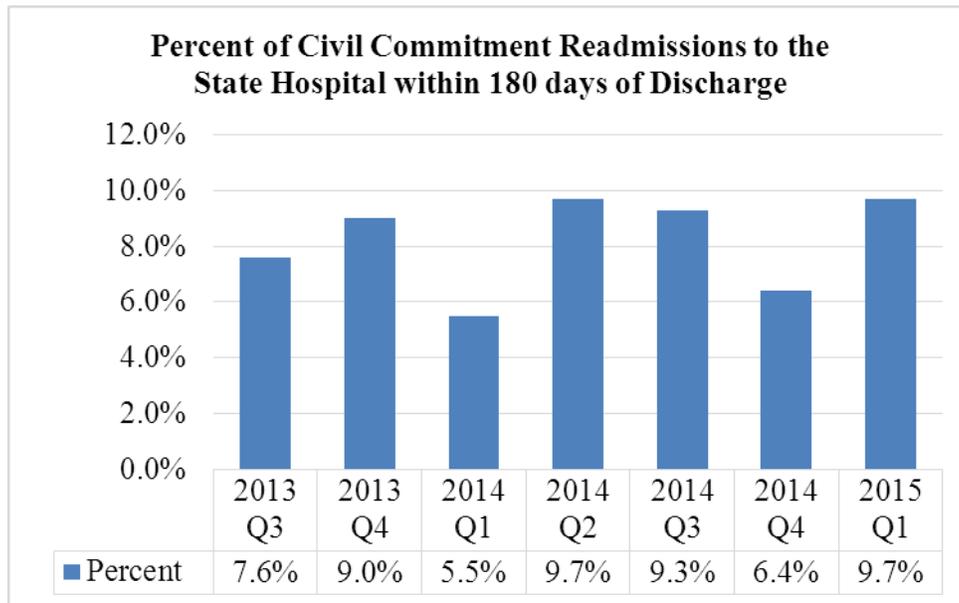


Figure 1(f)

The number of civilly committed individuals readmitted to OSH in 180 days continues to remain relatively stable in the this reporting period. The readmission rate for Q3 2014 was 6.4%, and in Q1 2015 the level rose to 9.3%.

Discussion

OSH has an initiative to meet the goals regarding hospital length of stay and has developed a new process to expedite transitions from OSH. Currently, the target is to discharge individuals to a community based setting within 30 days once designated Ready to Transition.

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**Acute Psychiatric Care in the Community**

Acute psychiatric hospital care is a vital service for individuals in need of intensive psychiatric intervention. This section has information about the utilization of the community psychiatric acute care system.

Figure 2(a) shows state hospital capacity and psychiatric acute care capacity as of December 31, 2014.

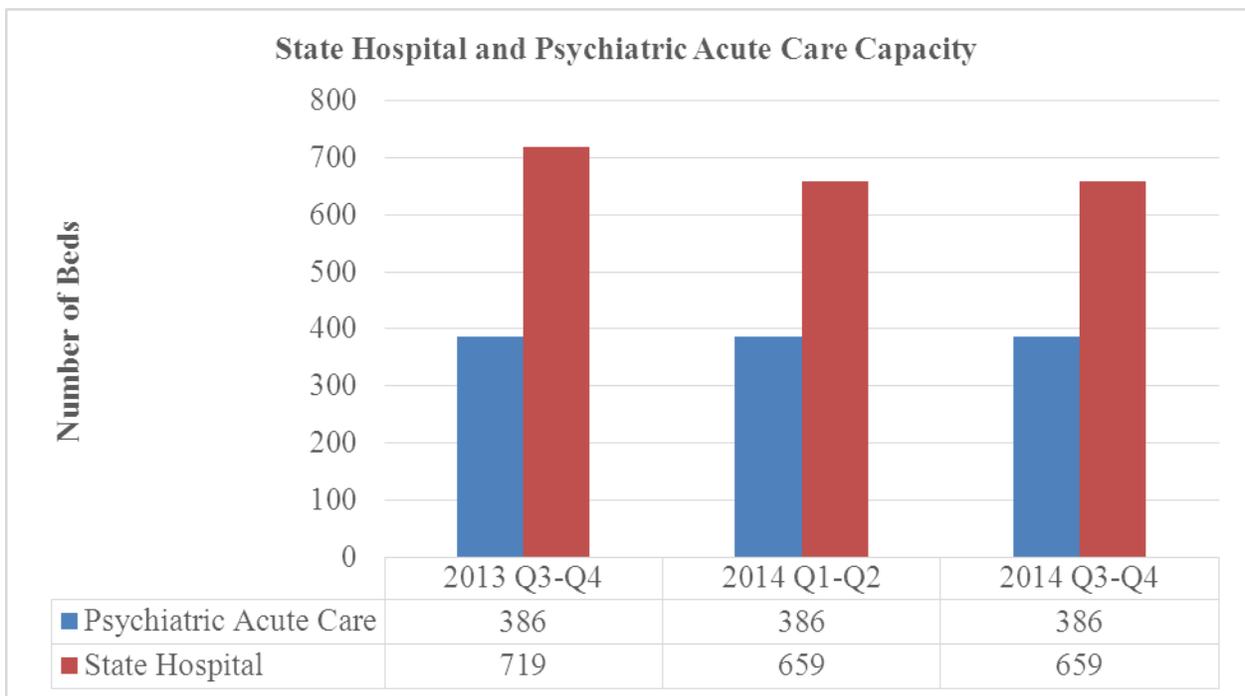


Figure 2(a)

Oregon State Hospital in Portland closed in March 2015, in coordination with the opening of the Junction City location. The state hospital capacity remains at 659, while the statewide acute care capacity remains at 386.

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Figure 2(b) shows the average and median length of stay for adults with a diagnosis of SPMI in community psychiatric acute care hospitals.

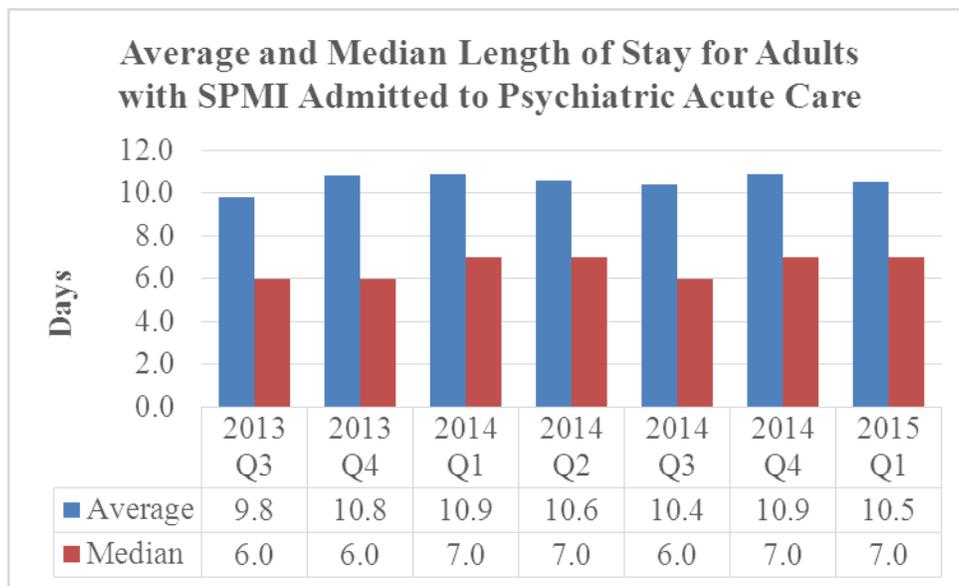


Figure 2(b)

The average and median lengths of stay has remained stable. This metric will continue to be monitored.

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Figure 2(c) shows the total number of acute care admissions for individuals with Medicaid, combined with a non-Medicaid group consisting primarily of people with no insurance whose care was supported by a state indigent fund. These numbers do not include voluntary commercial insurance patients.

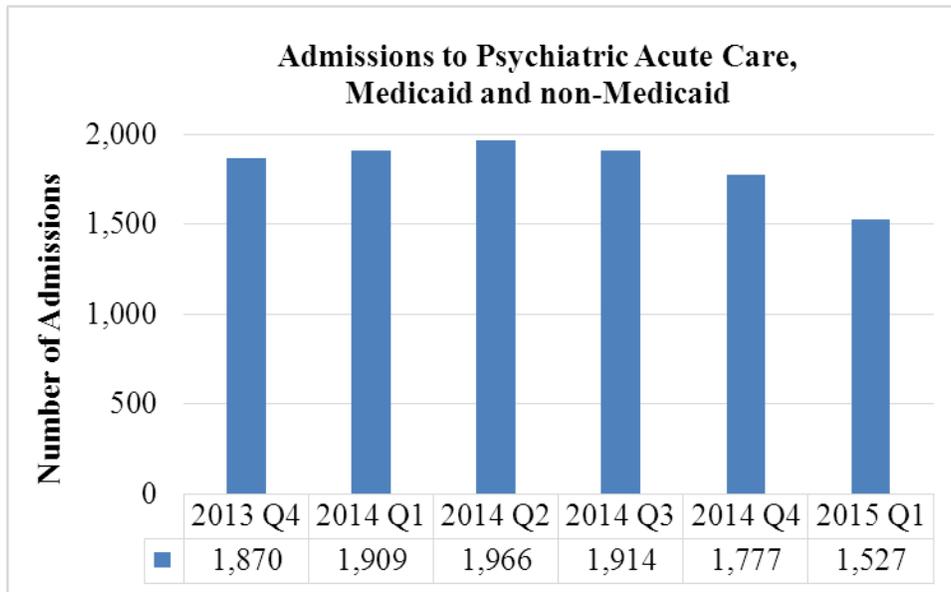


Figure 2(c)

Admission to acute psychiatric hospitals decreased again in the first quarter of 2015. The trend over the last six quarters is downward. The first quarter of 2015 is also the third quarter in a row in which admissions to acute care hospitals for this population decreased when compared to the previous quarter. This metric will continue to be monitored.

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Figure 2(d) shows the percentage of readmission for adults with SPMI to psychiatric acute care hospitals within 30 and 180 days from discharge.

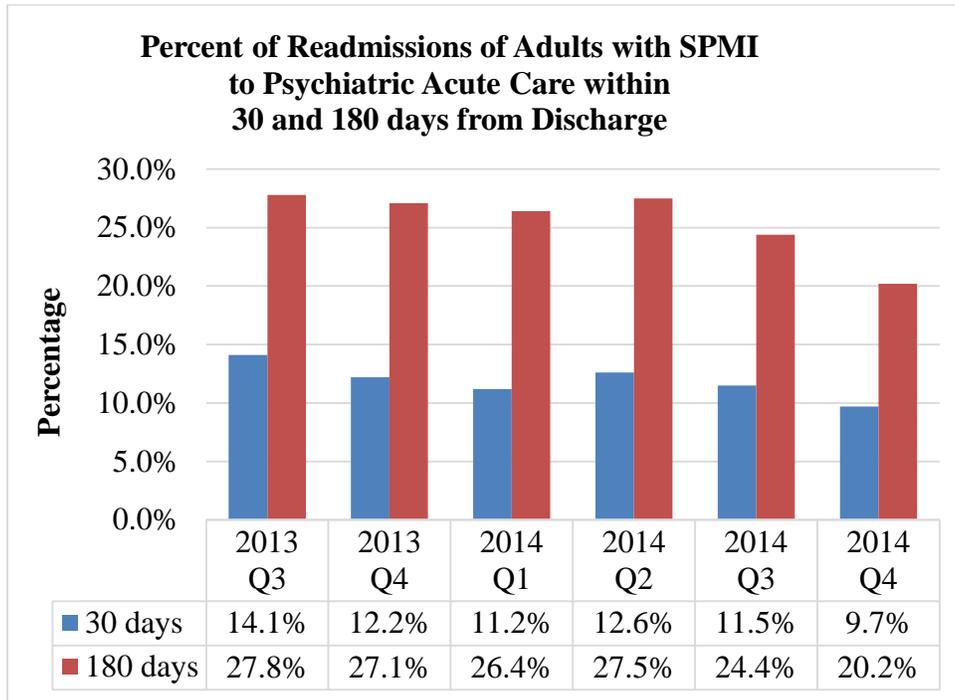


Figure 2(d)

Readmission rates for the fourth quarter of 2014 show a decrease in readmission rates at both 30 and 180 days.

Discussion

Readmissions to acute psychiatric care decreased for the second straight reporting period. Over the last six quarters, this metric has trended downward.

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Figure 2(e) shows the percentage of adults with SPMI who have a follow-up visit with an outpatient provider following 7 and 30 days of discharge from an acute psychiatric care hospital.

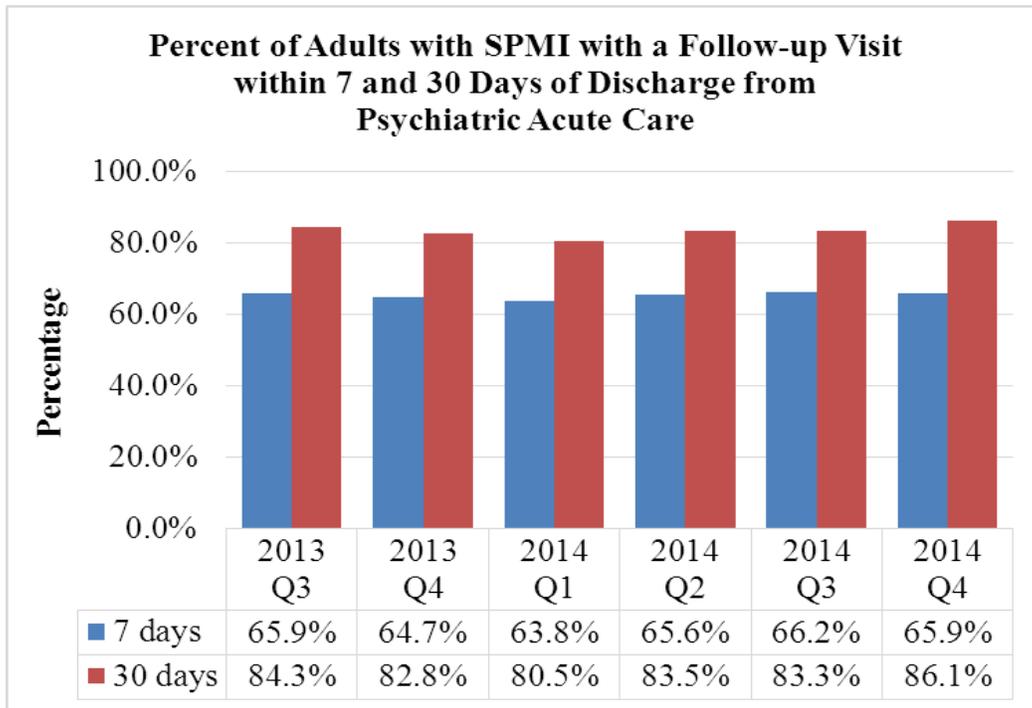


Figure 2(e)

Discussion

The data continues to fluctuate slightly, without a trend emerging. For the most recent reporting period, follow up rates increased slightly for 30 days from discharge. National benchmarks are found in the National Committee for Quality Assurance 2014 Accreditation Benchmarks and Thresholds Mid-Year Update Report, which provides the following thresholds for follow up within 7 days:

- 90<sup>th</sup> percentile - 70%
- 75<sup>th</sup> percentile - 58%
- 50<sup>th</sup> percentile - 46%
- 25<sup>th</sup> percentile - 33%

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At 65.9%, Oregon’s 7-day performance in Q4 of 2014 is closer to the 90th percentile threshold (70%) than to the 75th percentile threshold (58%).

The current data is based on the data collection parameters used in collecting CCO metrics. The current methodology does not count same day billings or encounters. OHA will begin including same day billings and encounters in June 2015.

Figure 2(f) shows the number of emergency department visits made by adults with mental illness who are enrolled in Medicaid.

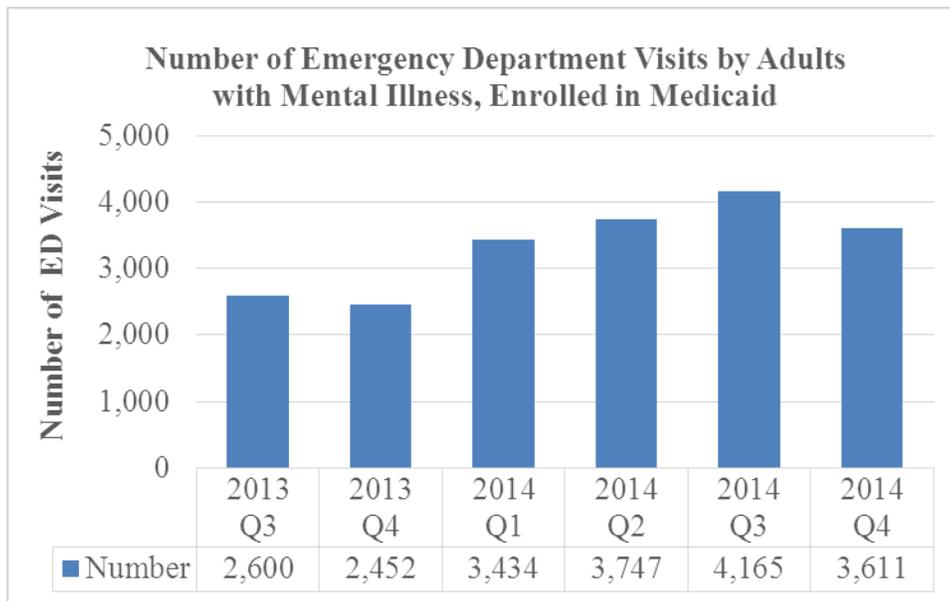


Figure 2(f)

Discussion

Emergency Department visits by Medicaid enrolled adults with mental illness decreased approximately 12% during this most recent reporting period. OHA will continue to monitor this metric to determine if additional community services made possible by recent investments are contributing to a decreased utilization of hospital Emergency Departments.

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Figure 2(g) converts the data from Figure 2(f) to a rate of visits per 1,000 member months to enable a comparison of emergency room use across four quarters. Visits per 1,000 member months is a common rate used to account for the variability in Medicaid enrollment over a period of time.

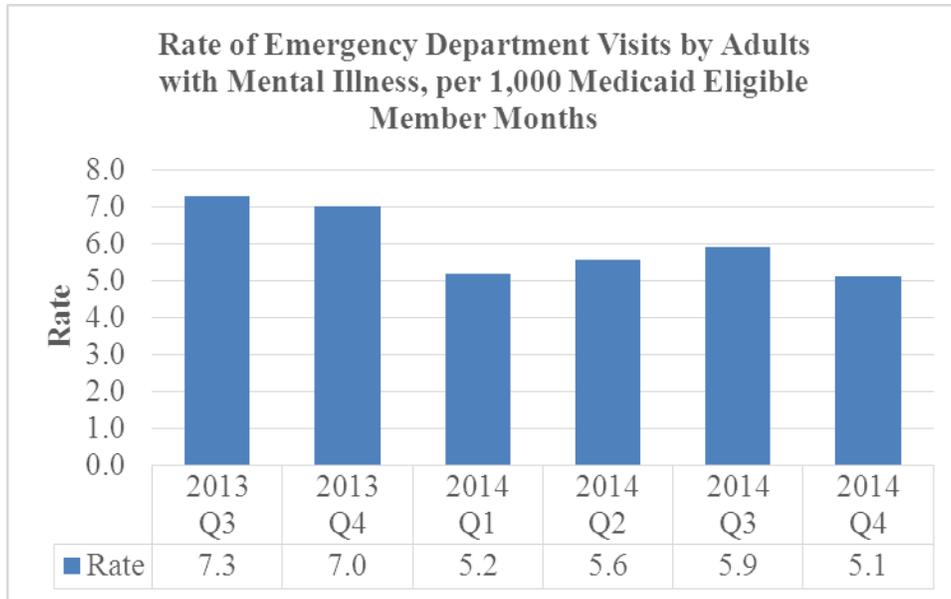


Figure 2(g)

Figure 2(g) shows a slight decrease in Emergency Department (ED) visits, to the lowest rates since Q1 2014. OHA will continue to monitor utilization of the ED.

### **Crisis Services**

A robust crisis system is key to supporting individuals with mental illness in the community and reducing institution-based care. The data collected regarding crisis services is vital to monitoring the capacity and utilization of community based services.

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Figure 3(a) shows the number of beds in the community for individuals experiencing a mental health crisis. There are three types of crisis beds being monitored. ‘Community crisis beds’ are located in apartments, private residences or unlicensed facilities that provide temporary housing. ‘Crisis stabilization beds’ are located in licensed, non-secure crisis respite facilities. ‘Sub-acute beds’ are located in licensed, secure crisis respite facilities.

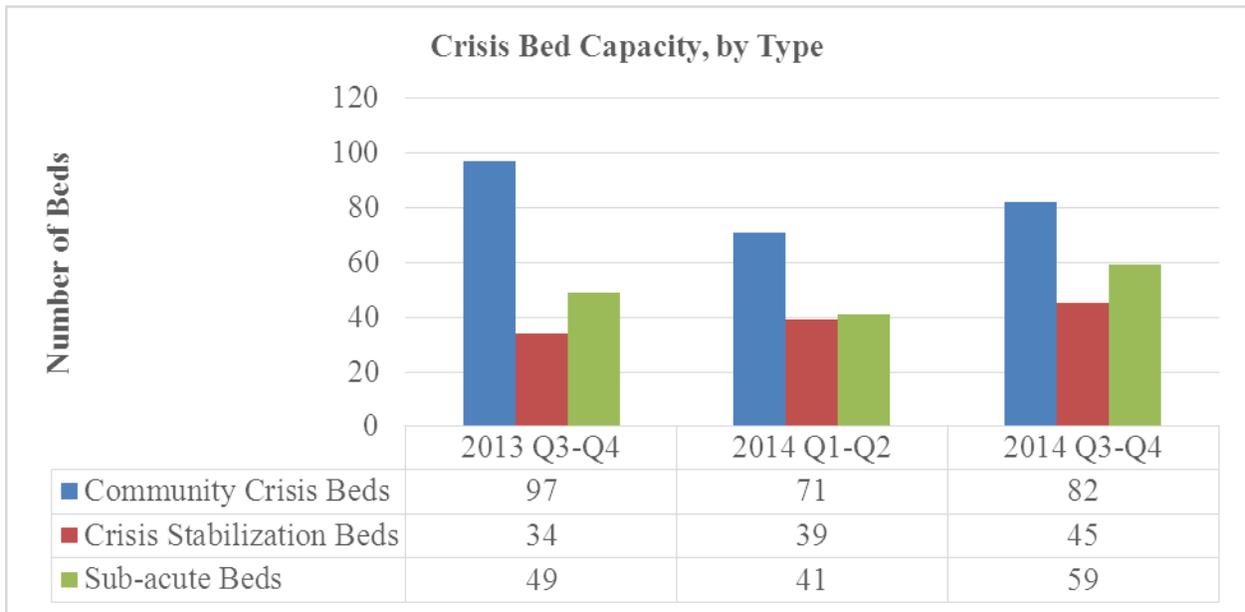


Figure 3(a)

Compared to the first half of 2014, the numbers of all types of crisis beds rose slightly for the reporting period, the second half of 2014. This was caused by the influx of new investment dollars into the crisis system. The total numbers for the three types of crisis beds also rose in the three periods, from 180 in the first period to 186 in the third period. OHA will continue to monitor this metric.

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Figure 3(b) shows the count of individuals who used crisis beds over five quarters.

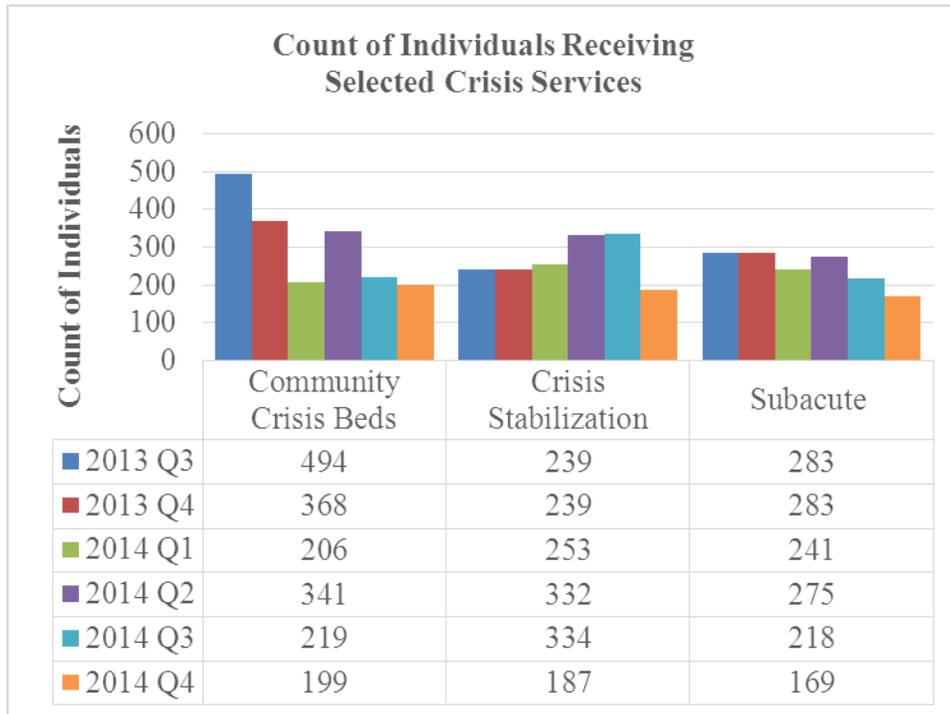


Figure 3(b)

Community crisis bed utilization has fluctuated over all reporting periods. In the most recent reporting period (Q4 2014), all crisis bed utilization dropped slightly. Community Crisis Bed utilization counts are not always tied to specific housing for crisis. This could be the use of a motel room with crisis supports or a private home contracted for crisis housing. This has led to some variability over time in how the communities are reporting this data.

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Figure 3(c) shows the count of individuals receiving mobile and walk-in crisis services.

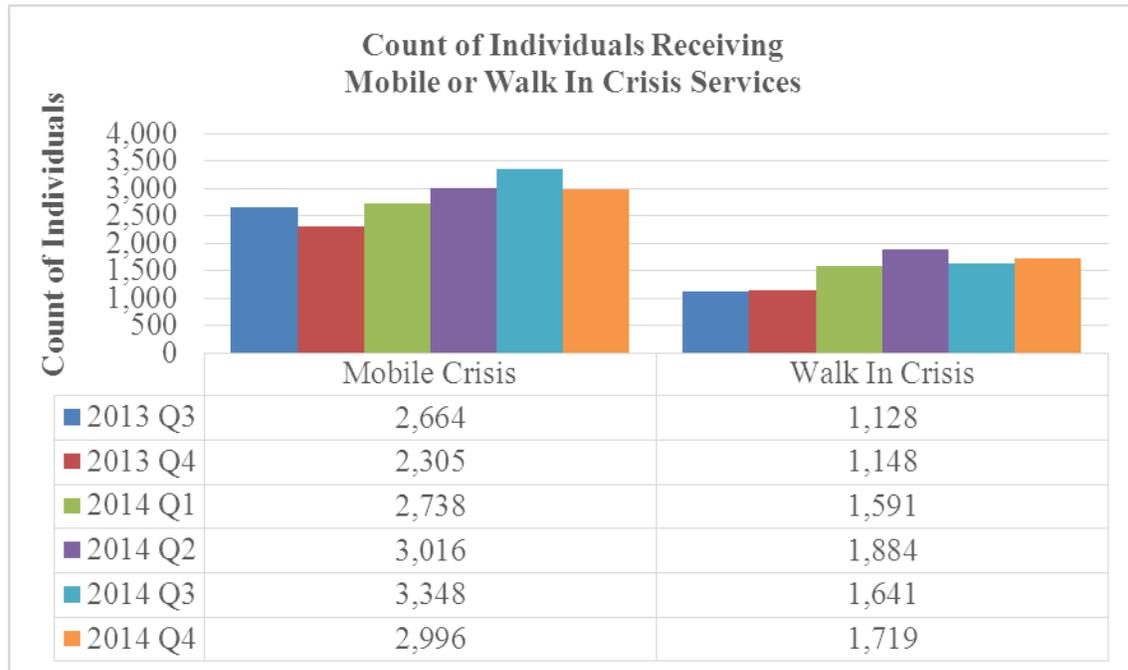


Figure 3(c)

As a result of the expansion and creation of new mobile crisis programs in the second quarter of 2014, the number of crisis encounters increased by 10%. The last quarter of 2014 saw stabilization and a decrease in the number of crisis encounters for individuals with SPMI over the previous quarter. Crisis programs have attributed this decrease to natural fluctuation in crisis events and increased community outreach to individuals with a serious mental illness.

Walk-in crisis service utilization rose for Q4 2014 approximately 4% over the previous quarter. Walk in crisis services remain higher than at baseline due to increased resources and improved access to services.

Discussion

New funding was awarded in the 2013-15 biennium to twelve counties to create or expand crisis services.

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Figure 3(d) shows the number of crisis calls to the crisis line services provided or subcontracted by CMHPs.

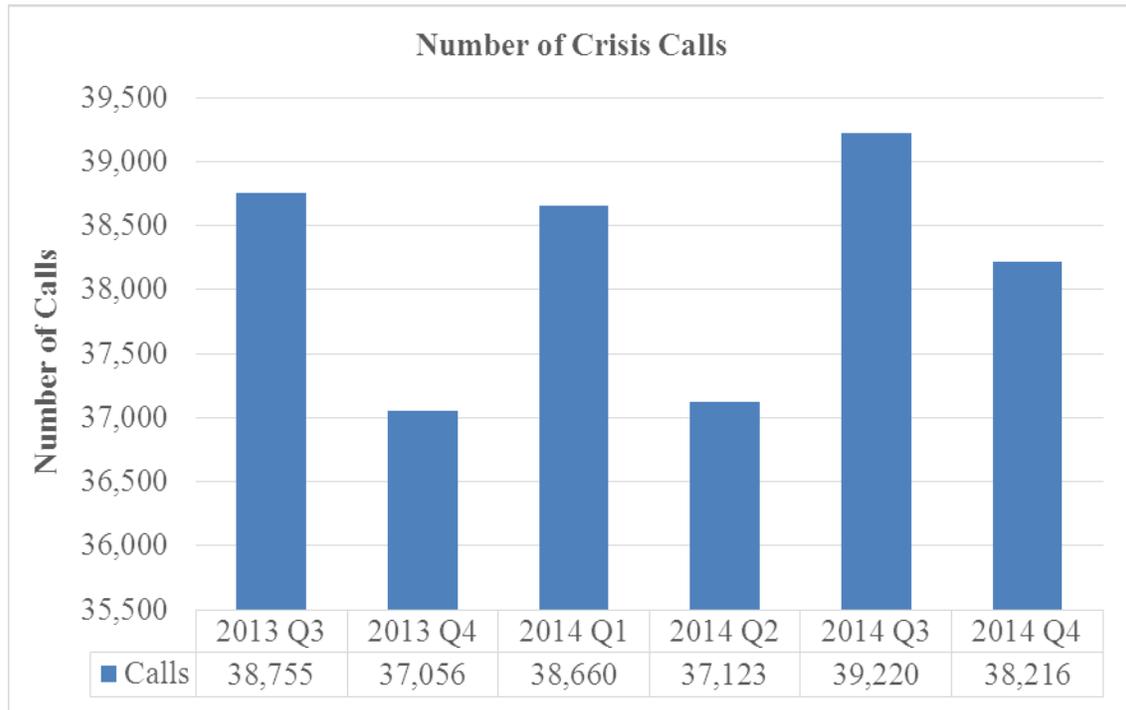


Figure 3(d)

While calls to crisis lines fell slightly during the recent reporting period (4Q 2014), the utilization over several quarters remains relatively stable.

Discussion

While the overall numbers remain relatively stable, there was some significant variation in the reporting period data when compared to the prior period by individual counties. This was most likely caused by several individual counties refining their definition of a “crisis call.” (In some counties, crisis calls came into a main number for a clinic, and some counties had been including calls in their crisis numbers which were actually just to access service.)

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**Evidence Based Community Practices**

*Assertive Community Treatment*

Assertive Community Treatment (ACT) and Supported Employment are evidence-based practices that help enable many individuals with SPMI to live in integrated settings in the community.

Figure 4(a) indicates the number of individuals with SPMI receiving ACT services.

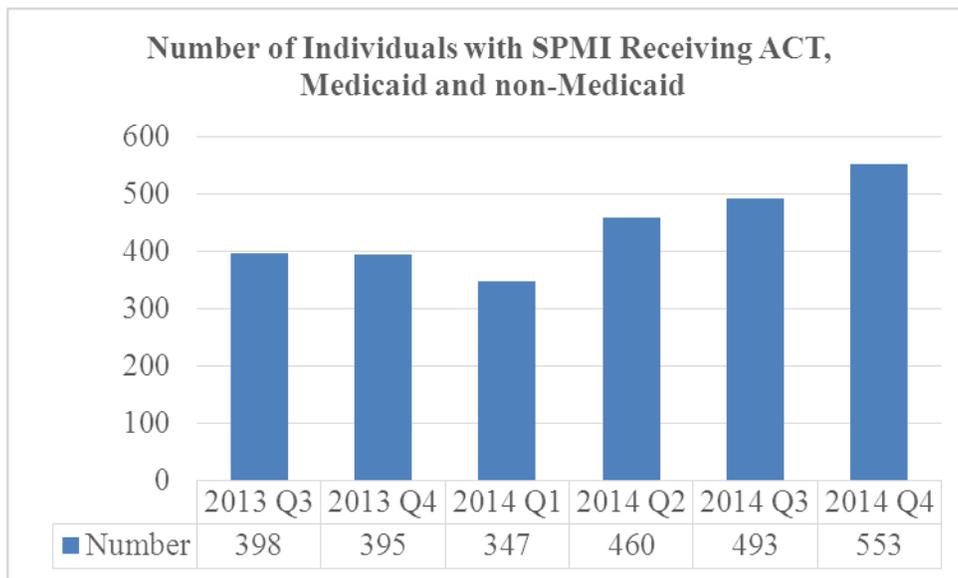


Figure 4(a)

ACT continues to see modest but steady growth. The pace of growth is due to, in part, enforced minimum fidelity requirements. Some ACT teams, while maintaining caseloads, restructured and received technical assistance from the Oregon Center of Excellence for Assertive Community Treatment (OCEACT) to improve their adherence to fidelity and did not bill Medicaid for ACT services during this time. The sixth quarter saw an increase in ACT participation as more ACT teams were developed and reached minimum fidelity standards.

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Discussion

In the 2013-15 and 2015-17 biennia, the Oregon Legislature made considerable investment in the community mental health system, and this was used to expand the availability of ACT across the state. This funding was designed to create new ACT teams and expand capacity of existing teams. An important aspect of this expansion is that fidelity to the ACT model be assured. In Oregon a provider must be approved by the state before it can bill Medicaid for ACT services. A new ACT provider may be provisionally approved while it builds its program. However, the provider must attain fidelity within one year. Oregon funds the Oregon Center for Excellence for Assertive Community Treatment (OCEACT), which provides technical assistance and conducts the fidelity reviews. This assistance and the review process will ensure that ACT services are provided at a high level of fidelity.

Large parts of Oregon are rural and frontier areas. Providing fidelity ACT services in these areas is challenging. The state is working with OCEACT and Dartmouth University on how to apply the fidelity scales to rural programs. OHA expects to see moderate increases in the numbers served, as the capacity to serve ACT clients expands across the state.

To increase ACT participation across the state, OHA is coordinating with OCEACT, the OHA Adult Mental Health Initiative, and the Oregon State Hospital to streamline the referral process for the program. The goal is to screen clients as they transition to different levels of care to see if ACT can best serve their needs. Additionally, OHA is working with the CCOs to familiarize them with the benefits of ACT; highlighting improved outcomes and lower costs.

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*Supported Employment*

Figure 4(b) indicates the number of individuals with SPMI receiving supported employment services.

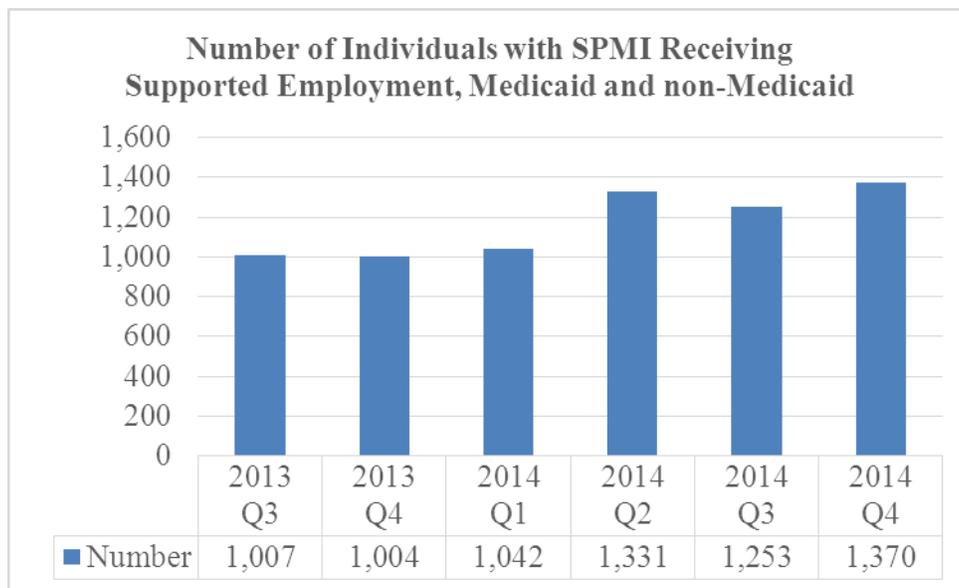


Figure 4(b)

Oregon recognizes the value of supported employment services to enable individuals with a SPMI to fully participate in the community. Since 2008, Oregon has contracted with the Oregon Supported Employment Center for Excellence (OSECE) to provide technical assistance and to conduct fidelity reviews. OSECE uses the Dartmouth fidelity tool when conducting reviews. In July of 2013, providers were required to achieve fidelity to qualify for billing Medicaid for those services.

Over the six reported quarters, the trend is to increase the number of individuals who have received Supported Employment services, from 1007 in Q3 2013 to 1370 in Q4 2014. The most significant increases over time can be attributed to the 2013 state general fund investment in adult mental health programs, which

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expanded the program statewide. The greatest increase in individuals who received Supported Employment services was seen in the second quarter of 2014 (28% from the previous quarter), as most programs that received mental health investments became provisionally qualified during that time. There was a 9% increase in the fourth quarter of 2014 over the previous quarter. While some programs have had success in hiring employment specialists, some programs continue to have difficulty hiring staff. It is anticipated that, as programs become fully staffed, there will be a steady, but moderate increases in individuals who receive services in future quarters.

*Peer Support Services*

Figure 4(c) indicates the number of individuals with SPMI receiving Peer Support Services.

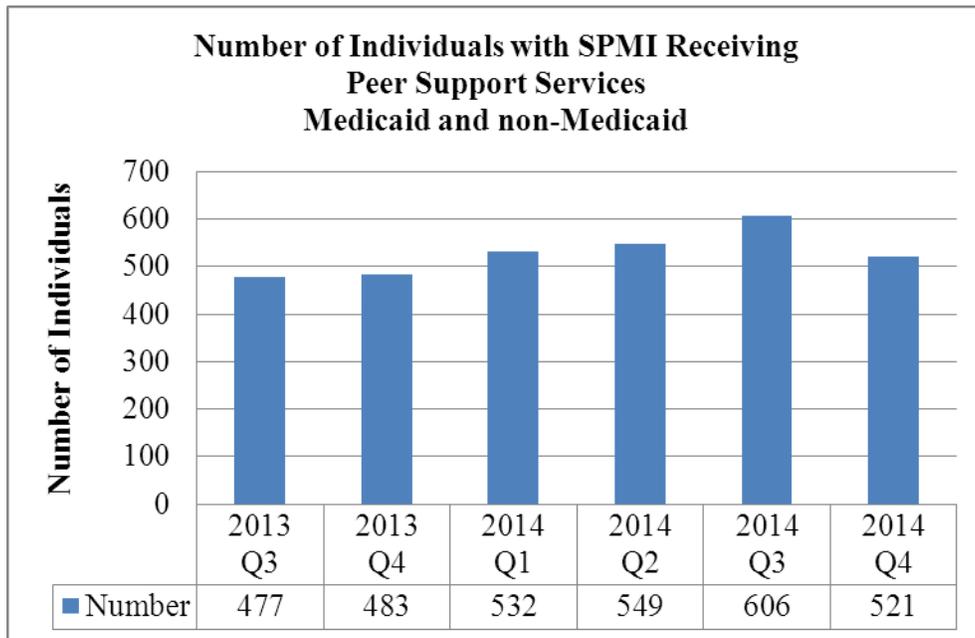


Figure 4(c)

Over the first five quarters, peer support services increased by 24%, from 477 to 606. There was a decrease of about 14%, from 606 to 521, in the sixth quarter. The overall trend is still a positive one.

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Discussion

Peers provide services and supports that enable individuals to embrace recovery and live in the most integrated setting. Peer Support Specialists are used to provide a wide variety of services including sub-acute services, supported housing, ACT, a warm-line and many other services and supports.

Oregon's Health System Transformation embraces the services of traditional healthcare workers, which include behavioral health peers and family members. OHA has implemented a registry for traditional healthcare workers, which will include Peer Support Specialists. Many Peer Support services are imbedded in other services or are provided in a setting that does not bill for services and will not be captured by the Peer Support code, which complicates efforts to count those services. The data represented in this report includes Peer Support Services that are billed to Medicaid. This data is being provided as a proxy.

*Early Assessment and Support Alliance (EASA)*

EASA is an early intervention program for adolescents and young adults experiencing symptoms of psychosis. EASA provides hope and support for young adults and their families and facilitates recovery and continued full engagement with school, work, and all the social tasks of adolescence and youth adulthood.

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Figure 4(d) displays the number of young adults who received EASA services over three six-month periods.

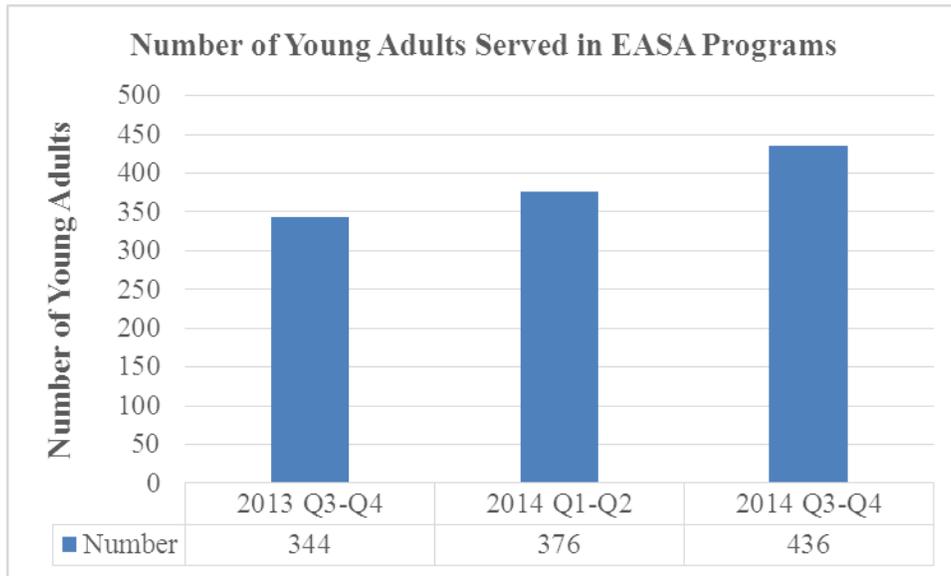


Figure 4(d)

There has been a steady increase in EASA services.

#### Discussion

The Legislative Community Mental Health Investments in the 2013-15 and 2015-17 biennia are expanding the availability of EASA statewide. It is anticipated that the number of young people served will continue to increase.

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**Supported and Supportive Housing**

Figure 4(e) shows capacity data for Supported and Supportive housing.

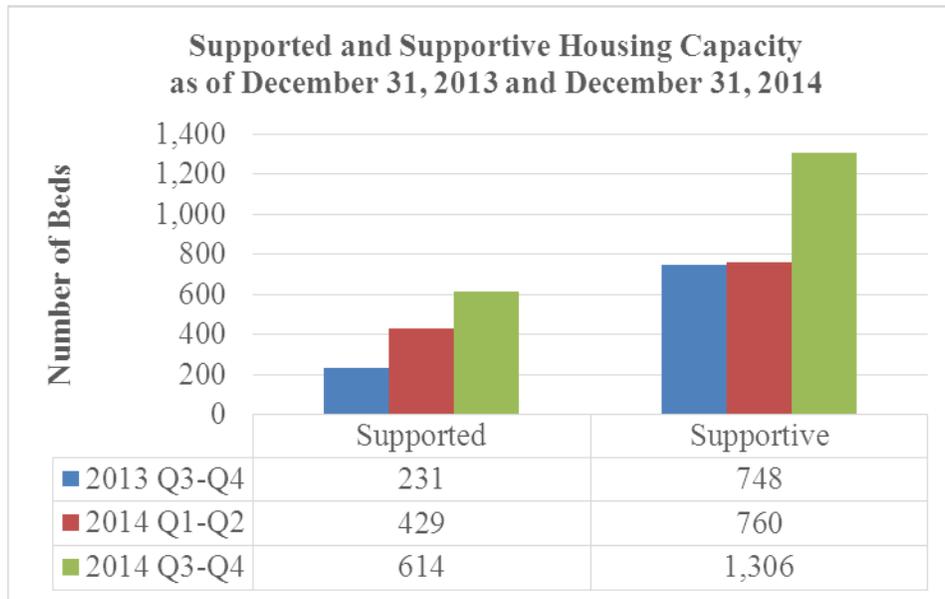


Figure 4(e)

The U.S. Department of Housing and Urban Development has awarded Oregon Housing and Community Services (OHCS) funding to provide rental assistance for individuals with a disability. OHA will use a portion of those funds to subsidize 40 units of existing affordable housing for individuals with a mental illness. OHCS will partner with OHA to identify housing units for the program from their portfolio of properties OHCS has financed.

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Figure 4(f) shows occupancy data for Supported and Supportive housing. The occupancy numbers represent the number of adults with SPMI in housing on the last day of the reporting period.

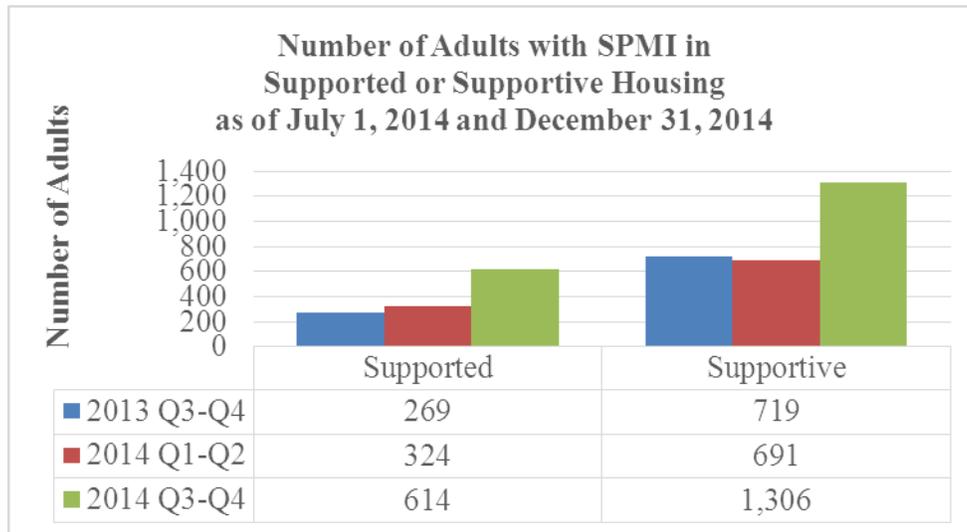


Figure 4(f)

The number of individuals served in Supported Housing units increased significantly during the first half of the year and nearly doubled by the second half of the year.

Two things are the most likely causes of these increases:

- 1) Increase in Supported Housing capacity being developed, and
- 2) Increase in accuracy of data.

OHA is now able to provide the Supported and Supportive Housing capacity and individuals served using internal data, rather than relying on a survey. The “Affordable” Housing Inventory is complete. Oregon is leveraging that report by using it as a foundation to add other types of Supported and Supportive Housing. OHA will be receiving quarterly reports for all Rental Assistance projects and will be incorporating that data as well.

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Figure 4(h) shows the percentage of civilly committed adults at OSH who were discharged to various living environments during the last half of 2014. The previous report stated that 2% of the discharges were to homelessness. After a review of the clinical record for these individuals, OHA determined that there were errors in how these discharges were coded. No one was discharged to homelessness.

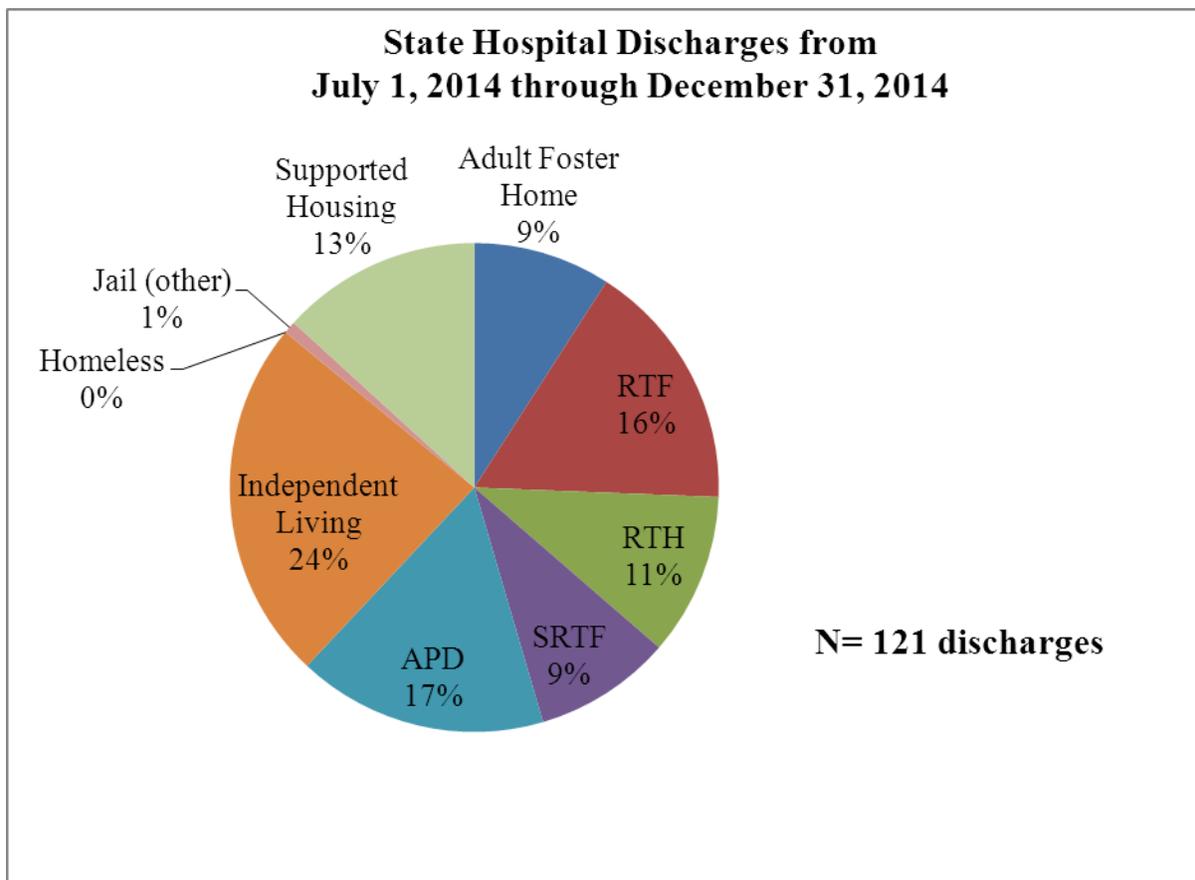


Figure 4(h)

During the second half of 2014, discharges to independent living decreased slightly, but discharges to more integrated levels of care, such as supported/supportive housing increased. Discharges to Secure Residential Treatment Facilities (SRTFs) fell by 6% over the period.

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Data collection methods have changed from previous reporting for this category. Rather than utilizing community self-report, data is now collected from OSH patient records resulting in increased validity and reliability.

The most significant changes between the first and last half of 2014 were the:

- Increase from 3% to 13% in discharges to supported housing;
- Decrease from 15% to 9% in discharges to SRTFs; and
- Increase from 4% to 9% in discharges to Adult Foster Homes.

#### Discussion

In collaboration with patients and community partners, OSH Interdisciplinary Teams are shifting away from consideration of residential treatment programs at discharge to increased independence with wrap-around services. All patients are provided discharge housing options and follow-up services requested or recommended.

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Figure 4(i) shows a more global picture of the living setting for individuals with SPMI who received Medicaid mental health services through December 31, 2014.

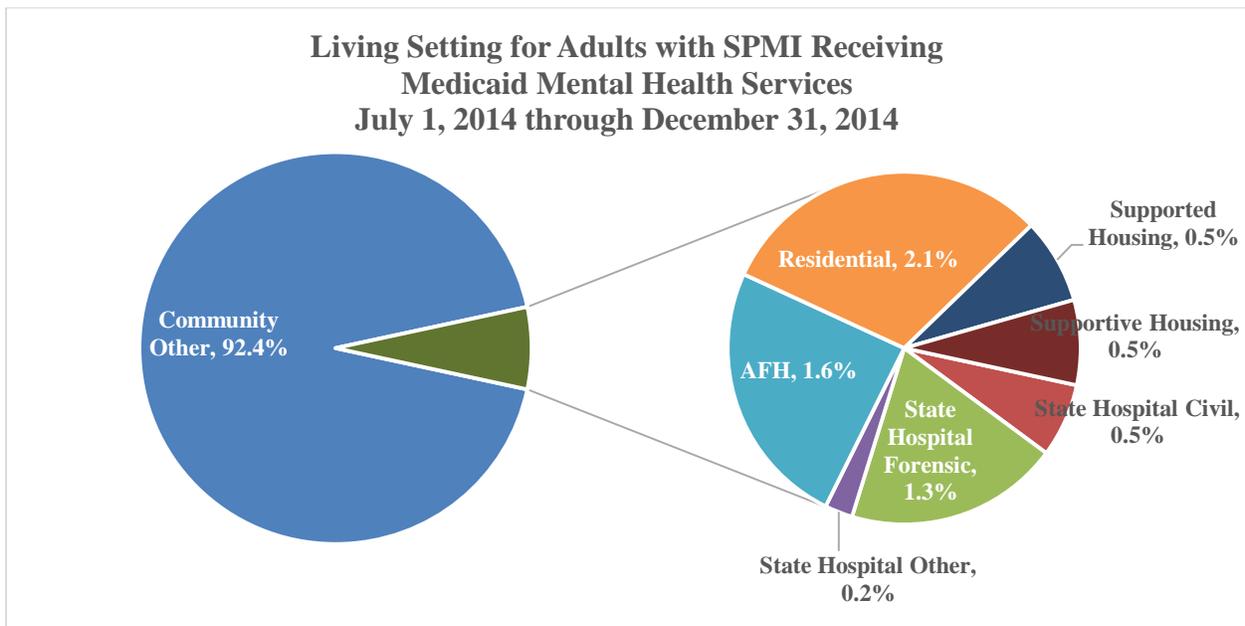


Figure 4(i)

The vast majority of people are living in the “Community Other” category. The number of individuals in this category was derived by subtracting the total number of individuals residing in the other identified settings from the total number of individuals served. The Community Other category does not include individuals who are homeless.

### Discussion

The capacity for supported housing will increase as the supported housing projects funded by the new investments from the legislature are implemented. The Supported Housing Rental Assistance Programs awarded \$8.3 million to 15 organizations in 32 counties to help over 500 people secure and stay in community

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housing. A total of \$5 million was allocated to a joint project with OHA, NAMI Oregon and the Oregon Residential Providers Association to develop housing options for individuals with SPMI. A total of \$3.9 million was awarded to 10 supported housing projects in September and October 2014. Subject to the actual terms of the relevant award documents, no more than 20% of the units in a building or complex of buildings may be reserved for tenants with serious mental illness referred by the state or its contractors, with reasonable best efforts to facilitate the use of those units by individuals with serious mental illness. The remaining housing is available to all individuals in conformance with Fair Housing and other laws.

**Case Management**

Figure 5(a) reports the number of individuals with SPMI who received case management, and psycho-educational and living skills training.

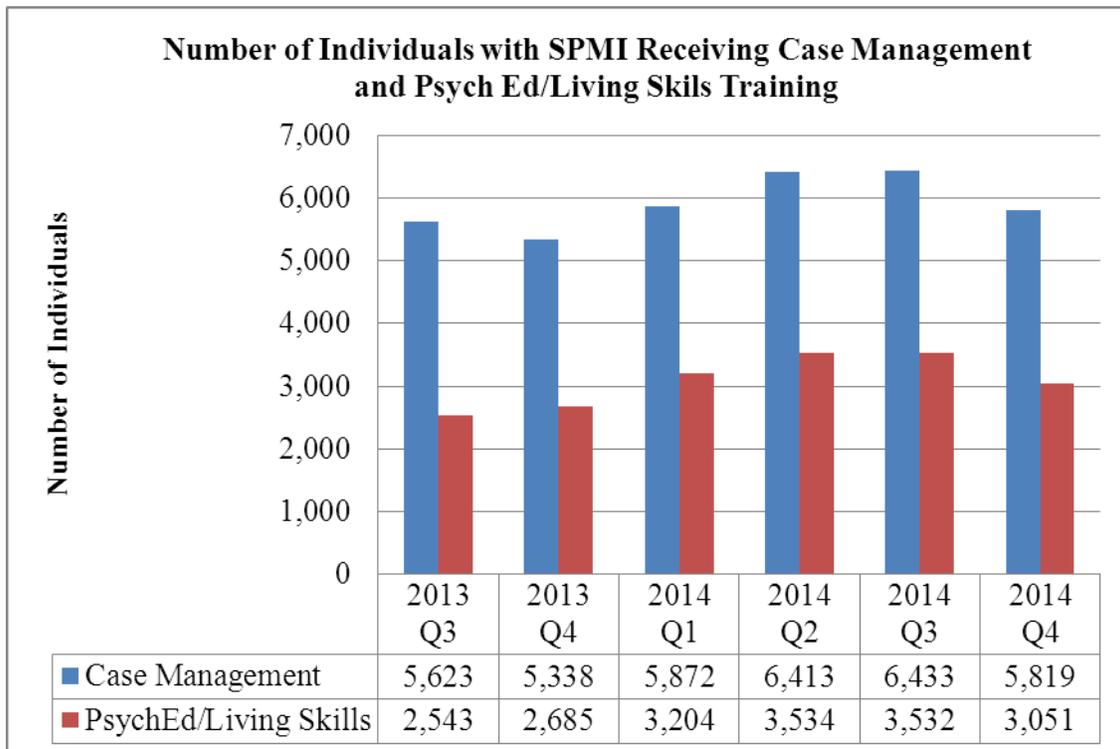


Figure 5(a)

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For the most recent reporting period the number of individuals served decreased slightly from the prior quarter. OHA will continue to monitor this metric to assess if a trend is developing.

**Community Mental Health Service Rates**

Figure 6(a) shows the count of selected community mental health services per 1,000 general adult population.

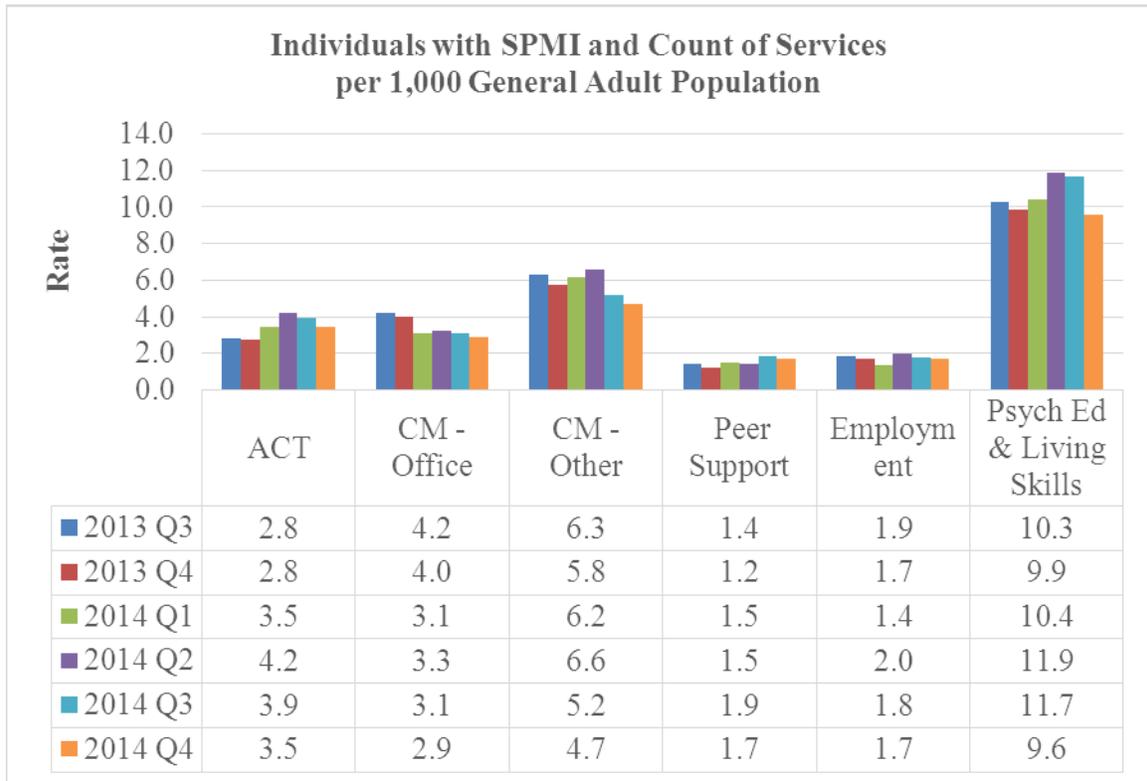


Figure 6(a)

**Discussion**

As stated for figure 5(a), there was a slight decrease in individuals served. OHA will continue to monitor for any developing trend.

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Figure 6(b) shows the number of assessments and routine service within 14 days after initial assessment for adults with SPMI.

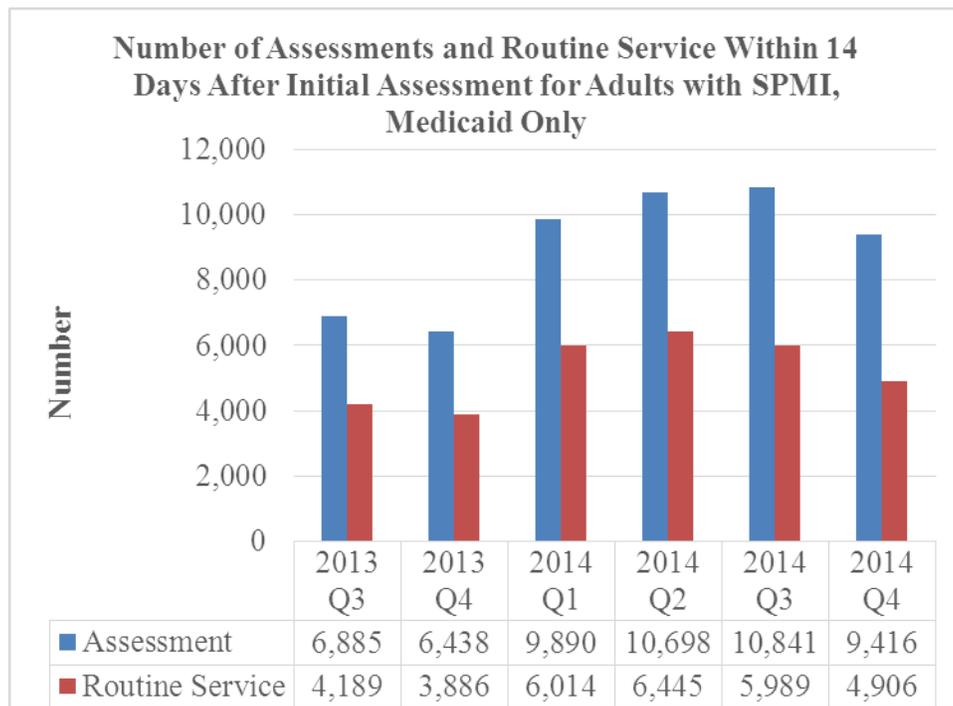


Figure 6(b)

The number of assessments and routine services continued to decline slightly for the Q4 2014 reporting period, as compared to the previous quarter. This is most likely due, in part to the dramatic expansion of the number of persons receiving Medicaid-funded services, and the resulting pressure on behavioral health service capacity.

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Figure 6(c) looks at the percentage of routine service rendered within 14 days after initial assessment.

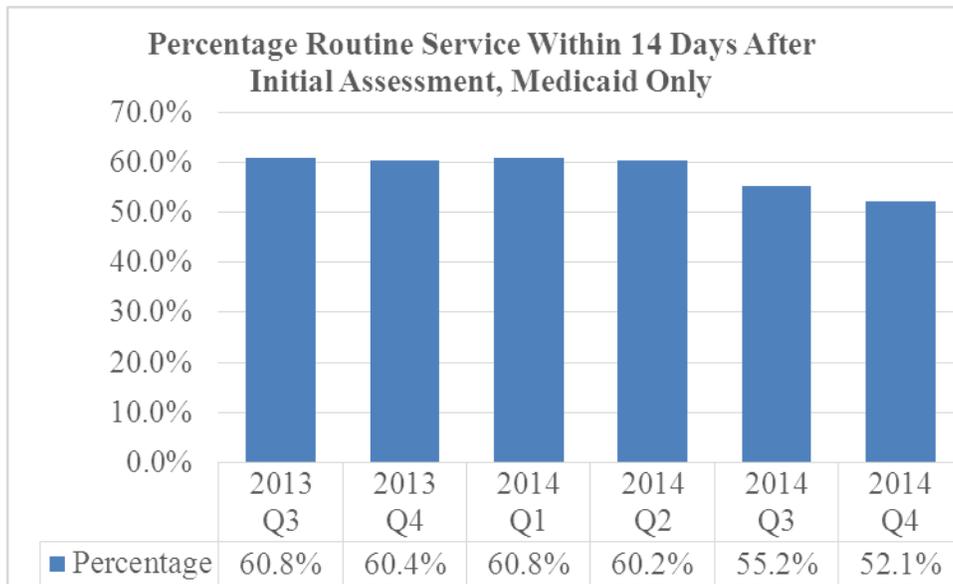


Figure 6(c)

The percentage of individuals with SPMI receiving routine services has decreased the last two reporting periods, dropping 8.1% since 2014 Q2.

#### Discussion

The percentage of individuals receiving routine services continues to decline slightly, most likely due to the need to the increased number of individuals served as a result of the Medicaid expansion.

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**Access to Mental Health Services for All Races**

It is important to examine the access to mental health services for adults with SPMI for all races.

Figure 7(a) presents data regarding the percentage of adults with SPMI accessing mental health services by race for individuals enrolled in Medicaid.

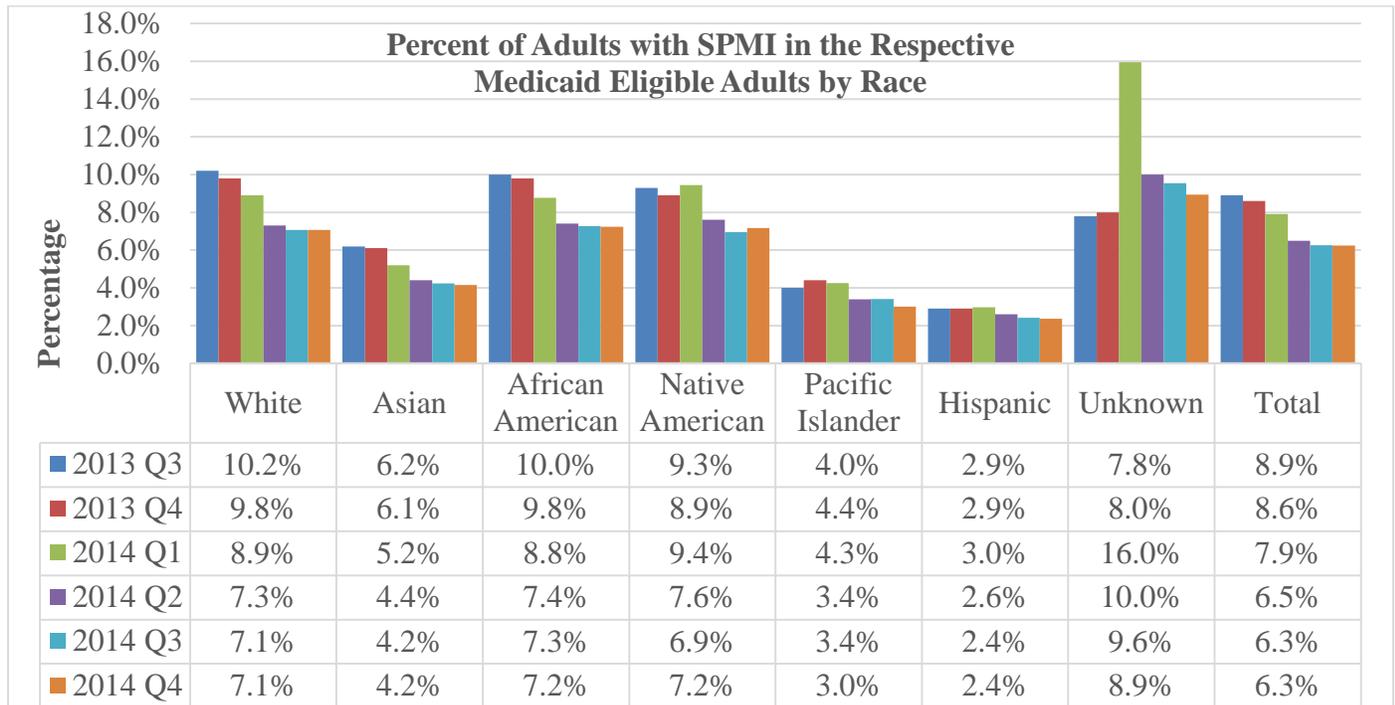


Figure 7(a)

There appears to be a decrease across most race groups. It is difficult to determine the significance of this data, since the decrease appears to be most present in the

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first two quarters of 2014, at the time of the influx of new Medicaid enrollees. The percentages in the last two quarters of 2014 are lower than those in the first half of that year. The Hispanic category continues to have the lowest percentage. OHA will monitor this metric.

Discussion

OHA is continuing to work to ensure true health equity among various groups. Strategic Plan initiatives, as well as the work of the Committee on Health Equity and Planning will be utilized to achieve this goal.

**Access to Primary Care**

OHA is continuing efforts to ensure integration of physical, behavioral and oral healthcare for individuals with SPMI statewide.

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Figure 8(a) shows the percent of adults with SPMI who had a visit with a Primary Care Physician (PCP) during the previous 12 months.

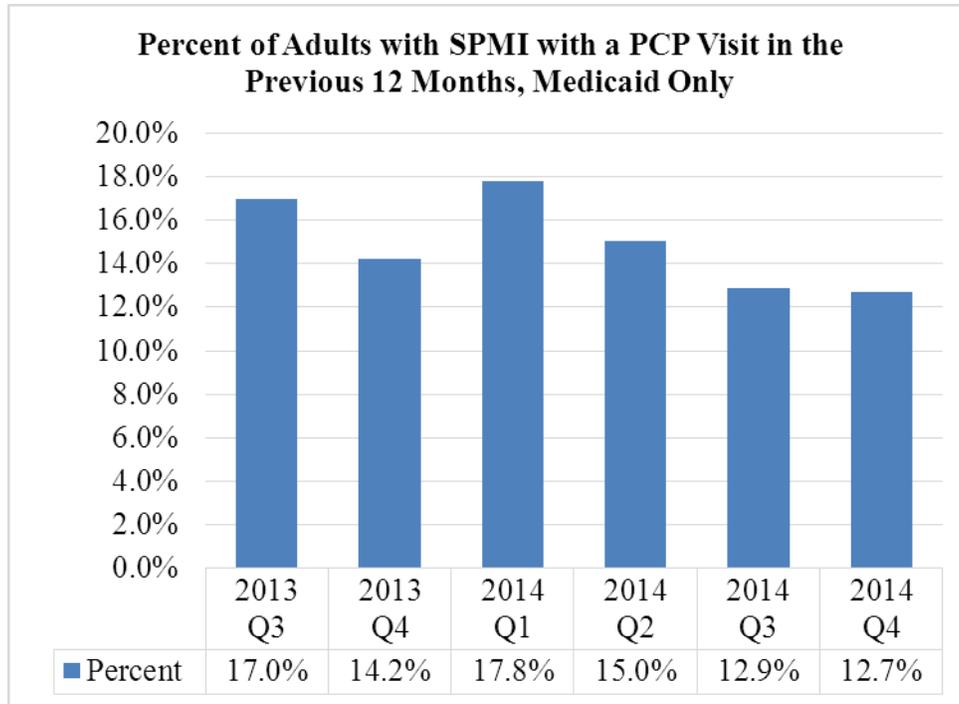


Figure 8(a)

Data for 2014 Q4 remains consistent with previous quarters, with a slight decline of two tenths of one percent over the previous quarter. It is expected that this decline will moderate somewhat after the initial surge in numbers that resulted from the Medicaid expansion.

### Discussion

Work continues to develop Behavioral Health Homes to improve integrated health care for individuals experiencing SPMI.

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**Cost of Medicaid Services**

Figure 9(a) presents the Medicaid expenditures for mental health services for adults with SPMI.

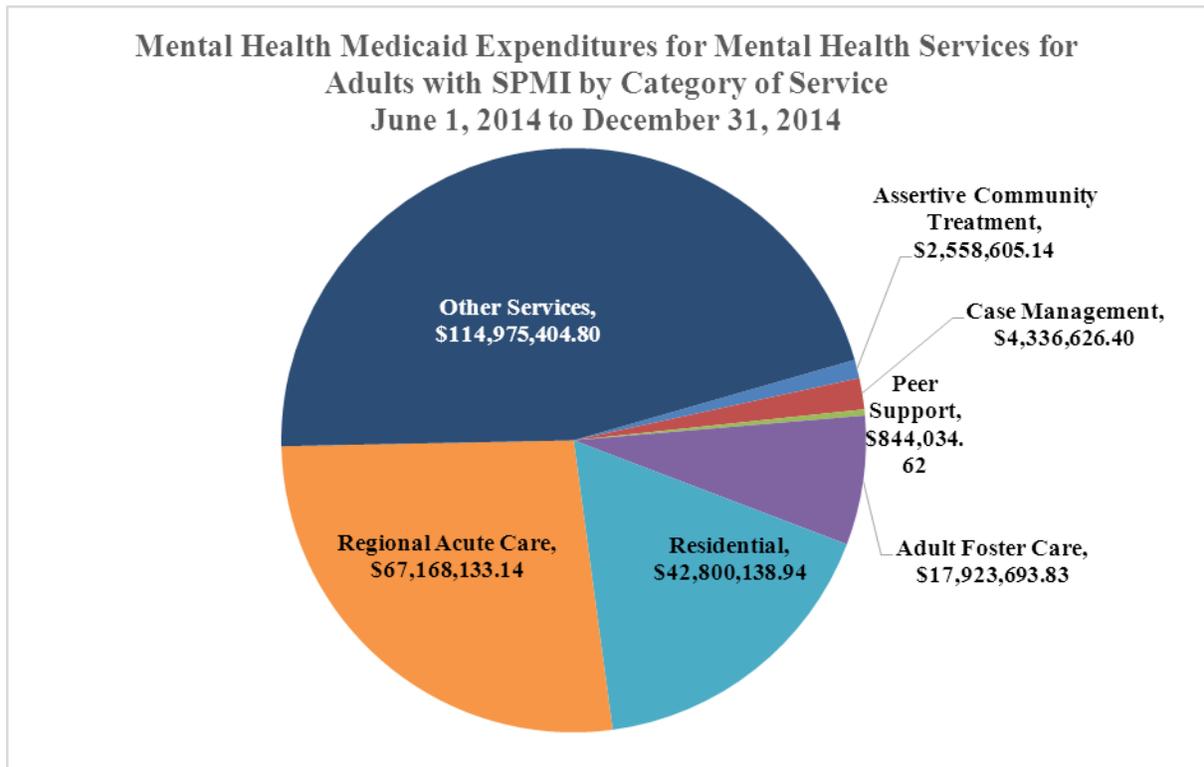


Figure 9(a)

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Figure 9(b) shows the percentages of total mental health Medicaid expenditures for mental health services for adults with SPMI by service category.

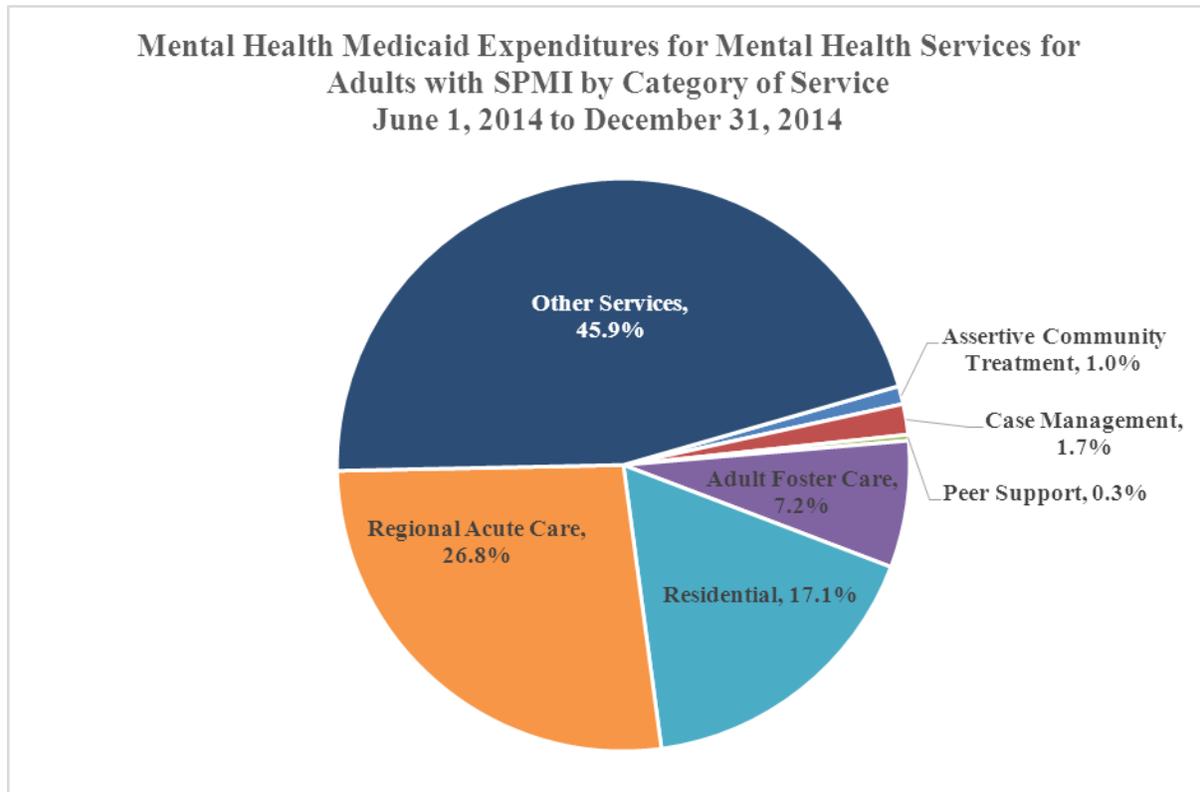


Figure 9(b)

Acute psychiatric care is 26.8% of the expenditures, and residential and adult foster care together is 24.3%.

### Discussion

OHA will monitor these expenditures looking for shifts to community services expenditures. Our goal in Oregon is to invest more in community services and reduce admission and length of stay in acute care and residential settings.

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This is the fourth report based on the revised data matrix. The narrative summarized key data elements with some analysis and discussion. These data provide a baseline to evaluate the impact of initiatives to improve processes and improve access to important community services and supports. The following opportunities identified in the first report are unchanged:

- Reduce the length of stay at OSH for adults civilly committed.
- Improve follow-up after psychiatric acute care.
- Reduce readmission rates to psychiatric acute care.
- Expand access to community crisis services.
- Expand the availability of Supported Housing.
- Expand ACT and Supported Employment throughout the state.
- Improve access to primary care for individuals with SPMI.
- Reduce behavioral health disparities.

The development of CCOs, expansion of Medicaid and the major Legislative investments support the improvements in services and supports for adults with SPMI. This report and subsequent reports will enable OHA to monitor the impact of these healthcare changes enabling adults with SPMI to be integrated in the community.