INDEPENDENT CONSULTANT REPORT #1

OREGON HEALTH AUTHORITY

ACTIVITIES TO IMPLEMENT

THE OREGON PERFORMANCE PLAN

Submitted by Pamela S. Hyde, J.D.
Hyde & Associates –
Policy and Practice Consulting, LLC

March 2017

Acknowledgements

Many Oregon Health Authority (OHA)[1] staff and Oregon behavioral health system stakeholders helped me over the last six months to understand Oregon's system and understand the status of various activities to implement the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP). They met with me, provided me with materials and information, and let me know their issues and questions about the OPP process and about my role as Independent Consultant. I cannot possibly name them all. However, I appreciate the openness with which they have accepted me and the kindness with which they have addressed my requests and answered my questions about Oregon and its services and system.

I want to especially thank Cissie Bollinger and Michael Morris of OHA's Behavioral Health Policy unit within the Division of Health Policy and Analytics. Cissie and Mike have worked tirelessly and closely with me to get me the information I requested, explain unique aspects of Oregon's health system and transformation efforts, and assure I had access to the OHA staff and data I need to understand and report the status of OHA's activities and their impact on services for individuals with serious and persistent mental illness, as well as all of Oregon's residents who are dependent on public resources for their care and, in many ways, their lives. I also want to acknowledge the commitment of Lynne Saxton, Director of OHA, to making this process successful. That commitment is evident in her presence at key meetings and in her knowledge of behavioral health needs of Oregonians as well as her engagement with health and behavioral health stakeholders which I have been able to watch on several occasions.

Finally, a note of thanks to John Dunbar, the lead attorney for the State of Oregon in this matter, and the United States Department of Justice attorneys working on this project, especially Jessica Polansky in Washington, D.C. and Adrian Brown in Portland, OR. Their consultation and input have helped me tremendously in understanding the OPP; Oregon's system, services, and stakeholders; and the Independent Consultant's role.

Respectfully and with gratitude,

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[1] See Appendix A for a list of acronyms used in this report.

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Table of Contents

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Introduction – Background and Context

This is the first report of the Independent Consultant (IC) engaged by the Oregon Health Authority (OHA) in keeping with the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP), effective July 1, 2016. This report is one of six bi-annual reports to be provided by the IC over the next three years to assess Oregon's performance and compliance with the provisions of the OPP.[2] This report provides a short description of the history of and context for the OPP as well as the status of Oregon Health Authority's (OHA's) activities through approximately February 2017 designed to implement the provisions of the OPP, utilizing baseline data provided by OHA from calendar year 2015. (See Appendix B for a summary of these activities and data.)

The OPP was entered into voluntarily by the State of Oregon acting through the Oregon Health Authority (OHA), by its Director, Lynne Saxton. The OPP indicates Oregon's intent to better provide adults in Oregon who experience serious and persistent mental illness (SPMI) with "community services that will assist them to live in the most independent setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization."[3]

While the OPP was entered into voluntarily by the State, because the elements of the OPP are best practice goals and good public policy for adults with SPMI, national laws and regulations provide a context for the requirements reflected in the OPP. For example, Title II of the Americans with Disabilities Act (ADA) requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[4] Many persons with SPMI are generally considered to be individuals with disabilities. In the OPP, Oregon specifically recognizes and supports the Congressional finding that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency."[5] Likewise, Oregon acknowledges it is committed to compliance with the ADA.[6]

Nationally, the United States Department of Justice (USDOJ) has been working with states to implement the ADA pursuant to Supreme Court findings in the *Olmstead v. L.C.* case and to assure states are in compliance with the Civil Rights of Institutionalized Persons Act (CRIPA)[7] by investigating allegations of rights violations in state-operated institutions, especially psychiatric facilities. In 2006, USDOJ began a CRIPA investigation at Oregon State Hospital (OSH) and a further investigation of the Oregon community mental health system in 2010 that resulted in a USDOJ and OHA agreement in 2012. OHA produced a performance matrix and four subsequent reports regarding its performance on those agreed upon outcome measures. The last of these reports was in July 2015.[8]

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[2] Section F, OPP. All future references to Sections and Subsections are to the OPP unless indicated otherwise.
[3] Subsection A.1.
[4] 42 U.S.C. §§12101 *et seq.*; *Olmstead v. L.C.*, 52 U.S. 581 (1999); 28 C.F.R. §35.130(d).
[5] Subsection A.3; 42 U.S.C. §12101(a)(7).
[6] Subsection A.4.
[7] 42 U.S.C. §1997 *et seq.*
[8] For these documents, see http://www.oregon.gov/oha/bhp/Pages/USDOJ-Agreement.aspx

The Oregon Performance Plan

Overview[9]

The current OPP[10] represents the next step in Oregon's commitment to increase and improve community services for adults with SPMI as well as USDOJ's efforts to assure ADA and *Olmstead* compliance for adults with SPMI living in and receiving publicly funded services in Oregon. The OPP was signed in July 2016, with quantitative targets in ten performance outcome service areas, including:

1. Assertive Community Treatment
2. Crisis Services
3. Supported Housing
4. Peer-Delivered Services
5. Oregon State Hospital
6. Acute Psychiatric Care
7. Emergency Departments
8. Supported Employment
9. Secure Residential Treatment Facilities
10. Criminal Justice Diversion

In addition, the OPP includes commitments regarding quality and performance improvement activities, and reporting on data to track outcomes and activities OHA is undertaking to achieve the goals identified in the OPP. As one of those deliverables, OHA produced and sent on January 31, 2017 to USDOJ and me a report[11] regarding many of the data specifications for the quantitative parts of the OPP with baseline data for calendar year 2015 (CY 2015, January 1 through December 31, 2015). In some instances these data are similar to data provided to USDOJ and the Oregon public during late 2014 and 2015. The last such data covered CY 2014, so these baseline data are either updates or are new data covering performance outcomes in the new July 2016 (OPP).It should be noted a few data elements are new and therefore data are not available for the baseline year (CY 2015). Additionally, some of the data elements are not required until later in the OPP reporting timeline, and therefore are not yet provided by OHA. As indicated later in this IC Report #1, I have discussed with OHA a few missing data elements for possible inclusion in future OHA reports.

As a result of the commitments in the OPP by the State of Oregon, in a letter dated July 25, 2016[12] USDOJ agreed to suspend its investigation and meet annually with the State of Oregon (OHA and its attorneys) and the IC over the three years covered by the OPP (July 1, 2016 through June 30, 2019) to discuss activities and progress in meeting the OPP goals and performance outcomes. USDOJ and OHA leadership met in the Fall of 2016 with the IC to acknowledge the completion and beginning implementation of the OPP and set expectations for the upcoming reports and meetings. The first of the three annual meetings agreed to by OHA and USDOJ is in the process of being scheduled for Fall 2017. In the meantime, USDOJ continues to be engaged, watching as the system and its services change, reviewing data provided, and talking from time to time with the IC to provide input, make recommendations and suggestions, and receive updates.

[9] See https://www.oregon.gov/oha/bhp/OregonPerformancePlan/Oregon-Performance-Plan-Executive-Summary.pdf for a summary of the OPP by OHA. See also, https://www.oregon.gov/oha/bhp/OregonPerformancePlan/Oregon-Performance-Plan.pdf for a copy of the full Plan.
[10] See http://www.oregon.gov/oha/bhp/Pages/USDOJ-Agreement.aspx for documents showing the history and current status of the previous agreement and this current OPP, as well as the January 2017 report from OHA to USDOJ regarding this current OPP. https://www.oregon.gov/oha/bhp/Pages/Oregon-Performance-Plan.aspx for current OPP and USDOJ letter of July 2016.
[11] Ibid.
[12] Ibid.

Current Context in Oregon and the Oregon Health Authority (OHA)

Two critical changes have occurred within Oregon and within OHA over the last few years and are important contexts for the OHA work on the OPP commitments and this IC Report #1. First, in 2014, Oregon exercised its option to expand its Medicaid program (Oregon Health Plan) to cover adults with household incomes up to 133 percent of the Federal Poverty Level (FPL). This allowed Oregon to utilize Medicaid as a source of healthcare services for hundreds of thousands more adults, especially for many individuals with SPMI. It also allowed Oregon to receive enhanced federal financial participation (FFP) or federal match for the first three years of this expansion, with declining but on-going higher FFP over time. While this expansion allowed more people to be covered and more healthcare data to be captured in a single source,[13] it also means that Oregon is facing a current budget shortfall in part due to the decline in FFP for this expanded population.

Second, OHA worked hard as part of this expansion opportunity to change its Medicaid program, receiving a Section 1115 waiver[14] from the federal government in 2012 in which it proposed to reduce the growth in Medicaid spending while expanding Medicaid eligibility. One aspect of this process has been to integrate healthcare, including behavioral health, dental, and vision care throughout the system.

As part of the effort to create a single system of health care services, Oregon reorganized its State structure so that behavioral health services and programs became one aspect of all parts of the newly designed OHA, rather than a freestanding division managing its own programs and services separately from other types of healthcare within Oregon. As a result, the leadership for behavioral health has changed from a single leader for policy, programs, funding, and data to an integrated part of the entire OHA organization. This change has been confusing at times for stakeholders who were used to behavioral health being its own division with its own relationships to county-based community mental health programs (CMHPs). However, with a newly appointed behavioral health policy lead within the policy unit of OHA and with behavioral health now incorporated throughout the OHA structure in operations, data management, quality and performance improvement, contracting, and licensing, Oregon's approach to integration of behavioral health within the larger healthcare system is being implemented and tested. However, this transition is not complete and the OPP outcome measures reflect some of the transition work yet to come with changes in contracts, regulations, quality management, and data collection and analysis still underway. Similarly, the roles of various community actors – hospitals, emergency departments, CMHPs, the Medicaid Coordinated Care Organizations (CCOs), other care coordination entities, local behavioral healthcare and other social services providers, and even OSH – are in flux, especially for the population of adults with SPMI served by public dollars (including Medicaid, Medicare, federal block grants, and State General Funds).

This changing system in Oregon brings incredible opportunities and, at the same time, many challenges. These opportunities and challenges are reflected in some parts of this report. The recent administration change at the federal level also portends additional likely but as yet unknown changes in the healthcare environment for which Oregon is perhaps as well situated as any state and yet which may bring new challenges beyond those already facing Oregon's changing system. These contextual factors will be watched and considered over the time period of the OPP and in future IC reports.

Independent Consultant's Role and Activities to Date

In the OPP, OHA committed to contracting with an Independent Consultant (IC), Pamela S. Hyde. The IC's role is to assess whether OHA is meeting the provisions of the OPP and if requested to provider

[13] Medicaid Management Information System or MMIS; see the later section of this report regarding quality and performance improvement for a description of data sources.
[14] See https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html for a general description of Section 1115 waivers. See http://www.oregon.gov/oha/hpa/Medicaid-1115-Waiver/pages/index.aspx for a description of Oregon's history with Section 1115 waivers and the most recent waiver renewal approved in January 2017 effective through June 30, 2022.

consultation to OHA to assist OHA in implementing provisions of the OPP. This assistance can include training, technical assistance, and recommendations to facilitate implementation, including quality and performance improvement processes, and identifying any obstacles to implementation and strategies to address such obstacles. This first year, I, as the IC, have spent considerable time learning the Oregon system; meeting and talking with stakeholder leaders and staff; understanding Oregon's strengths and constraints; and helping OHA staff work through the vagaries of assuring the data strategies and specifications for the quantitative OPP performance outcomes are sufficient and appropriate. In some cases, the IC has informally assisted OHA staff to find examples, national standards, or specific experts that may be helpful for different aspects of OPP activities. OHA's first report delivered January 31, 2017 includes data specification sheets worked through with me as the IC to assure baseline data and data going forward is consistent, comparable across reports, accurate,[15] and useful to assess progress on OPP measures. In the Spring, I will be visiting programs in various parts of Oregon to see firsthand how individuals with SPMI are being served and how program leaders see the benefits and challenges of the OPP provisions and the State's efforts to implement them.

Independent Consultant Reports

I as the Independent Consultant (IC) am charged with providing semi-annual reports to assess compliance of OHA with the OPP provisions. This Report #1 and all others by the IC assume compliance assessment will be about all parts of the OPP commitments, not just the quantitative performance measures. Hence, this Report #1 includes a comment about status on all of the OPP commitments. Per the OPP, these IC reports will be made public by OHA once finalized after a 30-day review period by OHA and USDOJ (Subsection F.3).

The scope of this Report #1 includes an overview of the OPP, the status of OHA efforts to address both quantitative and non-quantitative commitments in the OPP generally as of the end of Quarter 2 of Year One of the OPP (December 31, 2016), and to call out areas of concern or areas to watch going forward. Since OHA's first report describes data specifications for the quantitative commitments in the OPP and provides baseline data for CY 2015 (ending December 31, 2015), this IC Report #1 will not assess compliance per se except in those areas where a very specific action has in fact been completed. (See Appendix B.) However, this report will provide updates on or comment on activities of OHA, some of which are described in OHA's first report of January 31, 2017.

Because of data lag and OHA's quarterly reporting using a rolling 12-month time period,[16] future IC reports will begin to assess compliance in non-quantitative commitments and later in quantitative performance outcomes. Just as with this report, the IC semi-annual reports will be released sometime after quarterly OHA data or narrative reports, as follows[17]:

- IC Report #2 – Summer/Fall 2017, considering status of activities as of Summer 2017 and data from 1/1/16 through 12/31/16;
- IC Report #3 – Winter/Spring 2018, considering status of activities as of Winter 2018 and data from 7/1/16 through 6/30/17;[18]
- IC Report #4 – Summer/Fall 2018, considering status of activities as of Summer 2018 and data from 1/1/17 through 12/31/17;
- IC Report #5 – Winter/Spring 2019, considering status of activities as of Winter 2019 and data from 7/1/17 through 6/30/18;[19] and

[15] Note: as of this report, I have not done any independent verification of the baseline data provided by OHA in its first quarterly report. However, I have asked for some data runs to check certain issues to assure data are not under or overcounting individuals or services. Issues remain, but I am comfortable that no data provided are significantly skewing the performance results, or if they are, it is all in the same direction so that future reports will be comparable.
[16] See later section of this report regarding quality and performance improvement, including data reporting.
[17] See also Appendix B for another depiction of these data lag and status reporting timeframes.
[18] This is the first IC report that will be able to consider data from Year One (FY 2017) of the OPP.
[19] This is the first IC report that will be able to consider data from Year Two (FY 2018) of the OPP.

- IC Report #6 – Summer/Fall 2019, considering status of activities as of Summer 2019 and data from 1/1/18 through 12/31/18.

It should be noted that data about the quantitative parts of the OPP for Year Three (FY 2019, July 1, 2018 through June 30, 2019) will not be available until January 2020. I assume OHA will continue providing quarterly data through that time, however, as of the date of this Report #1, I have not been requested to provide a compliance report at that time.

As indicated earlier, OHA and USDOJ agreed they would each have 30 days to review draft IC reports. Such a review occurred with this report before it was finalized. For any IC report, if the review process reveals any errors of fact, I will correct the draft report before finalizing it for public release. Otherwise, the views and perspectives expressed herein and in future reports will remain my own in my role of assessing status moving toward what is hoped by all to be compliance by Oregon with the OPP.

This first IC report attempts to address the general or specific status of all aspects of the OPP. This Report #1 also raises and/or settles various concerns and provides conclusions and issues to watch over the time period of the OPP. In future IC reports, I may focus more intently on specific parts of the OPP commitments, depending on what efforts are underway, what programs or services I have been able to visit or review, or areas I feel need special attention. If OHA or USDOJ request special attention in an IC report on any particular area, I will try to accommodate those requests to the extent possible. The rest of this Report #1 describes the status of various OHA activities associated with the OPP, as I understand that status at this point.

OPP Recitals and Definitions (Sections A – B)

Section A. Recitals

The OPP begins with recitals about intent and goals, including the aspirational nature of the document, along with OHA's commitment to make diligent efforts to meet the goals of the OPP. (Subsection A.7.) OHA acknowledges in the OPP the work done since November 2012 and the investment of substantial new funds in that effort.[20] OHA also states within OPP Section A the State's goal, through the use of the performance measures in the OPP, to "make additional system reforms in the next three years." (Subsection A.7.) Accordingly, the OPP provides OHA the option of working with the IC on any particular target or outcome measure that is not met to "determine the underlying reasons why the outcome measure was not achieved, whether adjustments need to be made . . ., and whether the State has developed the infrastructure necessary to improve its performance and reach the outcome measure, whether to provide additional time for accomplishment of that measure, and whether to increase the term of this Plan." (Subsection A.8.) Any modification of the OPP would have to be in writing.

While it is too early in the three-year timeframe covered by the OPP to invoke this subsection, it is also true that the measures, targets, and commitments in the OPP are significant, and meeting some of them would be a stretch for any jurisdiction. This provision is not viewed by OHA or by the IC as an "out" for any particular commitment, but rather as a way to continue forward movement even if a specific target or measure proves to be unattainable as written or in this specific three-year period.[21] While OHA and the IC have discussed this provision allowing adjustment and continued progress, no specific targets or measures have been discussed and no decisions have been made to date regarding any adjustments.

[20] See discussion of OPP Section C, later in this report.
[21] See also Section E.6 noting that OHA's performance "shall be measured by whether it substantially complies with those performance outcomes and the other obligations specified in Section D, and whether OHA establishes or maintains the quality improvement measures required by . . . Section E."

Section B. General Terms and Conditions (and Background Issues)

OHA's Commitment to Advocate: Section B of the OPP includes a specific commitment by OHA to advocate with the Oregon Health Policy Board and the Oregon Health Plan Quality Metrics Committee[22] to develop additional metrics consistent with the performance outcome measures in the OPP. Just as with Subsection A.8 discussed above, it is too early to ascertain whether this advocacy has occurred or will be successful. However, OHA is beginning this engagement process, which is described in a later section of this report having to do with quality and performance improvement.

Language in Definitions re Goals and Intent: The rest of Section B of the OPP contains definitions to be used in connection with the OPP. Most of these definitions are straightforward although some of them include descriptions, intentions, or obligations that need to be addressed as compliance with the provisions of the OPP is assessed. For example, the definition of "discharge planning" includes a commitment that "[d]ischarge planning teams at OSH include a representative of a community mental health provider from the county where the individual is likely to transition." (Subsection B.6e) Similarly, the definition of "jail diversion services" includes the concept that such services are "intended to result in the reduction of the number of individuals with mental illness in the criminal justice system or Oregon State Hospital." (Subsection B.6i)

Likewise, the definition of supported housing (Subsection B.6o) not only defines scattered site housing and the types of housing units that will count as supported housing for purposes of the OPP, but it also includes phrases descriptive of the intent, for example, that support services offered to people living in such housing are "flexible and available as needed and desired, but not mandated as a condition of obtaining tenancy;" that tenants in such units will "have a private and secure place to make their home, just like other members of the community with the same rights and responsibilities;" and that two people living together "must be able to select their own roommates." This definition makes it clear that supported housing providers cannot "reject individuals for placement due to medical needs or substance abuse history." Similarly, the definition of "homeless" as used in the OPP (Subsection B.6h) is limited to adults with SPMI who are homeless. As indicated elsewhere in this report, it is sometimes difficult to know when a person who is homeless (without a fixed address) is also SPMI. Sometimes, it is more appropriate to provide anyone who presents with an apparent mental health issue and who has no home with services to connect to housing agencies or community mental health programs with access to housing services rather than try to make fine distinctions about diagnoses and service needs in the first instance.

As a final example, the definition of "mobile crisis services" (Subsection B.6j) includes not only a description of such services, but includes a statement that the goal is to "help an individual resolve a psychiatric crisis in the most integrated setting possible, and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration."

In all these instances, the goal or intent is laudable, and OHA holds to those goals and intent, even though they may not be achieved for any particular client in a particular situation. It should be noted that the data for OHA's and this report will count those services that meet the service descriptions regardless whether the intent is achieved in any particular individual situation. Sometimes the qualifying statements are aspirational and would be tough to measure. In other cases, the goal or intent is reflected in the data about dispositions or other means reflected in the OPP. Generally, such qualifying statements about goals and intent will be addressed as this report describes work being done by OHA in each of the respective areas that pertain to those types of services.

Serious and Persistent Mental Illness (SPMI): A definition of SPMI is not included in the OPP. However, a definition of SPMI was developed pursuant to the 2012 agreement between USDOJ and OHA which had a four-year term. OHA continues to utilize this definition of SPMI for the OPP which extends through FY 2019. This definition is critical because it defines the group of individuals about whom the OPP is concerned. The OPP is clear that the terms of the OPP relate specifically to adults with SPMI and

[22] Oregon Revised Statutes Chapter 413.

reiterates in some sections that the OPP relates *only* or *specifically* to such individuals. (See, for example, Subsections D.1, D.37, D.45a, and E.1) However, in some sections of the OPP, the reference is narrower (for example, specifically to civilly committed individuals in OSH, Subsections D.19 and D.49; or individuals with SPMI who interact with emergency departments or law enforcement only *for mental health reasons*, Subsections D.41 and D.51). In the latter case, an individual may in fact be SPMI, but not the focus of the OPP activities and commitments. In fact, decisions about such individuals' community services may be out of the hands of OHA (for example, a guardian or another State department may be responsible for and making decisions about their care, or a court or psychiatric review board may be the legal decision-maker about discharge timing and planning). In most cases, these distinctions are easy to make. In others, it is not.

Likewise, the very definition of SPMI may be somewhat illusive in a given situation. For example, persons who utilize mobile crisis services may or may not have SPMI, and it may be impossible to make this determination at the time of the mobile crisis service utilization. Similarly, a person exhibiting mental health issues and interacting with law enforcement or presenting at an emergency room may not be easily determined to be SPMI at the point of that interaction. That is, the service may occur before the determination about diagnosis occurs; and a diagnosis may change because of a particular service encounter.

SPMI was defined for purposes of Oregon's 2012 agreement with USDOJ as an individual 18 years of age or older and based on certain diagnoses, namely:

- Schizophrenia and Other Psychotic Disorders
- Major Depression and Bi-Polar Disorder
- Anxiety Disorders
- Schizotypal Personality Disorder
- Borderline Personality Disorder.

An adult could also be considered SPMI based on having one or more mental illness diagnoses and having a Global Assessment of Functioning (GAF) score of 40 or less that results from the diagnosed mental illness(es). While this definition is still utilized by OHA for data development and reporting for OPP purposes, several considerations make this definition by itself insufficient for purposes of the data driving the OPP activities and performance outcomes.

First, GAF scores are not consistently used to assess or to conduct treatment planning. And, the data systems used by OHA and most other states/jurisdictions do not routinely collect this data for billing or quality management purposes now or in the past. Therefore, use of GAF scores by OHA to identify individuals with SPMI is not practical or possible.

Second, the SPMI definition refers to diagnoses and diagnostic categories listed in the Diagnostic and Statistical Manual, Fourth Edition or DSM IV. Today, DSM V has superseded DSM IV and no longer includes GAF scores for diagnostic purposes. Likewise, as OHA has moved toward a single system of healthcare, the broader International Classification of Diseases (ICD) is used for Medicaid billing and other diagnostic and data classification purposes. The federal government currently requires use of ICD 10 codes for billing purposes, which may vary somewhat from the DSM V classification and coding used in behavioral health.

Third, as we have learned more and more about SPMI and the persons who experience such a condition or diagnosis, and as persons with lived experience have taught us about the concept and process of recovery, we increasingly understand that many individuals can have serious diagnoses related to these long term psychiatric illnesses, but this does not make them incapable of independent functioning or productive living. And, just like other long-term illnesses, the seriousness of the mental illness and related needs can vary over time. In other words, a specific diagnosis is not in and of itself a recipe for dysfunction or for high intensity service needs, especially with the right supports, services, and service planning over time, whether those are publicly or privately funded services, or whether the individual utilizes self-help and mutual aid approaches to managing his/her recovery rather than formal services.

OHA does not maintain a master list of individuals with SPMI in Oregon, and the OPP does not require service recipients to be part of a particular group of which an individual is determined to be a part always or not at all. An adult with one of the listed diagnoses may be included in the group that needs the intensity of community services described in the OPP at one time and not at another. The OPP requires OHA to report whether it is providing or assuring the right types, amounts, and quality of community services are available for (in some cases specified numbers of) adults with SPMI who are in need of intense interventions in a given time period.

The definition of SPMI for purposes of data reporting was a topic of considerable discussion as OHA and the IC began to discuss how to set the data specifications and pull and report baseline (and eventually performance) data for the elements of the OPP. Significant discussion occurred about how to do this to assure the right data specifications are being used to be accurate, consistent, and comparable over time, and yet recognize that this is not a class of specific individuals, and that a particular individual cannot and should not necessarily be tracked through the system over time. As part of this discussion, several data questions were tested to assure OHA was neither under nor overcounting the individuals and services to be reported. Similarly, since the OHA January 2017 baseline report is for a 12-month period (CY 2015) and the future OHA reports will be for rolling 12-month periods, the question to be answered is how many persons with SPMI received the identified services or were living in the identified housing or service programs during that particular 12-month period.

In the end, OHA's decision to report the data as it indicates in its January 2017 report makes sense. OHA indicates it will first identify individuals that received a specific service during the relevant 12-month period (e.g., ACT, supported housing, mobile crisis services, emergency department service, or inpatient service in OSH or in an acute psychiatric care facility, etc.), and then secondly, identify which of those individuals also had one of the diagnoses listed in the former definition of SPMI. Hence, it is the combination of the intense service use and the severity of the diagnosis that constitutes SPMI for purposes of the data reports, not the diagnosis alone and not the service use alone. This decision was arrived at after much discussion about implications in a variety of circumstances, and does not vary significantly from how OHA pulled and reported data to USDOJ in the past. While I have not independently verified any specific data, I am convinced the process OHA is using neither over nor undercounts the baseline numbers substantially, if at all, and will not do so in reporting its performance in the future. To the extent there is even a small number of instances in which an over or undercount could occur, it will be done over time in a way that assures consistency and comparability from one time period to the next so that OHA's progress can be appropriately assessed.

Funding Limitations and Efforts (Section C)

This Section of the OPP acknowledges that OHA's performance is subject to Oregon law, specifically with regard to monetary obligations. However, OHA commits that the "State of Oregon will make diligent efforts to obtain the funding, appropriations, limitations, allotments, or other expenditure authority necessary to implement the terms of this Plan."

Investments Since 2012

Since the 2012 approval of Oregon's §1115 waiver and Oregon's expansion in 2014 of Medicaid for low-income adults without children in the household as allowed by the federal Affordable Care Act, Oregon's approach to an integrated healthcare system has meant a significant growth in Medicaid expenditures for adults with SPMI. This growth in Medicaid as a source of critical services for adults with SPMI is expected to continue within the constraints of Oregon's renewed §1115 waiver approved January 13, 2017. According to OHA's July 2015 report to USDOJ,[23] $250,606,336.87 was spent in CY 2014 for Medicaid expenditures for mental health services for adults with SPMI. As IC, I will work with OHA to determine

[23] See http://www.oregon.gov/oha/bhp/Documents/USDOJ%20Report%20Narrative%20Document_7.1.2015.pdf

how the amount or types of these expenditures have grown or changed in future years. These Medicaid expenditures generally do not include services for the OPP population provided by OSH, including the Junction City facility, since services for adults 18 to 65 years of age provided in such an Institution for Mental Disease (IMD) are excluded from receiving federal financial participation (FFP) by federal law.[24]

Oregon has continued to utilize increasing federal Community Mental Health Services Block Grant (MHBG) funding and other federal grant resources to bolster services for adults with SPMI as well as for youth that may be SPMI in the future without significant interventions prior to adulthood. Oregon's MHBG funding has increased since Federal Fiscal Year (FFY) 2012:

- FFY 2012 – $5,380,731
- FFY 2015 – $5,983,509
- FFY 2016 – $6,726,815
- FFY 2017 – $6,726,815[25] (estimated)

However, with these increases came additional federal set aside requirements for programs to address first episode psychosis (FEP) in young people. These FEP services are critical to helping prevent the dysfunction that often leads to SPMI service needs as adults and should have an impact on services and needs in the future.

In addition to MHBG expenditures and increased expenditures for Medicaid and OSH services, significant additional investments have been made by OHA and the Oregon State Legislature for services specifically targeted by the OPP. Table 1 shows Oregon's investments for the last two biennia since July 1, 2013 (FY 2014).

Table 1:
Additional Non-Medicaid Adult Community Mental Health Investments 2012 – 2017

SERVICES	2013 – 2015 INVESTMENT (in millions)	2015 – 2017 INVESTMENT (in millions)	TOTAL	TARGET ENTITY FOR FUNDING
Crisis Services	$ 10.55	$ 21.37	$ 31.92	CMHPs
Jail Diversion Services	$ 3.99	$ 8.66	$ 12.65	CMHPs
Supported Housing and Peer Delivered Services[26]	$ 10.29	$ 17.21	$ 27.50	Housing Providers
Supported Employment Services	$ 2.00		$ 2.00	CMHPs (non-competitive)
ACT and Case Management	$ 7.32		$ 7.32	CCOs
Tribal Set Aside	$ 2.40		$ 2.40	Tribes (non-competitive)
Supported Housing Development (State Housing Finance Agency)	$ 5.00	$ 20.00	$ 25.00	Housing Developers
TOTAL[27]	**$ 41.55**	**$ 67.24**	**$108.79**	

[24] See https://www.macpac.gov/wp-content/uploads/2016/03/The-Medicaid-Institution-for-Mental-Diseases-IMD-Exclusion.pdf for a short presentation about the IMD rule and its implications for adults with behavioral health issues.
[25] States have two years to spend these federal block grant funds. In FFYs 2015, 2016, and 2017 (estimated), Oregon will have spent approximately $12.9 M of these funds. Note: the federal government utilizes the prior year amount until the federal budget is finalized; therefore, the FFY 2017 amount is estimated.)
[26] Note: these are not peer delivered services (PDS) reportable for Subsections D.16 – 18 because they are not Medicaid funded PDS. However, they do represent services provided by peer specialists.
[27] These figures include housing development funding administered by Oregon Housing and Community Services, the State's housing finance agency, as well as behavioral health services funding, administered by OHA.

Current Requests for State Funding Increases for 2017 – 2019 Biennium

The Oregon Legislative session began in January 2017. During this session, the Legislature is discussing and will act on a two-year budget for FYs 2018 and 2019 (beginning July 1, 2017). While the State is facing a significant budget deficit[28] caused in part by the reduction in FFP for Medicaid expansion populations, the commitment by State Legislative leaders to enhancing State funded behavioral health services for adults with SPMI appears to be continuing. The Oregon Governor's budget did not seek an increase in funding for OHA's non-Medicaid behavioral health services. Rather, it proposed to cut funding by closing the Junction City facility part of the OSH system. Discussions about the community investments that will be needed in order to deal with the closure of this facility in 2018 are underway.

In October 2016, the Senate President's office requested and OHA's Legislative Coordinator for Behavioral Health Programs provided the following preliminary information about items OHA internally identified and stakeholders have expressed as needs for non-forensic adults with SPMI:

- Psychiatric Emergency Services (non-Medicaid) ($11 M)
- Mobile Crisis ($15 M)
- Jail Diversion ($12 M)
- Housing Development
- Rental Assistance
- Care Coordinators for OSH Patients (until returned to CCOs responsibility after discharge)
- OPAL – A (Oregon Psychiatric Access Line for Adults ($1.5 M)
- Peer Services (before a diagnosis)
- Peer Services Center of Excellence
- Workforce Development (a career pathway pool/scholarship funds)
- Residential Services Rate Increase (to reflect increase in minimum wage).

While these service needs and figures are not final, work continues with members of the Legislature to determine what additional investments can be made for this population for the next two years. As indicated earlier, Medicaid funding is also expected to continue to grow. Both Medicaid and State Legislative investments will be tracked and discussed in future reports.

OPP Performance Outcomes (Section D)

Introduction to Measures and Data Issues

In this Section of the OPP, the State of Oregon, through OHA, has made a number of quantitative and qualitative or process commitments to improve services for adults with SPMI. As indicated earlier, OHA recently produced its first quarterly narrative report setting out data specifications and baseline data for those quantitative performance targets for which CY 2015 baselines were available. As OHA continues its quarterly reporting using rolling 12 month data, USDOJ, the IC, and the public will be able to see how the Oregon system is evolving on these quantitative performance measures.

OHA's narrative report also provides some information about activities being undertaken by the State to advance the quantitative targets as well as the overall performance outcomes being sought. This IC Report will discuss these and other activities that may provide some additional context as we watch the Oregon system evolve and improve. Descriptions and comments on activities and status of each of the ten performance outcome areas follow, but first a word about data sources used to report the data for the quantitative measures.

[28] See https://www.oregon.gov/das/Financial/Documents/2017-19_gb.pdf for the Governor's budget projecting a $1.7 billion deficit over the biennium.

Oregon uses primarily four data sources for reporting on the OPP performance outcome measures – Medicaid billing data, a measures and outcome system (especially for safety net programs and services), the Oregon State Hospital electronic health records system, and various survey and/or data reports collected by OHA itself or by its contracted centers of excellence.[29] One of the sources of data collected by OHA itself is the Avatar system utilized by OSH to collect and report treatment and discharge data on OSH patients. These various data sources each have limitations but are improving over time. In some cases, the improvements will make the data provided by OHA more accurate and timely, but may also make the data different from previous reports to USDOJ. A good example is the supported housing data which was provided in the July 2015 report showing a higher number of units than is reported in the recent January 2017 OHA report regarding the OPP performance outcomes. OHA indicates this is because of a change in the data reporting process and that the newer methodology is more accurate, although showing a lower number. Likewise, as the care delivery system evolves, the Medicaid billing data should provide a more complete set of information about various services and the measures and outcomes data system should be more accurate and timely about a variety of services.

A significant limitation of concern to me as IC is the inability to easily track services provided for undocumented immigrants who may show up in Medicaid billable or safety net services, but who are not eligible for Medicaid reimbursement. It is unclear at this point how much undercounting is occurring of services for undocumented adults with SPMI being provided but not captured. Similarly, some services are not well developed enough or have special concerns associated with the services such that they or the providers that deliver them are not able to utilize the Medicaid billing system or even the measures and outcomes system easily. An example of this potential undercounting is peer-delivered services that may be provided by peer-operated programs or individuals that are funded by state, federal MHBG, or local funding and which are unable or do not choose to become Medicaid billable.

While these are issues of concern regarding potential undercounting of services provided within Oregon, the OPP seems to acknowledge and accept that potential by agreeing the OPP covers only those services billed to Medicaid or paid for with specific state general funds (interpreted to include federal MHBG utilized by the State, state funds used in the OSH system, and state funds utilized by the State's housing finance agency for housing unit development. See OPP Section D, Subsections 5, 17, 18, 36, 44, and 47).

Finally, it should be noted that some parts of the OPP require a discussion and collaboration with various system players (e.g., jails and sheriffs in Subsection D.52; and hospitals for certain data regarding warm handoffs after acute psychiatric care facility stays and 23+ hour stays in emergency rooms, Subsections D.29 and 43 respectively). These discussions are underway and may impact data sources about these services going forward. In other parts of the OPP, OHA commits to developing a methodology for tracking and reporting certain data later in the three-year period of the OPP (e.g., Subsection D.8 regarding mobile crisis services dispositions) or even after the OPP period is completed (e.g., Subsection D.17 regarding peer-delivered services). As IC, I will continue to follow and report on OHA's progress in these efforts.

The rest of this section of this report describes the status of work on the 10 outcome performance measures in Section D of the OPP.

1. Assertive Community Treatment (Subsections D.1 – 5)[30]

The OPP commits Oregon to increasing the number of individuals with SPMI served by Assertive Community Treatment (ACT) teams and to providing ACT services to "everyone who is referred to and eligible for ACT" (Subsection D.1) and to admitting to ACT those individuals who meet admission criteria

[29] See the Quality and Performance Improvement section, later in this report, for a fuller description of these data sources.

[30] Referral and access to Assertive Community Treatment (ACT) teams for civilly committed adults with SPMI leaving OSH are also referenced in OPP Subsections D.23 a-b, and E.4c). These are discussed in the later sections of this report about OSH and about Quality and Performance Improvement.

for ACT (Subsection D.2). According to quarterly reports received by the Oregon Center of Excellence for Assertive Community Treatment (OCEACT) checked and verified by OHA, 815 adults received ACT services in CY 2015, up from 553 at the end of CY 2014. The target is 1,050 adults to be served by the end of FY 2017 (June 30, 2017), and 2,000 by the end of FY 2018 (June 30, 2018).

During CY 2016, 23 ACT teams were functioning and met fidelity requirements in Oregon, with a 24th one provisional and to be reviewed in January 2017.[31] Twelve more teams were receiving technical assistance and in the development stage. These numbers are up from 17 qualified in 2015 (i.e., meeting at least the minimal fidelity score of 114 out of 140), with four provisional and six additional teams in development. Only six ACT teams were functioning in 2013 and only two of those were functioning with fidelity to the evidence-based practice standards.

The growth in this evidence-based practice is due largely to the investment by the Legislature of $5.5 M in the 2013-2015 biennium to provide funding for ACT team infrastructure development and for services for non-Medicaid eligible individuals. The 2013 start of OCEACT and the commitment to provide technical assistance through the OCEACT for those teams in development also assisted the growth in the number of teams. ACT is a Medicaid covered benefit in Oregon; therefore, additional funds were utilized to provide enhanced rate development for ACT team services.

This CCO Medicaid rate enhancement funding was continued in the 2015-2017 biennium, but the funding has not to date been targeted by geographic areas of need. As IC, I have recommended OHA consider any additional funding committed in the future be used to target areas where ACT teams do not exist or where evidence-based alternatives are not readily available for those individuals who are eligible for ACT but live in areas where ACT teams are not available or who refuse ACT services.

Another commitment in the OPP (Subsection D.1c-d) is that after June 30, 2018, if 10 or more individuals are appropriately on an ACT team waiting list for more than 30 days, OHA will take action to reduce the waiting list and serve these individuals by increasing team capacity or adding additional teams. OHA also committed to making it possible to waive certain fidelity requirements regarding the number of individuals served by an ACT team and a proportional reduction in staff for ACT teams in rural areas if the teams re unable to achieve fidelity. As of the end of CY 2016, no rural ACT teams needed a fidelity waiver of this nature.

The OCEACT conducts fidelity assessments annually on all teams to assure they are meeting fidelity requirements and receive the technical assistance they need to maintain these requirements. In conjunction with OHA, the OCEACT has developed a reporting template to begin collecting information from ACT teams about waiting lists and other elements of ACT team programs including denials of individuals and the criteria for that denial (Subsection D.3). (See Appendix C for ACT Reporting Template.) Since many of the 23 ACT teams currently operating are in urban or semi-urban areas, and some do not yet serve the full number of individuals they are able to serve, the issue of team expansion in underserved areas will be an issue to watch and consider over the next couple of years.

OHA also commits in the OPP to develop criteria for admission to ACT consistent with the OPP and with national standards, and to do so by July 1, 2016, the effective date of the OPP. OHA also commits to incorporate these standards into OHA administrative rules (Subsection D.1e-f). Changes were proposed to Oregon Administrative Rule to incorporate the ACT criteria and identify requirements for use of the ACT Universal Tracking Form. A public hearing was held on October 20, 2016, and in December 2016, this rule was finalized (OAR 309-019). While I as IC have read drafts of this rule, I make no assertion at this point whether the regulation as finalized is sufficient. However, the OCEACT and the OHA staff working on these issues who met with me indicate the right national standards and national experts in this evidence-based treatment were used and consulted in the regulatory process.[32]

[31] See www.oceact.org/programs for a list and map of the currently qualified programs.
[32] See http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345. I was told by OHA staff, but did not independently verify, that the expert consulted was Lorna

OHA commits in the OPP to assessing denials of individuals to ACT teams to determine if denials are based on established admission criteria. (See Appendix D for the Draft ACT Universal Tracking Form OHA created in August 2016 to track referrals, refusals, denials, and waiting list information. This form is currently being revised.) OHA also commits to taking corrective action if providers are improperly rejecting individuals for ACT services (Subsection D.3). While the reporting template will track numbers of denials, and the rule allows for technical assistance to providers improperly denying individuals, the rule also allows each individual ACT team to make its own admission decisions, consistent with fidelity requirements of the ACT team service. OHA is still working on the process it will use to determine whether these denials are improper. Another OHA rule change (OAR 309-008) is in process with a Rule Advisory Committee (RAC) meeting held February 28, 2017. This rule change would update OHA's process for plans of correction or other procedures for providers out of compliance with OHA rules or with contract requirements. It is currently unclear to this IC whether these rules together give OHA sufficient leverage to fulfill the commitments made in Subsection D.3 of the OPP with regard to ACT team denials. This issue will be discussed further in future IC reports.

Finally, in OPP Subsection D.4, OHA commits to capturing nine data elements about individuals with SPMI receiving ACT services.[33] These data include:

a. Number of individuals served;
b. Percentage of clients who are homeless at any point during a quarter;
c. Percentage of clients with safe stable housing for 6 months;
d. Percentage of clients using emergency departments during each quarter for a mental health reason;
e. Percentage of clients hospitalized in OSH during each quarter;
f. Percentage of clients hospitalized in an acute care psychiatric facility during each quarter;
g. Percentage of clients in jail at any point during each quarter;
h. Percentage of individuals receiving Supported Employment Services during each quarter; and
i. Percentage of individuals who are employed in competitive integrated employment [as defined in the OPP.]

While the OPP indicates these data will be collected regularly and reports made available to USDOJ, the OPP also makes clear the information collected on these data points "will be used to identify areas for technical assistance and training" rather than as performance outcomes with targets. The new reporting template developed by OCEACT and OHA will collect this information, and OCEACT will use it to provide technical assistance and training for ACT team programs. OHA also plans to make this information available as part of its regular quality and performance improvement process. However, because this reporting template is new, it will be a few months before reports will be available and before this IC will be able to determine if the information is in fact available, is being reported, and is being used as agreed.

2. Crisis Services (Subsections D.6 – 13)

In the OPP, OHA commits to expanding mobile crisis services so they are available statewide by June 30, 2018. (Subsection D.6) As of this time, contracts for these services appear to cover all Oregon counties, but the services themselves may not yet do so. OHA also commits to increase the number of individuals served with mobile crisis services so that 3,500 are served in FY 2017 (ending June 30, 2017), and 3,700 are served in FY 2018 (ending June 30, 2018). (Subsection D.7) OHA is poised to meet these targets since the State reported 3,732 unique individuals[34] received mobile crisis services during CY 2015.

Mosher at the University of North Carolina, Department of Psychiatry, lorna_moser@med.unc.edu, who is in fact considered a national expert on ACT.

[33] Note: pursuant to national standards and to OHA ACT rules, all individuals in Oregon receiving ACT services should be adults with SPMI.

[34] Note: this subsection of the OPP refers to "people" rather than to individuals with SPMI since the nature of this service is to assist any individual in a behavioral health related crisis, and individuals served may not be determined to be SPMI at the time the crisis service is provided.

OHA commits in its January 2017 report to continue improving mobile crisis services, specifically regarding statewide coverage and response times. OHA intends to make mobile crisis services a required component of CMHPs' array of services statewide. To determine the current gaps in service capacity, OHA surveyed CMHPs in the Fall of 2016. (See Appendix E for the survey questions.) As of the end of CY 2016, the information from this survey had not been tabulated or provided to me, although OHA indicates the analysis of survey results will be available in May 2017. Further, OHA recognizes the limitations involved in using current data systems to capture data related to mobile crisis services, specifically response times; the designation of urban, rural, and frontier areas; and dispositions following a mobile crisis event. OHA indicates it is developing a data reporting template mobile crisis teams will be required to use to capture this data in the future.

In its January 2017 report to USDOJ, OHA indicates an investment this biennium of $7 M in mobile crisis and crisis respite services, specifically in 20 counties, for nine new and six expanded programs plus an additional $4 M for CMHP mobile crisis and crisis respite services throughout the state. As IC, I plan to visit some of the mobile crisis services programs during the spring of 2017 and will use information learned from these visits in later reports. I will also work with OHA to determine the reach of these programs to confirm statewide coverage by the end of FY 2018.

OHA also commits in the OPP (Subsection D.8) to track and report the number of individuals receiving a mobile crisis contact, and specifically to develop a methodology by June 30, 2017 to track dispositions after a mobile crisis contact and report:

- Six months after the development of the methodology, (no later than by January 1, 2018), "OHA will begin reporting the number of individuals whose dispositions from mobile crisis is admission to Acute Care;"
- By June 30, 2018, "Oregon will report the number of individuals whose dispositions after contact with mobile crisis result in community stabilization in stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care psychiatric facility."

I will continue to follow and work with OHA on its progress in the development of this methodology and reporting of these data.

In Subsections D.9 –12 of the OPP, Oregon commits to assure by the end of FY 2017 (June 30, 2017) face-to-face response times from the initial call to a mobile crisis line occur:

- within one hour "for areas that are not rural or the frontier";
- within two hours for rural areas; and
- within three hours for frontier areas.

Additionally, Oregon commits to assure in frontier and rural areas, a person trained in crisis management (such as a crisis line worker or peer) will call the individual in crisis within an hour, even if the face-to-face contact takes longer to occur. By the end of FY 2018, OHA commits to reviewing its progress on these standards and against best practices to determine if adjustments are needed.

OHA has currently defined the following geographic areas:

- Urban – counties that include at least one Metropolitan Statistical Area (MSA) as defined by the Census Bureau, i.e., an urbanized area of 50,000 or more population;
- Rural – counties that do not contain an MSA and/or all geographic areas that are 10 or more miles from a population center of 30,000 or more; and
- Frontier – counties that have a population density of six or fewer people per square mile.

Some Oregon counties may contain urban and rural areas, or rural and frontier areas. However, since mobile crisis services are funded to and provided by county-based CMHPs and data about these services are provided by CMHPs, OHA has identified each county as being one of the three types of geographic areas. (See Appendix F for map.) Presumably, the data about response times will be reported using these designations. Response time requirements have been included in revisions to Oregon Administrative Rules (OAR 309-019) in process. Pursuant to input from me as IC as well as based on input from other states and programs, the standard set by the OAR is 90 percent of requests for mobile crisis assistance shall be within the required face-to-face response timelines. As IC, I will work with OHA to determine how data about response times will be appropriately tracked and reported in the future.

Oregon has a statewide crisis response line (Lines for Life), but each CMHP also has its own crisis hotline and response approach, some connected to local 911 programs or local law enforcement entities and some standing alone. This multiplicity of crisis response lines may or may not be the most efficient and/or effective, and may create confusion at times about where to call for help. While creating a single statewide crisis response hotline capacity is not a part of the OPP commitments, I have recommended to OHA that the current design should be re-evaluated over time as mobile crisis response and hotline service needs in Oregon are clarified. OHA did commit in the OPP (Subsection D.13) to develop and enforce to uniform standards for hotline services and county-operated crisis lines. OHA reports it is in the process of engaging with CMHPs on the development of such standards which will eventually be included in the OAR. As IC, I will follow the development of these standards to help determine their potential impact on crisis response capacity statewide.

In my role as IC, I have provided information to OHA staff regarding examples from other states and programs in the country about mobile crisis response times and potential training content for crisis workers, and about individuals leading national hotline services who may be of assistance on uniform standards for hotline services and county-operated or funded crisis hotlines. I have also discussed with OHA suggestions about collection of the location of various crisis events, for technical assistance and quality assurance purposes in the future.

3. Supported Housing (Subsections D.14 – 15)

The OPP commits OHA to increasing the number of individuals with SPMI living in supported housing to at least:

- 835 by June 30, 2017;
- 1,355 by June 30, 2018; and
- 2,000 by June 30, 2019.

It also commits OHA to make best efforts to match individuals to housing that meets their needs and their individual choices, and to “collect data regarding the housing stock or inventory that is available for individuals with SPMI.” Finally, the OPP commits OHA to track the number of individuals with SPMI “receiving” supported housing, and use this information to make a budget request for “affordable housing” for individuals with SPMI for the 2017 – 2019 biennium.

Because of Oregon’s significant budget deficit going into the current legislative session which will decide the 2017-2019 biennial budget (described earlier in this Report #1), this request for supported housing funding was not included in the Governor’s budget request for OHA. This is consistent with OPP Section C regarding funding limitations, also described earlier in this IC Report #1. However, as indicated earlier, housing development and rental assistance have been identified by OHA to the Senate President’s office as areas in need of additional investment, albeit without specific dollar figures. OHA staff continues to work with Senator Courtney’s office and other state legislators regarding these and other service needs for adults with SPMI and for youth in transition that may become SPMI but for appropriate and early service interventions.

The distinctions between supported and supportive housing have been discussed by the U.S. Department of Housing and Urban Development (HUD) in addition to many states. These distinctions are not uniform

throughout the country. Both describe housing approaches in which a person with support needs receives housing in a community setting more like housing that others in that community enjoy with the same rights and privileges and with the necessary services to help such individuals obtain and maintain that housing. HUD and most of the laws funding such housing generally use the term "supportive housing" to describe a variety of community-based housing options.[35] The goal in either case is to assure appropriate housing and supports for individuals with supportive services needs and not simply re-institutionalize such individuals in large facilities in the community.

However, for purposes of the OPP, the term supported housing is used to distinguish housing for adults with SPMI that is as integrated as possible into the community and is scattered rather than segregated in multi-family dwellings in which many or most of the units are occupied by persons with disabilities. (See Appendix G for a side by side description of housing that meets the definitions and characteristics of these two terms.) OHA indicates it sees value in both supported and supportive housing, in part because of Oregon's housing challenges, and it intends to continue reporting the number of adults with SPMI in supportive housing in addition to the number in supported housing. In its recent January 2017 report, OHA reports 442 individuals with SPMI living in supported housing in CY 2015, and 1,321 such individuals living in supportive housing units at the end of CY 2015. Neither of these numbers has been independently verified by me as IC, and doing so may be challenging, given the definition of supported housing would require an inquiry into the circumstance of those living in other units within the dwelling.

Supported housing is clearly preferable for individuals with SPMI especially if such scattered site integrated housing is their individual choice. However, given Oregon's housing market issues, especially in urban areas like Portland,[36] it may be difficult for Oregon to meet its commitments about individuals with SPMI living in supported versus supportive housing units in the time period covered by the OPP. Similarly, while additional investments have been made in the State's housing finance agency (OHCS) for development of supported housing units, this type of development often takes multiple years, so may not be fully effectuated during the term of the OPP. Likewise, the Technical Assistance Collaborative, Inc.'s (TAC) *Priced Out 2014* comparison of the states regarding the percentage of an individual's Supplemental Security Income (SSI) payment it would take to pay for a one-bedroom or for an efficiency apartment[37] shows 95% and 82% respectively would be required to pay for such housing at the published Fair Market Rent (FMR) for such modest housing. In the last two years, the FMRs in some parts of Oregon have risen significantly, making these costs even higher.[38]

For example, the FMR amounts for the Portland Metropolitan Statistical Area (MSA)[39] at the end of CY 2015 were $682 for an efficiency apartment and $793 for a one-bedroom apartment. These FMRs for the Salem MSA were $538 and $569 respectively. In 2017, these amounts have risen to $946 and $1,053 for the Portland MSA and $546 and $612 for the Salem MSA. This represents a 39% and 33% increase in just two years in Portland and a 1.5% and 7.6% increase respectively for these types of units in the Salem area. Since many – and in fact most – low-income adults with SPMI live on or eventually will live on SSI as a source for their entire living expenses,[40] the housing market in much of Oregon is beyond their reach without living in more shared, subsidized, and perhaps less integrated settings or without rental subsidies provided by HUD. Long waiting lists exist for HUD subsidies,[41] and the Oregon's rental assistance funding is limited.

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[35] See https://portal.hud.gov/hudportal/HUD?src=/hudprograms/supportive-housing
[36] See http://www.bizjournals.com/portland/news/2016/12/16/whats-in-store-for-portlands-housing-market-in.html which describes 2015 and 2016 housing issues in Portland while offering some hope for less difficult rental markets for 2017.
[37] http://www.tacinc.org/media/51752/Table%202.pdf. TAC is working on its *Priced Out 2016* publication now for release later this Spring. Personal communication February 20, 2017
[38] See the HUD User Portal at https://www.huduser.gov/portal/datasets/fmr.html#2017 for details re FMR changes in various parts of Oregon.
[39] See https://www.census.gov for a delineation of the MSAs in the country.
[40] The SSI cost of living adjustment for 2016 was 1.7% and only 0.3% for 2017. See https://www.ssa.gov/news/cola/
[41] See https://affordablehousingonline.com/public-housing-waiting-lists for information about HUD Section 8 waiting lists, by state.

Oregon's Rental Assistance Program supports individuals in Oregon with a serious mental illness (SMI)[42] to live independently by securing affordable rental housing, Those individuals eligible for the program are homeless, at risk of homelessness, transitioning from a hospital or a licensed facility, or at risk of reentering a hospital or a licensed facility. (See Appendix H for a description of the Rental Assistance Program.) Eligible individuals may receive help with move-in assistance costs such as deposits and application fees, as well as monthly subsidies. The balance of the rent must be paid by the individual from SSI or other individual income. This rental assistance funding requires that the individual seek other rental assistance funding for which he/she is eligible such as HUD Section 8 vouchers.[43] While the Oregon rental assistance funding is a significant investment and is critical to helping individuals with SPMI find appropriate housing in the community, it is limited and cannot, in and of itself, solve the problem of inadequate number of available housing units.

Oregon's $2.35 M in new investments in the Rental Assistance Program has increased the rental assistance capacity as well as the amount of rent subsidy that can be provided based on increasing FMRs. An additional $25 M in housing development funding has been targeted for increased supported housing units which will be targeted to, but not necessarily limited to, adults with SPMI when they are finally on line in a couple of years.[44]

The data source used by OHA to report the number of individuals with SPMI living in supported housing units is now a combination of the available supported housing units (which are assumed to be at 100 percent occupancy) and individuals receiving rental assistance in existing affordable housing units that meet the definition of supported housing. (See Appendix G.) As of September 2016, only 87% of rental assistance program housing slots were filled by eligible program participants because of the difficulty in finding available supported housing units. While the occupancy rate in available supported housing units may be slightly less than 100 percent at any given time, the turnover timeframe is short so that occupancy is not significantly below that number.

As indicated by OHA in its January 2017 report, the data source used for the July 2015 report to USDOJ was a survey and therefore subject to reliability issues. Hence, the number reported for CY 2014 (614) was noted by OHA to be inaccurate. Given the lower baseline number for CY 2015 (442), the difficulty in developing additional units, and the current housing market especially in urban areas of Oregon, the ability to meet the targets for supported housing may be challenging for the State, especially in the time frame covered by the OPP, as the development of additional units as well as additional rental assistance resources may be needed.. OHA and I have discussed these challenges and particular approaches and will continue to do so. I have also discussed these challenges with service providers and representatives of county programs. I have requested and OHA has agreed to a future discussion with the State's housing finance agency and the HUD national technical assistance center to determine if additional actions can help the State to meet these challenges. In the meantime, the continued reporting of individuals with SPMI living in supportive housing as well as those living in supported housing is appropriate and are numbers OHA, USDOJ, and I will want to continue tracking.

OHA also commits in the OPP (Subsection D.15) to collect data regarding "the housing stock or inventory that is available for individuals with SPMI." This description of a housing type and a later reference in that same subsection regarding a budget request for "affordable" housing for individuals with SPMI are somewhat confusing. The goal is to increase appropriate community-based permanent and stable housing options for persons with SPMI. However, the units and/or options to count and report are

[42] The definition of SMI is similar to the definition of SPMI for purposes of this contract language. Contracts and regulations will need to be made consistent as they are updated or renewed.
[43] See https://affordablehousingonline.com/public-housing-waiting-lists
[44] See OHCS at http://www.oregon.gov/ohcs/Pages/nofa-2017-mental-health-housing-smi.aspx and http://www.oregon.gov/ohcs/Pages/nofa-2017-mental-health-housing-crisis-respite.aspx, for recent Notices of Funds Availability (NOFAs) for development of housing units for persons with serious mental illness and for crisis respite housing, applications for which are due from housing developers by April 21, 2017.

somewhat unclear. In its January 2017 report, OHA reports an inventory[45] of 53,323 units of affordable housing throughout Oregon, based on HUD definitions of affordability.[46] Theoretically, these units are available for individuals with SPMI as well as any other low-income individual eligible for such units. Given the vacancy rates of these units range from one to five percent, the actual available number of units may be significantly less. Likewise, these units are clearly not all supported housing, although may count as supportive housing in most cases.

In addition, other supported housing units and affordable housing units available for persons with SPMI may exist that are not subsidized in ways that allow counting for purposes of this inventory. In fact, individuals with SPMI may be living in supported or supportive housing units throughout Oregon with the help of families or other non-government resources. It is not likely that such units can be identified for an inventory or reported by OHA for OPP purposes. Similarly, other supported housing units need to be developed within Oregon for this and other populations in need of low-income housing supports. TAC, as the HUD technical assistance provider for federal homeless and Section 811 housing development programs,[47] continues to consult with OHA and OHCS to assist Oregon identify ways to increase housing capacity for low-income Oregonians, including those individuals with SPMI.

Finally, OHA recognizes individuals may decline housing offered to them and commits in the OPP to make best efforts to match individuals to housing that meets their needs and individual choices. This is a philosophy and culture incorporated into Oregon's housing assistance programs and will continue in the future. As the IC, I will review how Oregon incorporates choice into its housing programs and work with OHA to determine if additional efforts would increase this capacity for individuals with SPMI. However, no data or reporting on these efforts is required nor will be done as part of the OPP process.

4. Peer-Delivered Services (PDS) (Subsections D.16 – 18)

In OPP Subsection D.16, OHA commits to increasing the availability of peer-delivered services (PDS), as defined in the OPP, by 20 percent by the end of FY 2017 and by an additional 20 percent by the end of FY 2018. Given the baseline in CY 2015 as reported by OHA in its January 2017 report of 2,790 individuals receiving PDS, the target for the number of individuals receiving these services is 3,348 by June 30, 2017 and 4,018 by June 30, 2018.

The issue of the difficulty in tracking PDS is acknowledged in the OPP in Subsection D.16, but OHA and USDOJ agreed to utilize the Medicaid billing system to track and report these numbers while acknowledging it likely undercounts the number of persons actually receiving PDS. OHA also commits to exploring better and more accurate ways to count PDS and notes that it may, but does not commit to, modifying the use of Medicaid billing to track the provision of PDS.

It perhaps goes without saying that PDS are expanding in Oregon and nationwide.[48] However, the funding of these services is not just through traditional sources such as Medicaid billing. Rather, the growth in consumer or peer-operated programs, including independently run drop-in centers and clubhouses as well as programs that are a part of larger community mental health programs, has resulted in a significant increase in PDS, many of which are not Medicaid billable. In addition, the training and certification of peer professionals has increased the billable PDS but also provides for peer professionals to work in positions and settings billed as some other service such as ACT or crisis services.

[45] This OHA inventory is available online at http://www.oregon/gov/oha/amh/Pages/affordable_housing.aspx
[46] The HUD definition of affordable housing is housing for which the occupant is paying no more than 30 percent of his or her income for gross housing costs, including utilities. Glossary of Community Planning and Development (CPD), https://portal.hud.gov
[47] See http://www.tacinc.org/technical-assistance-consultation/recent-clients-projects/hud/ and https://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811 for a description of TAC's roles.
[48] Psychiatr Rehabil J, 2016 Sep;39(3):193-6. doi: 10.1037/prj0000223; retrieved February 20, 2017 from https://www.ncbi.nlm.nih.gov/pubmed/27618456

Oregon does not currently have a way to track all of these peer professionals nor does it have a way to track where they are working and what services they are delivering. There is even some disagreement whether a peer providing a licensed and otherwise billable service such as counseling should even count as a PDS or whether a service can only count as PDS if it has the characteristics of peer support or peer advocacy alone. The Office of Consumer Affairs (OCA) with OHA is tackling these data collection and definitional issues, but agrees that for now, the best indicator of PDS increases is the Medicaid billing system, even though it is capturing only a portion of the PDS provided. Given the developmental nature of this process and the commitment to work on peer- or person-directed planning processes, it is unlikely that a standardized data collection methodology to take the place of the Medicaid billing system (MMIS) will be developed and in use before the end of the three-year period covered by the OPP.

Nonetheless, the commitment is high in Oregon among peers themselves, at OHA, and within CCOs, CMHPs, and other groups concerned about behavioral health issues to increasing Medicaid billable PDS, to the support of peer-operated programs, and to the use of peers in a variety of settings and services regardless of the funding source. For example, Mental Health America of Oregon (MHAO) has a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to train CCOs and has created a non-academic specialty center as a hub for training and technical assistance for PDS.[49] The OHA Office of Equity and Inclusion (OEI) is creating a database of certified peer support specialists, with subspecialties in addiction, adult mental health, child, and family peer specialists.

The OCA is also creating a database which attempts to recognize those who are doing peer work but are not recognized or paid as such. OCA is developing a peer leadership network to promote ways the peer voice is and can be heard. The Office is also working on drafting language regarding peer supervision of peers for the regulatory process to assure that PDS remain true to their purpose of being peer driven and directed rather than subsumed under non-peer structures. Likewise, peers at OSH are working hard to incorporate peer-directed planning into treatment and discharge planning for those receiving services at OSH. All of these efforts, along with Medicaid-billable PDS in Oregon, deserve to be watched for positive developments beyond the commitments in the OPP.

5. Oregon State Hospital (Subsections D.19 – 26)

The commitments within the OPP regarding Oregon State Hospital (OSH) are primarily commitments regarding civilly-committed adult individuals at OSH (Subsection D.19).[50] Civilly-committed individuals in the OSH system (including the Junction City facility) currently represent about one-fourth of all the individuals served by OSH (1,426 in 2015; and almost 600 patients on any given day, rising to about 625 on the two campuses in November 2016). About two-thirds of the patients served are forensic individuals admitted to restore competency (aid and assist) or guilty except for insanity. The remaining approximate eight percent are either neuropsychiatric/geriatric or on other corrections/hospital hold designations.

The OSH budget for the Salem and Junction City campuses is proposed for the next biennium at almost $527 M assuming the Junction City campus closes in July 2018. The increased utilization of the hospital for forensic patients – especially those on aid and assist status – has an implication for use of these scarce behavioral health resources. The Governor has proposed to close the Junction City facility in July 2018. This proposal, if implemented, will have an impact on available inpatient beds operated by the State, and on the need for development of community-based services alternatives.

OHA's commitments in the OPP regarding OSH are primarily focused on assuring those civilly committed adults in OSH are discharged as soon as possible to appropriate places in the community to live and

[49] See https://www.mhaoforegon.org/services/

[50] Subsection D.26 applies to any individuals for whom OHA decides to utilize interim, short-term, community-based housing (that is not supported housing) for individuals ready to discharge from more restrictive settings and for whom permanent housing is not yet available. In such cases, Subsection D.26 outlines significant limitations on the use of such housing for any particular individual and the phase-out or conversion of such housing by July 1, 2019. At this time, OHA has indicated it does not intend to utilize this type of housing at all.

receive needed supportive and on-going psychiatric services. Specifically, Subsection D.20 and 22 states commitments regarding the process and timing of discharge. The process assumes individuals will be determined to be "ready to return" to the community as soon as possible (Subsection D.24) and will then be discharged within a decreasing number of days after being so determined. The OPP includes the following discharge targets for civilly committed patients determined to be Ready to Transition[51] (RTT) and placed on the hospital's RTT list:

- By June 30, 2017, 75% will be discharged within 30 calendar days of being placed on the list;
- By June 30, 2018, 85% will be discharged within 25 calendar days; and
- By June 30, 2019, 90% will be discharged within 20 calendar days.

Additionally, Subsection D.21 indicates a preference for discharging individuals within 72 hours of an RTT determination. This target is extremely aggressive given the available housing and community services available for transitioning individuals. As OSH, in collaboration with CCOs, CMHPs, and specialty OHA contractors) becomes more dynamic and facile in its discharge planning activities, the number of days to discharge may continue to decrease. On the other hand, as those who are easier to discharge or who have quicker access to available community housing and services are discharged more quickly, the ability to discharge those civilly committed patients with higher or more intense community living and service needs may mean the overall time to discharge may become more difficult to shorten. This 72-hour timeframe will be watched by OHA and the IC along with the specific discharge targets, to determine whether OHA is able to get closer to that desired performance over time.

As of January 2017, OHA reports that 50.5% of civilly committed patients placed on the RTT list were discharged within 30 days.[52] While this percentage appears to be significantly below the first target for the end of FY 2017, OHA and OSH indicate that a combination of their efforts to engage CCOs, their new contract with a specialty care coordination entity (KEPRO), and their transition to a more automated data system (Avatar) will help to improve the discharge process and timing as well as provide more accurate and up-to-date data in the future.

The concept of RTT and placement on the RTT list raise several issues to watch and review in the future. First is the definition and implementation of RTT determinations. OSH has created a Ready to Place (RTT) Form used as a discharge readiness assessment tool (see Appendix I) and a Community Living and Assessment Referral form (see Appendix J) to aid the process of discharge planning. I have reviewed these forms, but have not yet reviewed OSH patient records to determine the way in which these forms and information are being recorded in patient files and used to assist patient-centered planning for discharge. Secondly, while I have reviewed some charts of individuals on the RTT list, I have not at this point analyzed the number of individuals on the RTT list over time to determine if this number or the proportion of civilly committed individuals on the RTT list is changing. With the pressure to discharge as soon as an individual is on the RTT list, and with the changing nature of those individuals who are remaining longer in OSH, it is possible that the incentives regarding whether to place individuals on the RTT list are changing. While there is no indication that such incentives are occurring, the OSH staff and I have agreed to watch this issue over time.

Subsection D.24 commits OSH to work toward discharging 90% of individuals from OSH within 120 days of admission. This is a lofty goal. OHA reports that 37.9% of civilly committed patients were discharged

[51] Note: the OPP uses the term "Ready to Place/Ready to Transition" due to historical uses of these terms. However, "placement" is an old concept that does not adequately incorporate the concept of returning to community living in as integrated a setting as possible and with the most appropriate services possible. Hence, the term "Ready to Transition" is a more appropriate term and is being used more often within OSH and the State of Oregon as a whole, and therefore will be used in this report.

[52] Note: Subsection D.20d – e commits OHA to tracking and reporting discharges extended by a business day due to the target time period ending on a weekend or holiday. OHA reports only one individual on the RTT list fell into this category for CY 2015. Since OHA will continue reporting on these individuals and since the number is expected to be small, the IC reports will not comment on these situations unless they appear to be a problem in the future.

within 120 days in CY 2015. While the average length of stay (ALOS) of civilly committed patients at OSH is not an outcome performance target in the OPP, the ALOS is noted in Footnote 2 on page 10 of the OPP to have been 7.3 months, or approximately 220 days, as of July 2015. OSH indicates that during CY 2015, 233 individuals with SPMI were discharged from OSH, with a mean or ALOS of 228.5 days, and a median[53] LOS of 147. The median in addition to the mean or ALOS is of interest because a single or a few individuals with extremely long or extremely short lengths of stay can significantly raise or lower the ALOS in a way that is somewhat deceiving about the length of stay trends for all individuals discharged from OSH. ALOS as well as median LOS are measures OSH/OHA and the IC will track, to determine if changes raise other issues that impact targets within the OPP and within Oregon's system.

As part of the process of working to discharge most civilly committed individuals from OSH within 120 days of admission, OHA commits to have a designee of the OHA Director (identified as the OSH Medical Director) perform a clinical review of any individual who has been at OSH for more than 90 days to determine whether a continued stay at OSH is necessary, and to clearly document the justification for the individual's continued stay. The Medical Director has a process in place to personally review and approve any individual's needed continued stay for up to an additional 30 days with follow-up clinical reviews every additional 30 days even though the OPP commits that these reviews will occur every 45 days. I will review documentation of efforts "to expeditiously identify and move [an] individual [who is not found to need continued stay] to an appropriate clinical placement." (Subsection D.24.f) OSH staff indicated they do discharge readiness reviews every 30 days for patients in their care and agreed that this timeframe may need to be reduced in order to focus staff more quickly on patient transition readiness and needs. OHA/OSH commits in the OPP to review annually best practices regarding discharging individuals within 120 days of admission. I will work with OSH to consider and discuss their process and progress in this effort.

OSH has created a Community Reintegration Committee whose stated purpose is "to provide individuals at OSH with services that will assist them to live in the most integrated setting appropriate to their needs, achieve positive outcomes and prevent unnecessary hospitalization." I have met twice with this Committee which consists of the Medical Director, directors of Social Work, Nursing, as well as other clinical, benefits, services, peer, and technology leaders, including the designated point of contact for the OPP effort at OSH, the Director of Hospital Systems Analysis and Management. This Committee's meetings also include OHA staff. This Committee appears to be a strong and dedicated group, clearly aware of the OPP requirements; working hard to assure the hospital's role is to treat and stabilize individuals in their care in as short a time as possible in order to prepare them to return to appropriate community living settings with appropriate community services; and documenting their efforts as clearly as they are able. They acknowledge issues about roles of various players, about the need to document better, and about the need to clear-up and clarify (as well as audit) RTT waiting lists and discharge referral processes, especially for secure residential treatment facilities (SRTFs) and ACT services in the community. The Committee has created an extensive flow chart clarifying roles and processes, and freely engaged with me as the IC regarding ways to improve their work and results. I will be reviewing OSH documentation in the future and expect to engage further with the OSH staff and the Community Reintegration Committee as they continue their work to help OHA meet the performance outcome targets of the OPP.

Subsection D.25 of the OPP commits OHA to discharging individuals who are RTT to a community placement in the most integrated setting appropriate for the individual, considering treatment goals, clinical needs, and the individual's informed choice. OHA/OSH has created a Community Living Assessment and Referral form (Appendix J) to facilitate and document the process of making the determination regarding the most appropriate type of housing and services needed by an individual who is on the RTT list. I will review examples of the use of this form and these determinations and report on them at a later time.

[53] The median is the middle point of the range of lengths of stay, or more precisely, the quantity lying at the midpoint of a frequency distribution of observed values or quantities, such that there is an equal probability of falling above or below it.

In Subsection D.25, OHA also commits that discharges from OSH shall not be to a secure residential treatment facility unless clinically necessary." In order to assure clinical necessity, this subsection further indicates no civilly committed adult with SPMI "will be discharged to a secure residential treatment facility without the express approval of the Director of OHA or her designee." In this case, the Director's designee is a newly contracted utilization review organization called KEPRO (since October 1, 2016). This organization is contracted to provide care coordination, utilization review (including admission and continued stay decision-making), and quality review functions required by the federal Centers for Medicare and Medicaid Services (CMS) for specific types of Medicaid covered clients and certain types of services, for example:

- Care coordination (including enrollment, outreach, communication, and other quality improvement services) for those Medicaid covered individuals who are receiving services paid for through Oregon's Medicaid fee-for-service (FFS) process rather than as a member of a managed CCO;
- Comprehensive Care Coordination management (and consultation to OHA) for Oregon's overall Medicaid program;
- Nurse Triage and Healthcare Advice Line services; and
- Independent and Qualified Agent Services, as required by CMS in Oregon's 1915(i) state plan amendment and Home and Community Based Services requirements

Two of these critical functions are significant for individuals who are civilly committed to OSH and are RTT. KEPRO is required to do person-centered, peer-directed planning for discharge once an OSH patient is placed by OSH processes on the RTT list. KEPRO is working toward its obligation to begin this process at 10 days after admission and at 30 days after the individual is in OSH rather than waiting until the individual is on the RTT list. KEPRO also provides conflict-free case management for those clients for whom it is responsible, and treatment episode monitoring to assure the individual is receiving the appropriate care. Hence, for the purposes of the OPP, it is KEPRO's responsibility to track and assure appropriate services and living settings for any FFS patient or for any patient determined to need an SRTF setting upon discharge from OSH, whether Medicaid funded or not. SRTF services are not yet covered by Medicaid managed care in Oregon, although the State plans to transition this service to CCO responsibility for those covered individuals in the Medicaid managed care program.

KEPRO's role is important, but also somewhat confusing for some players at this point in the State's transition. (See Appendix K for a side by side description of the Roles of KEPRO, OSH, Choice Contractors, CCOs and Community Providers, specifically related to discharge of patients from OSH.) The Choice program (previously called Adult Mental Health Initiative or AMHI[54]) provides OHA funding to 19 CMHPs and/or CCOs which are then responsible for assisting those civilly committed individuals leaving OSH or SRTFs to connect with providers and find and be successful in the appropriate living settings in the community. This program is one of several contracts with CMHPs and CCOs to help OHA fulfill Subsection D.22 requiring OHA to enter into "performance-based contracts . . . with . . . CMHPS, CCOs, or with other entities, as appropriate" to help it pursue its commitments to return individuals who are ready to return to the community within the OPP specified timelines.

The role of CMHPs and CCOs in treatment and discharge planning processes are key, especially since CCOs are not responsible for payment or care coordination of an individual member's services while he/she is in OSH. Subsection D.20f states: "OHA agrees that discharges from OSH of members of a CCO should be consistent with the Oregon Administrative Rules. OHA will work with CCOs to help them meet their obligations regarding the discharge of their members from OSH, consistent with the Oregon Administrative Rules." OHA is in the process of revising its rules and contracts to update requirements associated with the OPP. A Rules Advisory Committee (RAC) meeting was held March 13, 2017 on OAR 410-141-3160[55] which requires CCOs to coordinate care for their members who enter OSH and develop agreements with CMHPs for management of services for adults entering and transitioning from OSH. This

[54] A description of the Choice Program can be found at http://www.oregon.gov/oha/amh/pages/cm.aspx
[55] See later section of this report on rule changes more broadly.

rule changes the requirement for CCO members to receive services to ensure discharge within five days of discharge readiness to receipt of services to facilitate discharge "as soon as reasonably possible."

As reported in OHA's January 2017 report, OSH has developed a benefits application process which includes identifying the CCO of responsibility. Likewise, the Community Reintegration Committee and I talked about ways to assure CCO involvement during a member's OSH hospitalization. In addition, the Choice contractors' role is in part to engage the CMHP in the geographic area where the individual is likely to be discharged to help in securing appropriate safety net services. OSH social work staff work to assure CCO and CMHP representatives are included in treatment planning activities. However, they acknowledge some participate better than others. In its recent Medicaid waiver request, OHA asked that CCOs be allowed reimbursement for care coordination services for individuals admitted to OSH, but this request was not approved by CMS. I will continue discussing with OHA/OSH ways to assure CCO inclusion in treatment and discharge planning for individuals with SPMI civilly committed to OSH.

The various roles of these different entities are part of training being developed regarding KEPRO's role. I will work with OHA to review and understand the content of that training and determine whether this training helps to clarify roles and processes so that they are most efficient and least confusing to OSH staff, community providers, and individuals with SPMI and their families. As IC, I have been provided the contract language for KEPRO and for Choice contractors and have provided some preliminary input to the terms and requirements in those documents. In the future, I will review these more closely to assure consistency and clarification of roles for efficiency and to assure individuals with SPMI are receiving the best possible assistance in achieving their community living needs and goals. These various entities all have functions directed toward fulfillment of the commitments in Subsections D.23b and D.25.

Subsection D.23 also commits OHA to specific requirements regarding OSH patients who are being discharged and who are appropriate for ACT services (see the earlier section of this report regarding ACT services more broadly). (See Appendix L for a Flow Chart of Referrals and Admissions to ACT Services.) OHA commits in Subsection D.23a that "[e]veryone discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative." OHA also commits to document efforts to provide ACT to individuals who initially refuse ACT services and document all efforts to accommodate their concerns, including offering evidence-based intensive services for individuals discharged from OSH who refuse ACT services or who do not meet the level of care for ACT. OHA is also committed (see Footnote 1 on page 10 of the OPP) to "provide data to USDOJ about individuals by quarter, who were offered ACT services and refused." The Draft ACT Universal Tracking Form (Appendix D) will be utilized to track refusals and dispositions in those situations and to report this data by quarter to USDOJ in the future.

Many stakeholders – CMHPs and CCOs specifically – indicated to me as IC that what counts as an "evidence-based alternative" to ACT is unclear. However, intensive case management (ICM) is one such service that providers utilize when ACT is not available or ACT services are refused by those appropriate for an ACT team. As IC, I will work with OHA and stakeholders to determine what types of evidence-based alternatives are in fact being provided for those individuals discharged from OSH who are appropriate for and refuse ACT or who are not ACT eligible.

During a recent meeting with the Community Reintegration Committee, we discussed the mutually exclusive nature of ACT services and SRTFs as a service setting. Given the nature of the discharge planning process up to now, and the changes to that process with the incorporation of Choice providers and KEPRO's role, the Committee agreed to work to clean-up the lists for those individuals determined to need ACT and those determined to need an SRTF setting. Additionally, the Committee will assure the process does not allow the same individual to be referred to both at the same time. I will review these processes again in the future to determine how OSH is proceeding with this effort. I will also review the process and documentation of determining an appropriate clinical reason for referral of an individual to an SRTF, since Subsection D.25 commits OHA/OSH to assure that "[d]ischarges shall not be to a secure residential treatment facility without the express approval of the Director of OHA or her designee," i.e., KEPRO in this case.

As noted in Footnote 50 of this report, Subsection D.26 strictly governs the use of interim, short-term, community-based housing for exceptional cases and for specified time limits. Since OHA/OSH indicated to me it does not intend to utilize such housing for OSH individuals or others with SPMI at this time, no further comment is made in this report about such housing or the process for its utilization.

Two final comments about OSH are in order here. First, the superintendent of OSH for the last several years is retiring and will be leaving in April 2017. He has led the staff, facilities, and programs offered within the Salem and Junction City facilities to be active treatment oriented with a clear goal to stabilize and return admitted individuals to community living as quickly as clinically appropriate and possible. As part of this process, the vision for OSH has been redirected to be "a psychiatric hospital that inspires hope, promotes safety and supports recovery for all." OSH's mission statement expresses the current philosophy to "provide therapeutic, evidence-based, patient-centered treatment focusing on recovery and community reintegration all in a safe environment." This vision and mission[56] has resulted from and in a culture shift at OSH which is acknowledged by staff and other stakeholders of OSH. OSH's future under the leadership of the next superintendent will be something to be watched to assure, as the staff believes and reports, continued commitment to the new culture and role for OSH as part of the OHA behavioral health/health system of care.

OHA has been engaged in an active search process for the superintendent's replacement with interviews and consideration of finalists in process. OHA hopes to be able to name a new superintendent by early summer 2017, and will identify an interim administrator or a transition leadership team from OSH until the new superintendent is in place. The current superintendent will continue in a contractual role after his retirement, to assist in the transition and be available as a consultant with OHA/OSH into the next biennium to provide needed assistance for OSH.

A challenge for the new leader, for OHA, and for the entire Oregon system will be the proposal by the Governor to close the Junction City facility in 2018 while increasing the OSH budget by three percent for the upcoming biennium.[57] This facility was opened recently in May 2015 and is now administered as part of the overall OSH services. The proposed closure of the facility caught many in the Oregon mental health and healthcare system by surprise. As IC, I have recommended to OHA leadership that this facility should not be closed without assuring some or all of the funds saved by the closure will be reinvested in housing and community-based services for individuals with SPMI. Likewise, OHA should assure the talents and training of as many of the Junction City staff as possible are utilized in community settings or at the Salem campus of OSH, if the closure proposal is implemented. I will work with OHA to follow the outcome of this proposal and subsequent closure process should it be implemented, along with its implications for the OPP civilly committed population of individuals with SPMI.

6. Acute Care Psychiatric Facilities (Subsections D.27 – 36)

A concern for OHA and USDOJ as they discussed the commitments OHA would make as part of the OPP was the use of local acute psychiatric facilities (ACPFs) other than OSH. In CY 2016, there were 434 psychiatric beds – 365 for adults not geriatric – in 16 different health systems across the state. How individuals are discharged from such facilities and the waitlist for admission to OSH from these facilities,[58] are issues of concern to OHA and to Oregon's ACPF system. As part of OHA's overall direction and culture shift including integration of behavioral health and dental care into the larger health delivery system, OHA commits in Subsection D.27 to work with local ACPFs to assure individuals discharged from

[56] See http://www.oregon.gov/oha/osh/Pages/about.aspx

[57] See news stories about this announcement on December 1, 2016 at http://ktvl.com/news/local/governor-proposes-closing-new-junction-city-campus-of-the-oregon-state-hospital and http://registerguard.com/rg/news/local/35046852-75/governors-plan-to-shut-junction-city-psychiatric-hospital-stuns-employees-local-residents.html.csp

[58] According to a PowerPoint presentation by the Oregon Association of Hospitals and Health Systems (OAHHS), approximately one-fourth of beds in ACPFs were occupied by court committed patients in April 2015, seven to nine percent of which were waiting for OSH admission. The OAHHS PowerPoint indicates an average of 14 days and up to as long as 60 days waiting for disposition to OSH or elsewhere.

ACPFs will have documentation of linkages to timely, appropriate behavioral *and* primary health care in the community prior to discharge. At this point, I have not reviewed that documentation and how OHA and ACPFs are assuring those linkages are occurring, but plan to do so in the future.

Subsection D.29 describes a desired "warm handoff" as "the process of transferring a client from one provider to another, prior to discharge, which includes face-to-face meeting(s) with the client, and which coordinates the transfer of responsibility for the client's ongoing care and continuing treatment and services." This definition of a warm handoff is included in revised rules setting forth Standards for Regional Acute Care Psychiatric Services for Adults (OAR 309-032-0850) along with requirements that the discharge planning process will include a warm handoff, a follow-up visit with a community mental health provider within 7 days, and an assessment of the housing needs of individuals with SPMI, including a consultation with the individual's CCO if they are a member of one of these entities.[59] OHA reports that it met with the Behavioral Health Advisory Committee of the OAHHS to collaborate on the standards to be included in these revised rules, and the OHA Acute Care Coordinator mentioned below is pursuing efforts with CCOs and CMHPs to assure the commitments in Subsection D.34 regarding housing and community services post-discharge are met.

Warm handoff characteristics and to whom the warm handoffs are to be made are further defined in the OPP along with the following performance outcome targets:

- By June 30, 2017, 60% of individuals discharged from ACPFs will receive a warm handoff;
- By June 30, 2018, 75% will receive a warm handoff; and
- By June 30, 2019, 85% will receive a warm handoff.

Since this is a new commitment and a new metric, OHA indicates in its January 2017 report that no baseline information is available. Likewise, the methodology for collecting this data is under discussion with acute care hospitals, as well as with CCOs and CMHPs. OHA has hired an Acute Care Coordinator to develop processes with CCOs, CMHPs, and hospitals for coordinating contact and offering community focused services for the target population in ACPFs (Subsection D.34). As IC, as of the date of this report, I had not yet visited an ACPF in a local community other than the new Unity Center program in Portland before the facility was completed and before the program opened. I will work with OHA to schedule example visits and with OAHHS to determine how this process is evolving.

Subsection D.29 also commits OHA to requiring ACPFs "to report to OHA all individuals who refused a warm handoff on a quarterly basis, and OHA shall report this information to USDOJ, beginning with data for the second quarter of year one (October 1, 2016 to December 31, 2016). OHA shall report this as aggregate data by acute care psychiatric facility." I understand OHA is still working with OAHHS to determine the process for collecting and reporting this refusal data in future OHA reports.

OHA commits in Subsection D.30 to require and report data about individuals receiving a follow-up visit with a community mental health provider within 7 days of discharge. The methodology for this outcome is consistent with the CCO metrics for other post-hospital discharge follow-ups. As such, the CY 2015 baseline for this target was 79.36%, according to the OHA January 2017 report, up from 65.9% at the end of CY 2014 as reported in OHA's July 2015 report to USDOJ. For this measure, national outcome data from the National Center for Quality Assurance (NCQA) indicates the Medicaid national percentile was 70 percent indicating that Oregon is above the 90th percentile on this measure compared to the nation as a whole. Still OHA commits to continue working to improve this outcome as part of its on-going quality improvement process.

OHA also commits to reducing recidivism to ACPFs by monitoring and reporting 30 and 180 day rates of readmission, by ACPF (Subsection D.31). As reported in the January 2017 report, these rates statewide for CY 2015 were 9.23% and 21.35% respectively. These compare to 9.7% (30 day) and 20.2% (180 day) readmission rates in CY 2014 (according to the July 2015 report to USDOJ). These readmission rates

[59] See later section of this report for the status of OHA's rule-making processes to effectuate OPP commitments.

appear to be relatively stable between the previous year and the baseline year for the OPP. In OHA's report, these readmission rates are not yet being reported by ACPF. I will work with OHA to assure these are reported by hospital system in future reports.

To help reduce recidivism to ACPFs (Subsection D.31b) and appropriate linkages to housing and services upon discharge (Subsection D.32) OHA commits to providing a management plan for contacting and offering services to individuals with two or more readmissions in a 6-month period, especially those who are SPMI and homeless, and specifically connecting the latter to a housing agency or mental health agency with access to housing in order to help ensure those individuals are linked to housing in an integrated setting, consistent with treatment goals, clinical needs, and informed choice. OHA's 20 Choice providers are responsible for helping to connect such individuals to CMHPs who have rental assistance or other housing programs to assure no one is discharged without a place to live that meets their immediate needs and without linkages to community services (see Appendices H and K and the earlier section on OSH in this report, for a description of the Rental Assistance Program and Choice providers' roles). OHA indicates it works through its contractors, as well as through CCOs and CMHPs to assure all individuals discharged from ACPFs are referred to appropriate housing[60] and receive appropriate community services. I have been told that OHA is working with hospitals on a management plan to satisfy Subsection D.31b, and I will delve further into this process with both OAHHS and OHA in the future.

Likewise, pursuant to OPP Subsection D.35, in its January 2017 report, OHA shows the cumulative ALOS for the state and by facility, with the four facilities comprising the new Unity Center serving the Multnomah County area shown with an asterisk. Watching how the opening of the Unity Center program in January 2017 affects these numbers will be important for future reports. As OHA indicates, the cumulative ALOS for all ACPFs for CY 2015 was 8.89 days, compared to 10.9 days in CY 2014. For CY 2015, these ALOSs range from 4.98 days at St. Charles System/Sage View to 12.43 days at Peace Health System hospital in Eugene). Overall, the number of individuals with SPMI whose LOS exceeds 20 days was 385 of 4,431 or 8.7% (Subsection D.35). The numbers of individuals whose LOS exceeds 20 days were not reported by facility in the January 2017 report.

The ALOS and stays beyond 20 days will be affected by the waiting time for an individual to be transferred and admitted to OSH (see Footnote 58 earlier in this report). OHA indicates in its January 2017 report that it will be able to look at how many of the discharges beyond 20 days are awaiting OSH admission, but that number was not reported this time. This number generally represents only about 5% of ACPF patients, although the length of time patients spend on the waiting list may very well affect the ALOS in ACPFs. In an October 2016 report provided to me as IC, OHA indicated that 478 individuals were on the waiting list for OSH in CY 2014, 438 in CY 2015, and 351 as of the time of the report in October 2016. Also, the percentage of individuals waiting longer than 14 days was also declining from 84% in CY 2014, 79% in CY 2015, and 65% as of mid-October 2016. The average number waiting for admission to OSH statewide ranges between approximately 30 and 50 per month. In the future, I will review these numbers and percentages with OHA to determine its progress on this goal of reducing the waiting list although these are not reportable outcomes for purposes of the required OPP reports.

Finally, note that Subsections D.28 and 39 indicate OHA will "continue with its process to enroll all or substantially all indigent individuals with SPMI not yet enrolled in Medicaid prior to discharge from acute care psychiatric facilities or emergency departments, consistent with state law." Since significant incentives exist for hospitals to pursue this enrollment process in order to bill and receive funding for services provided, no additional performance targets are named in the OPP for this process. However, OHA produced a report for me as IC indicating almost six percent of those visiting Emergency

[60] Note: Subsection D.33 of the OPP states that OHA may make use of interim housing described in Subsection D.26 for individuals who are homeless and leaving ACPFs, and that Subsection D.26b does not apply to for these individuals. That subsection would require the transfer of an individual in interim housing to long-term integrated housing within two months, and that "individuals in such interim housing shall receive all services specified in their discharge plan." As indicated earlier, in Footnote 50 of this report, OHA indicates it does not intend to utilize interim housing at this time.

Departments (ED) for a mental health reason who are self-pay (including those who choose not to obtain insurance and can truly self-pay as well as those who are unable to pay, but are unable to be enrolled in Medicaid or Medicare coverage due to being an undocumented immigrant or other ineligible status).[61] Assuming this number holds for those admitted to ACPFs, it would appear that hospitals in Oregon are doing a good job of getting individuals enrolled into coverage for which they are eligible. According to the PEW Hispanic Center,[62] the percentage of unauthorized immigrants in Oregon in 2014 was 3.2% and according to the US Census Bureau, the uninsured rate of Oregonians under age 65 was 8.3%[63] in mid-2015. While the proportion of individuals who are eligible for Medicare and enroll is extremely high nationwide, it is significant that Medicare limits payment for inpatient psychiatric care to 190 days in an individual's lifetime.[64] All of this together suggests that the five to six percent of individuals in EDs and likely in ACPFs who are self-pay is appropriate for the Oregon population. It appears hospitals are doing their best to maximize enrollment and payment sources for their services, which will carry over into coverage for community-based services once the individual is discharged.[65]

It should be noted that the impact of potential federal changes to the Affordable Care Act, and especially to states' ability to receive enhanced FFP for expanded Medicaid eligible individuals, could be substantial for Oregon, for its hospitals, and for Oregonians with SPMI. This is one of many policy issues I will be tracking over the time period covered by the OPP and of course OHA will be following and reacting to as needed over time.[66]

7. Emergency Departments (Subsections D.37 – 44)

OHA recognizes the high incidence of and makes several commitments in the OPP regarding the use of hospital Emergency Departments (ED) by individuals for mental health reasons.[67] These commitments include collecting and analyzing data related to individuals staying in EDs for over 23 hours, and providing proposals for solutions to address this issue. This issue is typically referred to as psychiatric boarding.[68] OHA commissioned the College of Public Health and Human Sciences at Oregon State University (OSU) to conduct this review which was completed in late 2016. OHA prepared a report briefing and summary of actions being taken to address this issue to add to OSU's report. Since this issue involves data and processes of Oregon hospital systems, these documents were provided first for review by OAHHS and its members and was released publicly in February 2017, with a presentation scheduled April 25 before the Legislative Human Services Subcommittee of the Oregon Ways and Means Committee, as stated in the OPP. (Subsection D.37). The data will also be used to assess the needs of individuals with SPMI who leave EDs and strategies for linking them to services at the time they leave EDs and collect data to measure the effectiveness of these strategies.[69]

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[61] See http://dailycaller.com/2017/02/22/oregon-considering-providing-health-care-to-undocumented-immigrants/ for a story about a bill being considered to cover all immigrant children in Oregon, regardless of legal status.
[62] See http://www.pewhispanic.org/interactives/unauthorized-immigrants/
[63] See http://www.census.gov/quickfacts/table/HEA775215/41
[64] See https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/medicare-coverage-of-inpatient-mental-health-services
[65] Note: this does not mean that community-based providers are maximizing that funding, but rather that Oregon hospitals are likely doing a good job of getting individuals they serve enrolled into available coverage.
[66] See later section in this report regarding policy issues to watch.
[67] Due to the nature of utilization of EDs for mental health reasons, and the nature of diagnostic processes in EDs, it is possible that data reported for this performance outcome area could include adults with immediate mental health needs who would not later be considered to be SPMI. However, as indicated earlier in this report, I do not believe these numbers to be significant and since OSH has tracked and/or reported these data in a consistent manner over time, I have no reason to believe this is an issue of concern at this point.
[68] Note: OAHHS apparently also refers to the process of holding an individual in an ACPF pending admission to OSH or other appropriate settings as "boarding." This report will use that term only for individuals with mental health issues staying for long periods of time in EDs.
[69] Note: this data is not a performance outcome with reportable targets over the time period of the OPP, although I will work further with OHA to determine how they will assess their progress on this issue over time.

In Subsection D.43, OHA states it is working with hospitals to determine a strategy for collecting data regarding individuals with SPMI who are in EDs for longer than 23 hours and will begin reporting this information in July 2017, by quarter and by region, with an effort to encourage hospital-by-hospital reporting. There is currently no baseline data for this measure, except what is available through the OSU study described below. Pursuant to Subsection D.42, OHA has and continues to meet with me as IC to discuss this issue of use of EDs by individuals with SPMI for mental health reasons.

The OPP states that "OHA agrees to meet with the Independent Consultant to discuss the use of emergency departments by individuals with SPMI who present to emergency departments by individuals with SPMI who present to emergency departments for mental health reasons, but an additional performance outcome on this issue will not be added to this Plan or otherwise added as a performance outcome." Such discussions will occur after I have had a chance to visit some hospital inpatient units and talk with Oregon hospital leaders. I will also work with OHA to assure reporting on the response of the Legislature after the OSU report on boarding is made available to them. Data in the OSU report show from October 2014 to September of 2015 the proportion of all ED visits that were psychiatric in nature reduced from about 18 percent to just under 14 percent of all admissions. During this same time period, the number of boarding in psychiatric episodes reduced somewhat (from 1,276 to 1,106), and the number of psychiatric patients in EDs reduced dramatically (from 852 to 179). On the other hand, the numbers of psychiatric ED boarding episodes by severity of mental illness was relatively stable during this period. The report also verifies that boarding in Oregon EDs for psychiatric visits was significantly higher than for non-psychiatric visits (using 6 hours as the standard definition of boarding). The average boarding time for boarded severe psychiatric visits was 27 hours (a total of 31 hours in the ED) during this timeframe, almost twice as long as the 15.2 hours for boarded non-severe psychiatric visits.[70] While these timeframes and numbers may not reflect actual or sustainable trends, they certainly suggest that psychiatric boarding in Oregon's EDs should be addressed – as across the nation – and that some of Oregon's strategies to address that issue may be having an impact, at least for the episodes involving less severe psychiatric issues.

In OPP Subsection D.40, OHA commits to efforts to reduce recidivism to EDs for psychiatric purposes by tracking the number of individuals with SPMI[71] with two or more readmissions,[72] by hospital, including the new Unity Center in Portland. In its January 2017 report, OHA reports 1,067 individuals were readmitted two or more times in a 6-month period for psychiatric reasons in all hospitals statewide during CY 2015. OHA has not yet reported this baseline data by hospital. I will work with OHA to determine how these hospital by hospital data can be provided in the future. OHA also commits to collaborative efforts with CCOs and CMHPs to develop and implement plans to address the needs of such individuals in less institutional settings where appropriate. Some of these efforts have been described elsewhere in this report. Specifically, OHA commits in Subsection D.40b to seek contract amendments to CCO contracts in 2018 that will require acute care psychiatric hospitals develop and implement plans to address the needs of these individuals in less institutional settings. As indicated earlier, rule revisions and staff specifically charged with these collaboration responsibilities are part of OHA efforts underway.

In Subsection D.41, OHA commits to reduce the rate of visits to general EDs (not including specialty psychiatric emergency services programs such as the new Unity Center in Portland). OHA reports for CY 2015, the rate of ED visits for psychiatric reasons was 1.54 persons per 1,000 Oregon Health Plan (OHP) members. That translates to the following targets for this OPP performance outcome:

[70] Note: the severity of a particular psychiatric visit to an ED does not necessarily equate to occurring with an individual who is SPMI. Likewise, a non-severe psychiatric visit could in fact occur for an individual otherwise determined to be SPMI.

[71] Note: the data OHA reports are for all persons receiving an ED visit and who have psychiatric diagnoses and have received certain mental health services as discussed earlier in this report. This may include some individuals with mental illness who are not technically SPMI, but based on data checking described earlier, I have no reason to believe this significantly overstates the number of individuals with SPMI who utilize EDs, and the data have been utilized consistently over time.

[72] OHA tracks this data by reporting the number of individuals with three or more admissions in a 6-month period.

- By June 30, 2017, a 10% reduction from baseline or 1.39 per 1,000 OHP members;
- By June 30, 2018, a 20% reduction from baseline or 1.23 per 1,000 OHP members; and
- By June 30, 2019, a quality improvement process to track whether ED visits are decreasing.

In the meantime, the work on rules and contracts with CCOs and CMHPs, and the OHA Acute Care Coordinator's work is focused on efforts to track, analyze and respond to ACPF and ED utilization by individuals with SPMI, as well as to assure better discharge planning and implementation to prevent excessive readmissions to either setting.

A word is in order here about the new Unity Center in Portland and its impact on these issues of ED utilization and psychiatric boarding, at least in the Multnomah County and surrounding areas. Unity Center represents a collaboration among four hospitals to create a single comprehensive (at this point adult) psychiatric emergency services setting complete with triage capability, clinical and medical services including pharmacy, mobile crisis response, crisis stabilization, crisis counseling, peer support (including a Living Room[73] model program), and care navigation coordination among a number of mental health, addiction, and social services providers, many of which will be co-located at the new site. I had a chance to visit the Unity Center building and talk with one of its clinical leaders a couple of months before it opened in January 2017. It will be important for me as IC and for OHA to determine how this program impacts the statistics about ED visits and crisis response in the area served by this new and promising program.

8. Supported Employment (Subsections D.45 – 48 and E.4c)

Supported Employment (SE) is a critical evidence-based program to assist individuals with SPMI to obtain and maintain competitive integrated employment (CIE) in the community. OHA commits in Subsection D.45 to track and report the number of individuals with SPMI who receive SE services and who are employed in CIE, as well as the number of individuals who no longer receive SE services and are employed in CIE without the assistance of an SE specialist. In its January 2017 report, OHA indicates 1,534 individuals received SE services as of the end of CY 2015, compared to 1,370 as of the end of CY 2014. However, there is no baseline data for the numbers in CIE as these are two new data points which the Oregon Supported Employment Center for Excellence (OSECE) has begun tracking via quarterly reports from SE programs that meet fidelity standards set by OSECE and OAR administrative rules. (See Appendix M for the new reporting format OSECE is using.) OHA is tracking this data for the purpose of improving SE services and the OSECE will utilize the information to improve training and technical assistance for Oregon's SE programs.

Oregon's 35-36 evidence-based SE programs covering 34 of Oregon's 36 counties[74] serve almost exclusively adults with SPMI. The evidence-based approach focuses almost entirely on CIE as a goal using the Individualized Placement and Support (IPS) model of SE developed and researched by Dartmouth University).[75] Hence, all the programs that meet fidelity requirements utilize this IPS model. Consequently, unless an individual decides on his or her own or via a voluntary guardian's decision to discontinue SE services or is readmitted to an inpatient or other setting in a civilly committed status, SE programs usually continue working with individuals in the program to gain the skills and opportunities to participate in CIE. In an interview with the leadership of the OCSEC in January 2017, I was told that about 45 percent of SE program participants are in CIE at any given time. According to their preliminary and internal working report, at the end of CY 2014, 1,315 individuals were being served by all SE programs with 500 working (38 percent). At the end of CY 2015, 1,594 were being served with 631 working (40 percent). As of the end of the third quarter of CY 2016, slightly fewer were being served (1,569) but more were working (713 or 45 percent). OHA and the OSECE are working to be able to verify and report these

[73] See http://www.recoveryinnovations.org/pdf/LivingRoom.pdf for a description of this peer-directed model of crisis resolution and support.
[74] See http://osece.org/supported-emp-programs/ for a map and list of programs.
[75] See https://www.ipsworks.org/about-ips/ and http://www.dartmouth.edu/~ips/page29/page31/page31.html for information about the IPS model.

numbers and the proportion of those who leave the program working in CIE in the future, pursuant to new language in its contract with OHA regarding data collection responsibilities. OHA has also worked with OSECE to incorporate updates to its rule covering SE services, OAR 309-019.[76] In the future, I will consider how OSECE is utilizing this information to change its training and technical assistance to improve SE services in Oregon.

It should be noted that neither OHA nor the OSECE currently have the capacity to follow individuals after they leave SE services to determine how many of them continue in CIE after SE services end. It is also important to note that individuals with SPMI in Oregon could be employed in CIE without the use of SE services or an SE services specialist. In such cases, OHA has no easy way to track this information. Therefore, this is one performance outcome which may not capture the full extent of persons with SPMI employed in CIE in Oregon. There are likely more individuals with SPMI being successful in some types and amounts of employment, including CIE, than OHA is able to track and report.

9. Secure Residential Treatment Facilities (Subsections D.49 – 50)

Secure residential treatment facilities (SRTFs) are locked community-based facilities in Oregon that provide a secure setting for civilly committed individuals whose clinical needs no longer necessitate inpatient care. Currently, there are 16 SRTFs in Oregon available for individuals on civil commitment.

In the OPP, OHA commits to moving civilly committed individuals from SRTFs when their clinical needs no longer necessitate a secure facility and to do so "expeditiously to a community placement in the most integrated setting appropriate for that individual" (Subsection D.49). OHA also commits that discharges of civilly committed individuals from SRTFs "shall be to housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice" (Subsection D.50). This housing must take into account the individual's geographic and housing preferences. While cost shall not be used as a justification for denying housing, the cost and availability of housing may affect housing choices, as it does for anyone living in the community. While no performance outcome measure or reporting requirement is associated with this commitment, in the future and in my role as IC I will examine some of these discharges and settings to determine compliance with this commitment.

In Subsection D.49b and c, OHA indicates an interest in reducing the length of stay (LOS) of civilly committed individuals in SRTFs and commits to the following targets:

- By June 30, 2017, a 10% reduction from baseline or 147.9 days; and
- By June 30, 2018, a 20% reduction from baseline, or 131.4 days.

In its January 2017 report, OHA indicates that as of the end of CY 2015, the ALOS for an individual who was civilly committed and in an SRTF was 164.3 days.[77]

OHA commits to regularly reporting on the number of civilly committed individuals in SRTFs, their ALOS, and the number discharged. OHA also commits to collect (and presumably report or make available) data identifying the type of and placement to which they are discharged, beginning July 1, 2017. Given the lag in data availability, these data are not likely to be available until several months after data collection begins. At baseline, i.e., CY 2015, OHA reports 36 discharged from SRTFs in CY 2015.[78] although it does not report the actual number in SPTFs during that year. I will address this issue with OHA for the future.

SRTF services are funded in part by Medicaid, but are not currently the responsibility of the CCOs. As a consequence, the new care coordinator entity KEPRO[79] as the Independent Qualified Entity to provide

[76] See later section in this report regarding rules and contracts.
[77] Note: the number for this metric found in the Comments on Progress section of OHA's January report (275 days) is a clerical error. OHA indicates it will correct this and clarify in future data or narrative reports.
[78] This number is found in the Data Specification Sheet for Subsection D.49b rather than in the report narrative.
[79] See earlier section of this report on OSH and Appendix K for a description of KEPRO's role.

utilization management for Oregon's residential system, including SRTFs. KEPRO is responsible for person-centered planning and initial as well as continued stay reviews for civilly committed individuals in SRTFs to determine if such individuals are ready to transition from a secure setting. KEPRO is also responsible to assure the services provided in SRTFs are sufficient and of high quality, and for discharge planning for individuals they determine no longer need SRTF level of care. Choice providers have the same role with SRTF civilly committed individuals as they do when such individual are in OSH,[80] so they help to find housing and appropriate community services for civilly committed individuals leaving SRTFs. OHA plans to transition SRTF services to CCOs. In the meantime, I am told KEPRO has a significant software system that tracks and reports claims and status of individuals and functions for whom it is responsible. I have been invited to look at that software system and will plan to meet with KEPRO to understand better its role, the upcoming transition, and the data it is able to provide regarding the care of individuals for whom KEPRO is the care coordinator.

This performance outcome area addresses only persons in SRTFs who are adults with SPMI under civil commitment. To the extent other types of individuals are utilizing these resources (adults placed in such facilities "voluntarily" by guardians or forensic individuals under the purview of psychiatric review boards, or individuals with geriatric needs), it will be important to understand whether civilly committed individuals with SPMI are waiting for "placement" in an SRTF but cannot find a spot – either because of SRTF beds being full or because there are no SRTFs where the individual wants to live upon discharge. And it will be important to track whether the reduction in LOS for civilly committed individuals is opening up beds for other Oregonians in need or are being "backfilled" by other types of individuals so that these resources cannot be redirected to other uses. It is always difficult to prevent beds of any type from being filled because they are there and available more than because they are the best possible setting for community-based services and supports. A visit or visits to SRTFs are planned for my future trips to Oregon. I will explore the issue of resources available for this type of service with OHA and its SRTF providers later in the OPP three-year timeframe.

To impact SRTF services more broadly, in its January 2017 report, OHA states it has provided targeted education to SRTF providers regarding Olmstead policy and the performance outcomes outlined in the OPP. As with other areas of Oregon's changing system and the OPP implementation, OAR regulatory changes are underway that will impact the use of SRTFs. OAR 309-035 governs SRTFs and is being amended to include requirements regarding community integration, client choice, and skill training to promote independence after discharge. This rule change will be discussed more fully at a later time.[81] OHA also reports it is amending Choice Model contracts for July 2017 through June 2019 to support efforts to reduce SRTF lengths of stay.

10. Criminal Justice Diversion (Subsections D.51 – 53)

In the OPP, OHA states the aspirational intent to reduce the contacts between individuals with SPMI and law enforcement due to mental health reasons, specifically to reduce arrests, jail admissions, lengths of stay in jail, and recidivism for this population. These are issues every jurisdiction in the country is dealing with and utilizing collaborative efforts, law enforcement training, jail diversion services, and intensive place-based and mobile crisis services separate from hospital emergency rooms to help accomplish. To decrease arrests and jail admissions for individuals with SPMI, OHA commits in Subsection D.52 of the OPP to the following strategies:

- Continued reporting of the number of such individuals receiving jail diversion services, as well as the number of reported diversions;
- By July 2016, collaborative work with the Oregon [State] Sheriffs Association (OSSA) and the Association of Oregon CMHPs (AOCMHPs) to determine strategies to collect data on such individuals entering jails;

[80] Ibid.
[81] See later section of this report on rules and contracts.

- By July 2016, contracting with the GAINS Center to consult on the expansion of the use of the Sequential Intercept Model (SIM)[82] by local jurisdictions;
- Tracking arrests of individuals with SPMI enrolled in services and provide data by quarter;
- Continued collecting of data regarding this population who are arrested, the county of law enforcement encounters, existing jail diversion services and their impacts, and obstacles to success of these services;
- Providing the results of any mapping and "any additional relevant data" to USDOJ and will allocate existing funding as necessary to support additional or enhanced jail diversion programs based on the results.

In order to accomplish these strategies, OHA commits to increasing jail diversion services contracts, and to include in those contracts the responsibility to report the number of diversions pre- and post-arrest with a priority for pre-charge diversion. (Subsection D.52f.) OHA also commits in Subsection D.52c to "encourage local jurisdictions to adopt and implement interventions in accordance with this [sequential intercept] model. New funding for jail diversion services will require the county to adopt the Sequential Intercept Model." In Subsection D.52a, the OPP indicates "OHA will require, under new contracts with entities providing jail diversion services, that contract providers report the number of diversions pre- and post-arrest. OHA will include this requirement in all RFPs for any new jail diversion programs." And in Subsection D.52e, OHA commits to "provide USDOJ with data quarterly from the jail diversion programs it funds, subject to paragraph F.6" of the OPP. OHA also commits in Subsection D.53 to working with local jurisdictions to develop strategies to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of individuals with SPMI who are incarcerated, in order to assure continuity of care while in local jails.

OHA was provided funding and solicited contractors for new and expanded jail diversion services in late 2015 (see earlier section in this report regarding financial investments showing increased jail diversion funding), prior to the finalization of the OPP in July 2016. The Request for Proposals (RFP) for that expanded funding does require the utilization of SIM and requires quarterly reporting. However, the newly amended quarterly reporting template for this program (see Appendix M) requesting reporting of pre- and post-arrest data came into use in late 2016. As a result, there is no baseline data on pre-charge jail diversion services or types of services being received by those individuals with SPMI encountering law enforcement. However, OHA was able to report in January 2017 that 1,409 individuals received jail diversion services in CY 2015. In addition, while it required special work with jail diversion programs, OHA was able to report that 499 of these individuals received services pre-arrest (35.4 percent), and 910 received post-arrest diversion services. These numbers can be expected to grow substantially as full-year data is available, the quarterly reporting requirement is included in amended contract language for FY 2018 and FY 2019, and new and expanded services come on line. The proportion of pre-arrest services can also be expected to grow, given the new attention to this area as a priority for the jail diversion contractors.

OHA contracted with the SAMHSA GAINS Center (via Policy Research Associates, Inc.) in early 2016. The GAINS Center staff conducted an Oregon Statewide Summit January 20 – 21, 2016 for 94 individuals from across Oregon's behavioral health and criminal justice systems to introduce and emphasize use of SIM as a planning tool, identify opportunities for coordination and collaboration among state and local stakeholders, inform these stakeholders about best practices in the behavioral health and correctional fields, and consider the impact of health reform and state behavioral health and criminal justice initiatives on justice-involved populations. Out of this summit emerged ten recommendations. The summit report[83] includes recommendations as well as relevant information from national and past Oregon efforts. One appendix to this report is the executive summary from a USDOJ Bureau of Justice

[82] See https://global.oup.com/academic/product/the-sequential-intercept-model-and-criminal-justice-9780199826759?cc=us&lang=en& for a publication released February 2015 describing SIM, its history, and current uses.
[83] OHA indicates it plans to post the GAINS Center summit report on the OPP website at http://www.oregon.gov/oha/bhp/Pages/Oregon-Performance-Plan.aspx.

Assistance document entitled *Corrections and Reentry: Protected Health Information Privacy Framework for Information* Sharing[84] which provides critical suggestions about the difficult issue of sharing medical/behavioral health information across mental health and jail settings.

After the summit, on February 16 – 17, 2016, select participants attended a train-the-trainer event to begin disseminating this information and training to their communities. Thirteen volunteers became SIM mappers, although it is unclear how OHA will track the expanded use of SIM throughout Oregon or how it will maintain trained trainers over time. No targets or data reporting requirements about this desired outcome were proposed or intended. However, OHA indicates in its January 2017 report that it will be following up with the community SIM trainers to determine next steps.

OHA now has agreements with Eastern Oregon Human Services Consortium (EOHSC) and the Oregon Department of Public Safety Standards and Training (DPSST) Center of Excellence for Crisis Intervention Team (CIT) Training. CIT is an innovative model[85] of community policing to help law enforcement (and other first responders), mobile crisis teams, and mental health providers collaborate in situations in which individuals with mental health issues are encountered by law enforcement personnel. These agreements provide funding to increase CIT capacity and services for law enforcement throughout the state.

OHA has also been engaging directly with OSSA and the Oregon Association of Chiefs of Police (OACP) on law enforcement's involvement with individuals with mental health issues. OSSA and OACP recently developed a joint workgroup to address issues of persons with mental illness interacting with law enforcement, especially when it seems clear to law enforcement personnel that an individual needs treatment rather than incarceration yet is unable or unwilling to consent to such treatment. I, along with the local USDOJ attorney working on these issues in Oregon and the OHA leader on mental health policy met, presented, and listened to input about these issues at a joint meeting of OSSA and OACP in September 2016. OHA leadership committed to follow-up with the joint behavioral health workgroup and did so, but was asked to wait until the joint workgroup had developed and presented to their respective organizations their legislative proposal recommendations. In early 2017, OHA leadership was preparing to reach out again to determine the status of this workgroup's efforts.

In 2016, OHA hired a former staff person from the Oregon Department of Corrections to lead this jail diversion and law enforcement related work. She brought significant experience and understanding to this role. Unfortunately, she left to take another position in another State department in December 2016. I met with her before she left and learned that her work at OHA included engaging with the State's Criminal Justice Commission (OCJC), OSSA, OACP, and the Oregon Sheriff's Jail Command Council (OSJCC), an association of jail managers across the state. She also began work with OHA staff who lead on health information privacy and confidentiality issues pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA) and federal regulations referred to as 42 CFR Part 2, the latter of which implements federal laws providing special protections and requirements about the sharing of information about individuals' substance use disorder assessment and treatment. These two federal laws make sharing of individual treatment data between clinical and law enforcement agencies challenging.[86] While the federal government worked to clarify HIPAA requirements for mental health purposes,[87] and has announced the promulgation of new regulations in March 2017 making sharing of addiction treatment information somewhat easier under 42 CFR Part 2,[88] the challenges are still significant and will require considerable time and expertise to navigate. It should be noted that OHA has formed an internal Behavioral Health Information Sharing Advisory Group "to help improve care coordination. This group is

[84] See https://www.bja.gov/Publications/APPA-Corr-Reentry-Health-Info.pdf for the full guidance document.
[85] See http://cit.memphis.edu/pdf/CoreElements.pdf and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/ for a description of the CIT model, its origins, elements, and successes.
[86] See https://newsletter.samhsa.gov/2016/02/24/comment-on-records-confidentiality-rule/
[87] See https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/
[88] See https://www.samhsa.gov/newsroom/press-announcements/201701131200 and https://www.federalregister.gov/documents/2017/02/16/2017-03185/confidentiality-of-substance-use-disorder-patient-records-delay-of-effective-date

focused on developing a strategy to support integrated care and services by enabling the electronic sharing of behavioral health information between providers."[89] This group's expertise and activities may help in the data sharing processes required by the OPP.

The OHA staff person who left had begun work on a SIM mapping tool for use statewide, and work with AOCMHPs to determine ways to do a data match of individuals with SPMI in jails who are enrolled in and receiving services from CMHPs (for Subsection D.52d). OHA indicates it is in the final stages of implementing a Memorandum of Understanding (MOU) with the Oregon Criminal Justice Commission to get the data needed regarding individuals enrolled in mental health services that are arrested. The MOU will be retroactive to July 1, 2016, the effective date of the OPP. This data will be reflected in OHA's July 2017 report. An Intergovernmental Agreement to share Law Enforcement Data System (LEDS) data with OHA is underway, and OHA states this agreement will be in place by April 2017. This methodology will be more robust than previous plans to collect this data via the safety net outcome data system. The loss of the OHA staff person is significant since this area of work requires significant collaboration and development over time. Existing OHA staff has continued work to manage the jail diversion contracts and collect the data reported quarterly by these program. However, it is unlikely that significant additional progress will be made on collaboration and data collection and sharing until another staff person with similar background and experience is hired and on board, projected by OHA for Spring 2017.

At this point, it is unclear to me as the IC whether these commitments and efforts alone will reduce arrests, jail admissions, jail lengths of stay, and recidivism as hoped by OHA. The obstacles to success in this area are significant, not only in Oregon but in the country as a whole. While individual local areas have seen some success, including in Marion County and other local jurisdictions in Oregon, it is not as easy to accomplish these goals across an entire state. In this OPP process, no data on issues other than jail diversion services were available as of the CY 2015 baseline. It is unclear what are the "other relevant data" requested by USDOJ and committed to by OHA in Subsection D.52f and no target or date by which such data will be provided, although OHA has committed to posting any such additional data online as part of its quality management program, as such data are available.

Finally, this is another area in which services and numbers of persons served could be under or overcounted. It is possible that CMHPs and CCOs are providing or paying for jail diversion services that are not being characterized as jail diversion but actually do help to divert individuals with SPMI who would otherwise be in jail (e.g., in mobile crisis services; see earlier section in this report about crisis services). On the other hand, it is unclear to me as IC at this point whether all the jail diversion services reported are being provided exclusively for individuals with SPMI. The 2015 jail diversion services RFP makes a distinction between individuals who are SPMI and those who are SMI but the reporting template does not make this distinction. It is highly likely that most of the individuals served are in fact SPMI pursuant to the way in which OHA is categorizing such individuals for data reporting for the OPP. However, it is also possible that individuals who are not SPMI but who are interacting with law enforcement due to mental health issues are being included in jail diversion service counts reported by the funded programs.

Quality and Performance Improvement (Section E)

In Section E of the OPP, OHA commits to continuing development and implementation of a quality and performance improvement (QPI) system with specific inclusion of the ten performance outcomes described in Section D of the OPP. The expressed goals of this effort is to ensure substantial compliance (Subsection E.6) with the outcome measures and to ensure that the described community-based services for individuals with SPMI are offered in accordance with the OPP. OHA indicates its intent to ensure the mental health and other services and supports described *and funded by the State* (emphasis added) are of good quality and sufficient to provide reasonable opportunities to help individuals achieve increased independence and greater integration into the community, as well as avoid negative outcomes (e.g.,

[89] See http://www.oregon.gov/oha/bhp/Pages/Behavioral-Health-Info.aspx

harm, hospitalization, contacts with law enforcement, and institutionalization). OHA does note, however, that neither Olmstead[90] nor the OPP establish a level of benefits or standard of care for these services.

QPI Governance Structure

OHA commits in Subsection E.2 and 3 to maintain a system for accountability through a governance structure, specific components of which are described in the OPP and are elements of OHA's USDOJ project governance structure, the specific components of which may be modified in consultation with the IC. The only modification at this point is the shift of the USDOJ Agreement Stakeholder Advisory Team to a newly revised and comprised OPP Stakeholder Advisory Team as described below.

OHA's QPI system starts with OHA's overall governance system beginning with Oregon's Health Policy Board (HPB), meeting notices and minutes of which are found on OHA's website.[91] A presentation to the HPB was made in December 2016 about behavioral health, specifically about the Behavioral Health Collaborative work underway.[92] This presentation included draft recommendations being considered at that time, including a recommendation to create a minimum data set for behavioral health to be used by alpha sites, clinics, and clinicians across Oregon that prioritizes client level outcomes. An update on behavioral health issues was presented to this group in January by the OHA Director.

The lead for OHA's Quality Management Team met with me in my role as IC in January 2017 and provided me information regarding OHA's internal and external quality management structure and activities.[93] (See Appendix N for a visual of OHA's Quality Management Structure and Activities, the latter noting the OPP and behavioral health elements are scheduled for discussion.) Behavioral health issues are being incorporated into the internal Quality Council and external Quality Health Outcomes Committee (QHOC) work, with presentations about the OPP, its metrics, and implementation activities, planned for May and December.

Two specific stakeholder teams are part of the OPP performance outcomes accountability structure. The first is the OPP Stakeholder Advisory Team[94] comprised of a diverse cross section of diverse stakeholders, including a minimum of 20% individuals with lived experience. This group's role is to review and comment on progress towards meeting the performance outcomes specified in Section D of the OPP, and provide advice to OHA regarding the strategies being employed. This group has been reconstituted from the previous such group since the previous agreement is no longer in effect and the OPP commitments OHA is now working to achieve are somewhat different from previous measures. This newly comprised Team met once in January, and I joined this Team's second meeting in March 2017. Additional meetings are scheduled throughout 2017, and I will participate as IC in as many as possible.

The second team is the Olmstead Plan Stakeholder Team which is comprised of members of the Addictions and Mental Health Planning and Advisory Council's[95] Housing and Olmstead Subcommittee, the USDOJ Agreement Stakeholder Advisory Team, OSH's Community Reintegration Committee,[96] and Oregon's Consumer Advisory Council (OCAC).[97] This Team's role with regard to the OPP is similar, that

[90] The OPP cites the *Olmstead* decision at 527 U.S. at 603, n.14 for this concept.
[91] See http://www.oregon.gov/oha/OHPB/Pages/2016-OHPB-Meetings.aspx
[92] See description of the Behavioral Health Collaborative's recommendations later in this report.
[93] See http://www.oregon.gov/oha/metrics/pages/index.aspx; http://www.oregon.gov/oha/analytics/Pages/index.aspx. See also http://www.oregon.gov/oha/hpa/csi/QHOCDocs/1-9-2017%202017%20QAPI.pdf for a January 2017 presentation regarding the OHA quality assessment and performance improvement system and activities.
[94] Note: In the OPP, this group is referred to as the USDOJ Agreement Stakeholder Advisory Team.
[95] This is the planning council required by the federal government in order for a state to receive federal MHBG funds. See http://www.oregon.gov/oha/bhp/amhpac/Pages/index.aspx for more information about Oregon's council.
[96] For information about this committee, see the earlier section of this report about OSH. See also, https://www.oregon.gov/oha/osh/Pages/Community-Integration.aspx
[97] See http://www.oregon.gov/oha/amh/Pages/ocac.aspx for information about the OCAC which advises the Director of OHA about behavioral health issues for all populations and services. Oregon utilizes other advisory groups and groups to disseminate information. For example, the Oregon Behavioral Health Network includes CCO, CMHP, and

is to review and comment on progress and provide advice on strategies being employed. This Team has additional roles regarding *Olmstead* decision issues more broadly. While this Team is not yet fully formed or implemented, I have been joined in many of my meetings with OHA by the staff person who will be leading this Team. I understand this team will begin meeting in May 2017. I will work with OHA staff to determine the best time and manner for me to understand this Team's ongoing role and activities with regard to the OPP. Minutes of meetings, formal correspondence and reports that may issue from these two groups are to be provided to USDOJ and the IC, pursuant to Subsection E.3a of the OPP. The minutes of the meetings of both these teams will be posted on the OHA website when they are available.

In Subsection E.4a – d, OHA commits to four elements of a QI system for behavioral health services, specifically for mental health services for individuals with SPMI (Subsection E.7):

- Data collection and analysis, including identifying trends, patterns, strengths, successes and problems;
- Regulations and performance-based contracts with CMHPs and other providers, either directly or through CCOs;
- Annual fidelity reviews of ACT and SE service providers by the centers for excellence for these services, provide technical assistance, and take action to remedy deficiencies; and
- Corrective action plans for CMHPs and CCOs which are acting in a way that will frustrate substantial performance of the OPP, with timelines for implementation, oversight, and monitoring by OHA.

While all of these elements have been discussed in some fashion within earlier sections of this report – especially ACT and SE services, further discussion about data collection and analysis and about regulations and contracts is included below.

Data Sources

OHA currently uses primarily four data sources to capture information provided in its January narrative report about OPP performance outcomes. The data source used for each performance outcome is provided in the data specification sheets appended that report.

The Medicaid Managed Information Systems (MMIS) is the primary data source about services delivered. MMIS captures Medicaid billing information for Medicaid eligible services by Medicaid eligible providers for Medicaid eligible and enrolled individuals. This system is governed by federal and state requirements and the data entered is audited to assure client, service, and billing information is as accurate as possible. CCOs are expected to submit all claims within 180 days of the date of service. Billing capacity and the need to first seek other resources that might be available[98] means there is often a data lag for complete information in MMIS, although most billing data is entered within 90 days.

Beginning in 2014, Oregon began using a client level service data system to capture service, event, and outcome data for non-Medicaid eligible individuals and services provided by state licensed behavioral health organizations such as CMHPs. This system is called the Measures and Outcomes Tracking System (MOTS).[99] MOTS is also used to capture event data and provides dashboards and other reports about individuals who are civilly committed, crisis services events, and other critical information captured by MOTS for both uninsured and Medicaid eligible individuals. OHA indicates the MOTS data have become increasingly accurate and complete as OHA has increased contract requirements and technical assistance on the use of MOTS. MOTS service data is required to be entered within 30 days of the

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other stakeholder representatives to facilitate information sharing and input about various aspects of Oregon's behavioral health care delivery system for adults, children/youth, and seniors.

[98] Medicaid is a payer source "of last resort" meaning any other available source of funding such as Medicare or commercial insurance must be sought before seeking reimbursement from Medicaid. For further information on this federal provision, see https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/downloads/tpl.pdf

[99] See MOTS website at http://www.oregon.gov/oha/amh/mots/Pages/index.aspx

service provision or event, and profiler status is captured at entry and every 90 days. The data lag in this system is similar to that of the MMIS, and according to OHA, processes are in place to assure accuracy of the data submitted.

The Avatar[100] system is a relatively new Electronic Health Record (EHR) system utilized by Oregon State Hospital (OSH) to track admissions and discharges as well as treatment and discharge planning, and assessment and clinical data to direct and capture treatment provided for individual patients at OSH. Avatar is now being utilized by OHA to report on OSH data required by the OPP.

OHA uses surveys, monthly or quarterly service reports, and other special data capturing approaches for specific performance outcome information not captured in MMIS or MOTS. These are described in the OHA January 2017 report and in earlier sections of this IC report. Monthly and quarterly special reports are generally accurate and timely based on contractual requirements and the process for how data are collected, although matching with MMIS or MOTS may be required before reporting can occur. Auditing of these data sources is less rigorous or routine. Data provided from these quarterly reports generally represent the number from the last quarter of the reporting period.

OHA has other data systems for other purposes, including the Oregon All Payer All Claims Database (APAC)[101] which is a large database that houses administrative health care data for Oregon's insured populations, including medical and pharmacy claims, enrollment data, premium information, and provider information for Oregonians who are insured through commercial insurance, Medicaid, and Medicare. While this data system is critical for some purposes, it is generally not used for reporting on the OPP performance outcomes.

OHA has also partnered with the Oregon Health Leadership Council[102] to create a data system called Emergency Department Information Exchange (EDIE) system[103] which provides real time notifications and key care summaries for patients who visit EDs frequently to provide quicker or better referral for care coordination and outpatient care, especially for those with complex health issues, to help avoid frequent use of hospitals EDs. A complementary system called PreManage[104] allows hospital event data to be pushed to health plan, CCO, and provider groups on a real-time basis for specified member or patient populations to enable timely and informed care coordination, population management and discharge planning. OHA is making this data system available to ACT teams to help with care of individuals with SPMI receiving ACT services. These data systems are helping with care coordination and improving service provision, but are generally not used as resources for data reporting.

Finally, Oregon has an older and no longer reliable system that tracked State funded inpatient services only. This system – the Oregon Resident Care Services System – is no longer the source of data reporting for this service, having been replaced largely by MMIS for this purpose. The KEPRO entity described earlier in this report also manages a data system for utilization and quality review of individuals and services for which it is responsible, including FFS Medicaid clients and SRTF services. This system is a significant data source for care coordination purposes, but is not generally a source for data reporting.

Metrics Committees and Utilization

The Oregon Metrics and Scoring Committee[105] was established in 2012 for the purpose of recommending outcomes and quality measures for CCOs. As such, these are metrics primarily for Medicaid and include

[100] See Secretary of State Audit Report from September 2015 at http://sos.oregon.gov/audits/Documents/2015-23.pdf
[101] See APAC website at https://www.oregon.gov/oha/analytics/Pages/All-Payer-All-Claims.aspx
[102] See http://www.orhealthleadershipcouncil.org/ for information about this collaborative council and its functions.
[103] See EDIE website at https://www.oregon.gov/oha/OHIT/Pages/Programs.aspx real-time notifications and key care summaries for patients who visit the emergency department frequently,and information at http://www.orhealthleadershipcouncil.org/our-current-initiatives/emergency-department-information-exchange-edie
[104] Ibid.
[105] See http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

national and state established metrics used to track system performance and provide incentives to CCOs and hospitals. Since Oregon is moving to a larger integrated Oregon Health Plan model,[106] incorporating more and more individuals and services into the Oregon Medicaid program, this metrics committee is critical for the future. Currently follow-up after hospitalization for mental illness and depression screening are included in the 2017 CCO incentive measures and benchmarks.[107] Additional measures will need to be presented and discussed by the committee members before consideration is given to including them in future CCO incentive measures.

Not all metrics for QPI purposes and not all metrics used to incentivize service delivery are included in CCO incentive measures. The desire for metrics and incentives is high nationwide. Yet the ability of health delivery systems to track numerous metrics and to receive financial or other incentives based on those metrics is limited. Many entities, from purchasers and payers to accrediting and quality review bodies, are grappling with how many and what kind of metrics and incentives to track and use. Pressure continues by managed care organizations and providers to balance the need for data and incentives with the need for standardization, limits on cost of data collection and analysis, and ease and cost of data reporting. As Oregon grapples with these issues, national trends will be relevant and useful in understanding both possibilities and pushback. Separately tracking and reporting specific behavioral health metrics may be necessary for some time, along with specific incentives in CCO and behavioral health services contracts

In light of Oregon's desire to have a common integrated Oregon Health Plan approach, a new overarching incentive metrics committee was established by the Legislature in mid-2015 to coordinate incentive metrics across all health systems. Senate Bill 440[108] established the Health Plan Quality Metrics Committee as part of the Oregon Health Policy Board's responsibility. This new law requires a strategic plan for health metrics across systems and creates this new metrics committee (as well as a workforce and other critical planning and coordinating committees) beginning in 2017. Influencing this new committee as well as the OHA Metrics and Scoring Committee to include additional behavioral health measures will not be easy. This process bears watching, and I will work with OHA staff to determine how behavioral health and especially the OPP performance outcomes are being included in the evolving QPI system.

Subsection E.4a – b of the OPP specifically commits OHA to:

(i) Identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including but not limited to, quality of services, service gaps, accessibility of services, and the success and obstacles to serving individuals with SPMI;
(ii) Develop preventative, corrective, and improvement measures to address identified problems and build on successes; and
(iii) Track the efficacy of preventative, corrective, and improvement measures and revise these measures as appropriate.

All these processes are typical of QPI programs and processes. Some have been described in this report and will no doubt be described further in future OHA and IC reports. However, no specific reporting or outcomes are required by the OPP other than in Subsection E.5 which indicates OHA's performance will be measured by whether it substantially complies with Section D. and whether OHA establishes or maintains the QI measures required by Section E. The OPP makes clear however, that "Section E . . . shall not be used to establish additional performance metrics for which OHA or the State would be responsible." Hence, my work as IC with OHA on these QPI commitments will be to discuss and watch

[106] See http://www.oregon.gov/OHA/healthplan/Pages/index.aspx
[107] See http://www.oregon.gov/oha/analytics/CCOData/2017%20CCO%20Incentive%20Measure%20Benchmarks.pdf. Other measures for children and youth mental health and for alcohol use screening are included.
[108] See https://www.oregon.gov/oha/analytics/Quality%20Metrics%20Committee%20Docs/Senate_Bill_440.pdf for the language of this bill.

the evolution of the behavioral health aspects of the OHA Quality Management system and whether it is sufficiently developing to help assure and improve quality of services for individuals with SPMI over time.

Finally, it should be noted that OHA has also embarked on a mental health mapping process to track trends in mental health service delivery and needs over time. Data from 2015 has been mapped and made available by county on the OHA website.[109] While this information is broader than the issues and population of concern in the OPP, it is worth watching these data as they unfold over time and for the state as a whole.

Contracts – Process and Status

The OPP includes many references to contract (see especially Subsections E.4b and F.6) and rule changes as a way to assure compliance and improvement of behavioral health services in Oregon's system, and especially for individuals with SPMI receiving the specific services identified in Section D of the OPP. This IC report comments on many of those efforts in the sections about each performance outcome. This section of the IC report will describe contracting and regulatory processes in preparation for further discussion about these issues in future IC reports.

Contracts – Many contracts are in place or in process and are important for OPP implementation issues. As IC, I have been provided, have reviewed (at least cursorily), and in some cases made comments on OHA's current or amended contracts (or RFPs) with its CCOs, CMHPs, KEPRO, and some specific service providers (e.g., jail diversion and mobile crisis services). OHA is working to assure these multiple and complex processes and documents, often moving on different timelines and through different parts of OHA and the Oregon system, are consistent in their definitions and requirements. However, this is no small task, and this process is not complete. I will be reviewing these documents more fully in the future, especially as the documents are finalized or revised, to determine what if any inconsistencies or language issues may need further adjustment in order to best implement the OPP. I will report on these efforts in future reports. The process and timelines for contracts with CMHPs and with CCOs are important to note now so commitments and performance on OPP outcomes can help inform future revisions of these contracts.

CMHP Contract Timeline – The revised CMHP contracts covering FY 2018 and FY 2019 (July 1, 2017 through June 30, 2019, the last two years of the OPP timeframe) are almost complete now and must be fully signed and executed by June 30, 2017. Significant changes to these contracts have been made incorporating OPP commitments as well as legal and financial changes. The process for developing CMHP contracts is done by OHA in conjunction with the State's procurement office and State attorneys, as well as with CMHPs, specifically through AOCMHP. OHA began its review and drafting process on these new contracts in mid-2016 with service descriptions drafted by September and county/CMHP review beginning that month. County/CMHP (and tribal) review and approval of the boilerplate and service descriptions began in December 2016 while non-county service description contracts were being written by OHA. Draft county agreements were sent to counties/CMHPs in March 2017 with final county agreements sent for review in April to begin the County signing process. In August and September of 2017, OHA will work with Counties/CMHPs to write and execute any contract amendments needed due to changes from the Oregon Legislative session scheduled to end July 10, 2017.

This process means that CMHP contracts for the first two fiscal years immediately following the end of the OPP (that is, FY 2020 and FY 2021 from July 1, 2019 through June 30, 2021) will be in development in the last year of the OPP timeframe, about mid-2018. Early 2018 will be an important time to consider what changes need to occur to implement OPP commitments going forward or to address issues arising from OPP experience. It will also be a critical timeframe for coordination with CCO contract development.

CCO Contract Timeline – CCOs were selected by a procurement process resulting in a five-year contract that ends December 2018. The new five-year contract will cover CY 2019 – CY 2023 (January 1, 2019

[109] See https://www.oregon.gov/oha/amh/Pages/bh_mapping.aspx

through December 31, 2023). The procurement for that process will depend on the results of the 2017 Oregon legislative session and any federal rule changes that may occur in the next year. That RFP or Request for Applications (RFA)[110] process will likely commence during late CY 2017 or early CY 2018.

Each year, CCOs sign a new one-year contract restatement of the five-year contract updating language required by state legislative or federal action along with rate changes determined by Medicaid rate development processes. The CCO boilerplate language remains relatively unchanged over the five-year process. The CCO contracts for CY 2017 were just completed in December 2016. CCO contract revisions for CY 2018 – the fifth year of this contracting cycle – is currently being developed and will be finalized in December 2017.

The process for the new five-year contract for CY 2019 through CY 2023 will begin in August 2017. OHA has tentatively scheduled time in the fall of 2017 (likely November) for USDOJ and IC review for OPP components. CCOs will be engaged beginning in December 2017 with all stakeholder input received and incorporated as appropriate by April 2018. Legal review and review by CMS will occur beginning in the Spring of 2018 with final contract template approved and signature processes beginning in the late fall of 2018. As indicated above, if an RFP or RFA process must be utilized, the process will likely commence in late CY 2017 or early in CY 2018.

Given these timelines, it will be critical to become familiar with the current CCO and CMHP contract language and changes needed for contracts beginning January 2019 (for CCOs) and July, 2019 (for CMHPs). Both these process will be in full swing during the last year of the OPP timeframe (FY 2019). The KEPRO contract recently executed in October 2016 also runs through June 30, 2019. Other contract language for service providers may be in process during this same time period. I will continue to work with OHA to determine the best approach for input to these processes as they continue and evolve. Table 2 below shows the tentative timelines for the upcoming CMHP and CCO contracting process.

[110] States' RFP and RFA processes varying depending on the type of contract and federal and state requirements.

Table 2:
Tentative Timelines for CMHP and CCO Contracts 2016 – 2019

MONTH	CCO 5-YEAR CONTRACTS (1/1/2019 – 12/31/2023)	COUNTY/CMHP 2-YEAR CONTRACTS (7/1/17 – 6/30/19)
February – March 2017		OHA begins processing County/CMHP agreements
March – April 2017		County/CMHPs review draft and final agreements
June 30, 2017		Contracts executed for 7/1/17 start date (for contracts through 6/30/19)
August 2017	OHA contract review and redesign begins	
July – September 2017		Contracts amended based on changes required from 2017 Legislative session
November 2017	USDOJ and IC review for OPP components	
December 2017	Contract templates out for CCO review	
April 2018	Contract template language updated with stakeholder input	
June 2018		OHA contract review and redesign begins
August 2018	Contract templates to CMS (45 days)	County/CMHP service descriptions review process begins
September 2018		AOCMHP review process begins
October 2018	CMS approval anticipated; signature ready contracts to CCOs to sign (within 60 days, by mid to late December 2018)	County/CMHP boilerplate template review process begins
December 2018	Executed copies to CMS	
Fall 2018 – Mid-2019	*KEPRO contract revisions begin w/ final contracts for FY 2020 and FY 2021 (7/1/19 – 6/30/21) completed by July 1, 2019*	
January 1, 2019	Five-year contract begins	
February 2019		OHA begins processing County/CMHP agreements; OHA begins drafting non-county service description contracts
March – April 2019		Counties/CMHPs (via AOCMHP and the OHA Behavioral Health Network) review draft and final agreements
June 30, 2019		Contracts executed for 7/1/19 start date (for contracts through 6/30/21)
July – September 2019		Contracts amended based on changes required from 2019 Legislative session

Regulations – Process and Status

OHA has made and continues to make considerable effort to revise and develop rules through the Oregon Administrative Rules (OAR) process to implement the OPP. As with contract language, I as IC have been provided copies of rule revisions underway or being considered and have met with staff and provided input to some of these processes and language. Given these processes are still underway, more discussion of regulatory language will be included in future reports after these rule-making process are completed and language is finalized.

The rules identified in the OPP are primarily OAR 309-019 (Outpatient Addictions and Mental Health Services), OAR 309-032 (Acute Care), and OAR 309-036 (Community Mental Health Housing Fund). Several other rules referenced in or related to these rules must also be revised as these rules are revised.[111] Other rules governing general matters (e.g., ACPFs and EDs) may be involved as this OPP process evolves. The rule-making process is managed by the OHA Health Systems Division[112] in conjunction with the Secretary of State's office[113] and includes development and publication of temporary rules when time is of the essence and finalized permanent rules once the full process has been completed. Stakeholders are engaged along the way and a formal public Rules Advisory Committee (RAC) meeting and a public hearing is held before permanent rules are finalized.

OAR 309-019, which affects ACT, SE, mobile crisis, and crisis hotline services among other things, was amended effective January 1, 2017 and was subsequently reopened for additional revisions incorporating provisions of the OPP. The acute care rule affecting EDs and ACPFs was also amended temporarily, effective January 1, 2017. Both are on a similar timeline for permanent rule-making. Rule 309-036 is also in process to be permanent as of June 30, 2017. Stakeholders were engaged about these rules beginning in January 2017, and the stakeholder review process for comments and edits on draft rules began prior to late February 2017 RAC meetings. Rule drafts and fiscal impact statements will be completed in March with final OHA administrative and management review through early April 2017. Final rule drafts along with fiscal impact statements will be completed and provided to the public along with a public hearing notice in mid-April, at least 49 calendar days prior to the hearing to be conducting in early June 2017. Edits resulting from input received at the public hearing will be completed in mid-June with the permanent rules becoming effective June 23, 2017.

Some content for these permanent rules is already developed (e.g., standards for ACT and SE fidelity assessments). Other content is in process (e.g., standards for mobile crisis services and locally operated crisis hotlines). However, OHA is working to have all the relevant permanent rules to implement the OPP in place by the end of this FY 2017. While rule changes are underway at this time, future rule-making and revisions are possible as the OPP process continues to unfold.

Use of Website for Transparency

Subsection E.5 commits OHA to further system transparency by posting on its website semiannual reports regarding its QI efforts under Section E of the OPP. As is evident by many of the references and footnotes in this report, Oregon makes wide use of its OHA website for various documents, information, and data reporting, including posting its reports about OPP data and status. The timing of the special semiannual reports about QPI efforts on behavioral health or the OPP has not been set at this time.

[111] For example, OAR 309-008 is in the process of being amended with a RAC meeting held February 28, 2017. This rule governs corrective action plans, an issue of interest in the OPP, especially in Subsection E.4d.
[112] See generally http://www.oregon.gov/oha/hsd/Pages/Index.aspx regarding this division, and specifically http://www.oregon.gov/oha/hsd/Pages/Mental-Health-Rules.aspx regarding mental health rules.
[113] See http://sos.oregon.gov/archives/Pages/oregon_administrative_rules.aspx

Pursuant to Subsection E.5, OHA also commits to using its website to post the Special Terms and Conditions of the July 11, 2015 Medicaid Demonstration,[114] the metrics established by the Oregon Metrics and Scoring Committee,[115] and external quality reviews of behavioral health services by CCOs.[116] All these are available on the OHA website. While the latter is posted and the report does indicate significant areas of positive performance along with recommendations for areas needing improvement, behavioral health is integrated throughout the report rather than pulled out separately. This is consistent with OHA's efforts to integrate behavioral health care and services within the overall health care system. As IC, I will discuss with OHA its plans for addressing behavioral health more specifically in future external quality review reports.

Conclusions and System Issues to Watch

While this report and the January 2017 report from OHA show considerable effort to establish baselines, assure data accuracy and consistency, and begin implementation of process commitments in the OPP, the fact is the OPP three-year timeline has just begun. OHA has mounted extraordinary effort across the entire State to address the commitments it has made on behalf of the State of Oregon in the OPP. As IC, I am convinced that the commitment to the OPP and to the system and services changes represented in the OPP is high. However, it is early in the process and much is on OHA's plate about this and other Oregon Health Plan transformations underway. The timelines are short in systems reform terms and budgetary constraints are pending. Likewise, the beginning of a new Administration in the White House and federal government beginning in January 2017 brings considerable uncertainty about the future of Medicaid, Medicare, the Affordable Care Act, and other federal resources for Oregonians as well as for the State. Oregon was fortunate to have its 1115 waiver renewed just before this Administration took office. This may provide some level of stability for Oregon's system while other federal changes are determined and implemented. These could be positive or negative for Oregon; only time will tell.

Other system issues to watch are described below.

Section 223 Demonstration Program for Certified Community Behavioral Health Clinics

One effort to watch is Oregon's involvement in the federal demonstration program for certified community behavioral health clinics (CCBHCs) – often referred to as Section 223[117] – Oregon received a planning grant to implement this program at many of its community behavioral health[118] provider agencies, and just received an implementation grant starting in January 2017. While this program offers considerable opportunity for increased quality[119] and funding for community behavioral health providers, it will also take additional state and local staff time and additional state funding to access additional FFS for these newly certified programs. OHA should be able to combine these efforts with the OPP efforts to assure consistency of direction and desired outcomes for individuals with SPMI. Likewise, whether Congress or the new Administration will continue, increase, cut back, or eliminate this new program and its promises is also unclear at this point. Nevertheless, Oregon's effort and the outcomes sought in this demonstration program are issues to be watched.

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[114] See http://www.oregon.gov/oha/OHPR/1115Waiver/CURRENT%20WAIVER%20-%207-5-2012%20to%206-30-2017%20(Eff.%206-13-2015).pdf and https://www.oregon.gov/oha/OHPB/Documents/oregon-medicaid-waiver.pdf

[115] See http://www.oregon.gov/oha/OHPR/1115Waiver/CURRENT%20WAIVER%20-%207-5-2012%20to%206-30-2017%20(Eff.%206-13-2015).pdf and https://www.oregon.gov/oha/OHPB/Documents/oregon-medicaid-waiver.pdf

[116] See https://www.oregon.gov/oha/OHPB/Documents/2015-OHA-Annual-EQR-Report.pdf for a summary of the CCOs 2015 external quality review.

[117] See https://www.samhsa.gov/section-223 for a description and requirements of this demonstration program. See http://www.oregon.gov/oha/amh/AdditionalResources/Excellence_in_Mental_Health_Certified_Community_Behavioral_Health_Clinic_Planning_Grant.pdf for a description of Oregon's approach.

[118] The term "behavioral health" is used here to mean both mental health and addiction prevention, treatment and support services as opposed to just mental health services referred to in the OPP.

[119] For example, one quality requirement is to assure the availability of mobile crisis services in the location where the crisis occurs for those who need such services.

Oregon Behavioral Health Collaborative

The Behavioral Health Collaborative is an effort begun by the OHA Director in late summer of 2016. The Collaborative was a facilitated group of behavioral health stakeholders from around the state who met 13 times from July 2016 through late January 2017 to discuss and recommend priority actions the state's behavioral health system needs to take to improve services and programs.[120] The OHA Director, Director of OHA's Health Policy and Analytics Division, and OHA behavioral health and Oregon Health Plan leaders met with these stakeholders each time to engage in extensive discussion about ideas and ultimately priority recommendations, captured as follows in a report posted on OHA's website:[121]

> **"Recommendation # 1: Governance and Finance –** Within each geographic service area, create a single point of shared accountability with a single plan for system coordination that builds on existing structures and partnerships and fosters further innovation and collaboration with other organizations. This local collaboration will encourage system recommendations for the allocation of resources; shared responsibility for reaching quality, outcome and cost targets; and prioritization of services and resources to meet local needs.
>
> Funding for health care will be aligned to produce desired outcomes. The local collaboration will be the single point of accountability to review and ensure funding within each geographic service area is effectively and efficiently invested to best meet local needs. The local collaboration will help promote rapid achievement of patient-centered quality, outcome and cost targets. Provider reimbursement should be value-based and encourage improved performance and quality, increased provider risk and population-based payment approaches that support a full continuum of services and behavioral health integration.
>
> **Recommendation # 2: Standards of Care and Competencies –** Establish and implement minimum standards of care and competencies for both mental health and substance use in multiple settings and at all levels of service both at the point of contact and the point of entry. Standards should emphasize trauma-informed care practices, person-centered planning, culturally and linguistically appropriate services, focus on prevention, the social determinants of health and other research-based, outcome-driven interventions.
>
> **Recommendation # 3: Workforce –** Assess the current behavioral health workforce to identify gaps. Develop standards for a well-trained behavioral health workforce, inclusive of certified, licensed and unlicensed, peer support specialists and community health workers throughout the state. Use learning opportunities to support a workforce that is trauma-informed, person-centered, culturally and linguistically appropriate and prepared to work in integrated settings.
>
> **Recommendation # 4: Information Exchange and Coordination of Care –** Strengthen Oregon's use of health information technology and data to further outcome-driven measurement and care coordination across an integrated community.
>
> Develop an outcome-focused, person-centered behavioral health measurement framework to assess the impact of integrated services and hold regional collaborations accountable for clinical and cost targets.
>
> Advance the use of technology to integrate and coordinate care across the state and behavioral health system. This would be a requirement for each CCO to ensure integration took place."

[120] See http://www.oregon.gov/oha/amh/Pages/strategic.aspx for a description of the process and all the materials utilized in the 13 meetings of the Collaborative.
[121] See report pages 1 – 2 http://www.oregon.gov/oha/amh/BHCMeetingDocs/BHC%20recommendations%20Final-exec%20summaryV01%20FINAL.pdf

On page 6 of the report, OHA states that these recommendations "align with and build on *Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness*, developed through a collaborative process with the Civil Rights Division of the United States Department of Justice (USDOJ) in July 2016." The report goes on to say "OHA will use its dual contracting relationships with CCOs and CMHPs to implement the recommendations in the next contracting cycle. All OHA grants and funding will support these systems working in tandem and without duplication."

These recommendations are laudable and do address many of the system issues many states face as well as system issues identified in the OPP or by me as IC. However, it is not yet clear which of these recommendations can be accomplished and how or on what timeline. The Behavioral Health Unit Director within OHA has made presentations to stakeholder groups indicating that the OHA Director has requested implementation plans regarding the BH Collaborative's recommendations within 90 days (approximately early May 2017). The expressed desire is to utilize existing structures to guide the work to implement the recommendations going forward. While not a part of the OPP performance outcomes or process commitments, the implications for these recommendations and implementation plans and their impact on services for individuals with SPMI in the future will be important to watch and perhaps to influence to assure OPP commitments are considered and fulfilled in these processes.

System Issues in Play

System issues previously identified in this report include the potential confusion among various system players; local versus statewide guidance and programs (e.g., crisis lines), the potential closure of the Junction City facility; courts' and psychiatric review boards' roles in filling OSH beds, including the impact on waiting lists for admission of civilly committed individuals from ACPFs; housing supply and costs especially in urban areas within Oregon; rural and frontier challenges such as service capacity and standards; workforce issues, especially pay equity issues for behavioral health practitioners and providers; consistency of language and requirements among various contracts and rules; OHA's willingness and ability to target new funding to areas of greatest need; and funding availability in general for Medicaid match as well as non-Medicaid services and providers.

One issue of concern bares further discussion here. To the extent that services for Medicaid eligible individuals cannot be funded while they are in OSH, the role of the CCOs is diluted or difficult for individual members when they enter OSH. In fact, there could be adverse incentives for CCOs to assist in keeping or moving individuals with SPMI out of OSH when those individuals represent challenges to serve in the community. Additionally, KEPRO's role with individuals in SRTFs who are members of CCOs will be changing over time as this type of service is incorporated into the managed care portion of the program and therefore become the responsibility of the CCOs. Likewise, the responsibility for non-Medicaid services and populations generally stretches across multiple players. There seems to be little appetite to move non-Medicaid services and populations to CCOs and also little appetite to change the role of local mental health authorities for local planning and service responsibility. Especially in urban areas, this latter issue can cause inefficiency or duplication of effort. While the Behavioral Health Collaborative recommendation regarding regional points of contact with shared responsibility for outcomes begins to identify these issues, it is unclear whether Oregon will address these issues at their core or will create additional inefficiencies and duplication of effort while trying to solve these issues.

None of these issues are surprising in a forward-thinking state engaged in significant system transformation such as Oregon is at this time. These are issues to watch to assure the best possible utilization of limited resources and the best possible outcomes for individuals with SPMI (and for other Oregonians with behavioral health needs) as the system continues to move and change. Oregon's path is positive even though its goals and vision are not yet realized. Future reports will address some of these issues as they continue to evolve.

LIST OF APPENDICES

APPENDIX A
Acronyms Used In This IC Report #1

- ACPF – Acute Care Psychiatric Facilities
- ACT – Assertive Community Treatment
- ADA – Americans with Disabilities Act
- ALOS – Average Length of Stay (or mean)
- AMHI – Adult Mental Health Initiative
- APAC – All Payer All Claims
- AOCMHP – Association or Oregon Community Mental Health Programs
- BH – Behavioral Health
- CCO – Coordinated Care Organizations
- CFR – Code of Federal Regulations
- CIE – Competitive Integrated Employment
- CIT – Crisis Intervention Team
- CMHP – Community Mental Health Program
- CMS – Centers for Medicare and Medicaid Services
- CY – Calendar Year (from January 1 through December 31)
- DPSST – Department of Public Safety Standards and Training
- DSM – Diagnostic and Statistical Manual
- ED – Emergency Department
- EDIE – Emergency Department Information Exchange
- EHR – Electronic Health Record
- e.g. – For Example
- EOHSC – Eastern Oregon
- FEP – First Episode Psychosis
- FFP – Federal Financial Participation
- FFS – Fee for Service
- FMR – Fair Market Rent
- FPL – Federal Poverty Level
- FY – Fiscal Year (July 1 through June 30)
- GAF – Global Assessment of Functioning
- GOBHI – Greater Oregon Behavioral Health, Inc.
- HIPAA – Health Insurance Portability and Accountability Act
- HPB – Health Policy Board
- HUD – Housing and Urban Development
- IC – Independent Consultant
- ICD – International Classification of Diseases
- ICM – Intensive Case Management
- i.e. – that is
- IMD – Institution for Mental Diseases
- IPS – Individual Placement and Support
- LEDS – Law Enforcement Data System
- LOS – Length of Stay
- M – Million
- MHAO – Mental Health America of Oregon
- MHBG – Mental Health Block Grant
- MOTS – Measures and Outcomes Tracking System
- MOU – Memorandum of Understanding
- NCQA – National Committee for Quality Assurance
- NOFA – Notice of Funds Availability
- OACP – Oregon Association of Chiefs of Police
- OAHHS – Oregon Association of Hospital and Health Systems
- OAR Oregon Administrative Rule
- OCA – Office of Consumer Affairs
- OCAC – Oregon Consumer Advisory Council
- OCEACT – Oregon Center of Excellence for Assertive Community Treatment
- OCJC – Oregon Criminal Justice Commission
- OEI – Office of Equity and Inclusion
- OHA – Oregon Health Authority
- OHCS – Oregon Human and Community Services
- OHP – Oregon Health Plan
- OPP – Oregon Performance Plan for Adults with Serious and Persistent Mental Illness
- OSECE – Oregon Supported Employment Center for Excellence
- OSH – Oregon State Hospital
- OSJCC – Oregon Sheriff's Jail Command Council
- OSSA – Oregon State Sheriffs Association
- OSU – Oregon State University
- PDS – Peer Delivered Services
- QHOC – Quality Health Outcomes Committee
- QPI – Quality and Performance Improvement
- RAC – Rules Advisory Committee
- RFA – Request for Applications
- RFP – Request for Proposals
- RTT – Ready to Transition (also Ready to Place)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- SE – Supported Employment
- § – Section
- SIM – Sequential Intercept Model
- SMI – Serious Mental Illness
- SOS – Secretary of State
- SPMI – Serious and Persistent Mental Illness
- SRTF – Secure Residential Treatment Facility
- SSI – Supplemental Security Income
- TA – Technical Assistance
- TAC – Technical Assistance Collaborative, Inc.
- USC – United States Code
- USDOJ – United States Department of Justice
- w/ – with
- w/in – within

APPENDIX B
Summary Status of Provisions of the Oregon Performance Plan

(Quantitative Baselines as of CY 2015; Qualitative Activities as of Approximately March 2017)

(Blue Shading Indicates Compliance as of Report Date)

OPP PROVISION NUMBER & TOPIC	TARGETS & ACTIONS IN OPP	BASELINE CY 2015 OHA JAN 2017 RPT IC SPRING 2017 RPT (OHA Data: 1/1/15 – 12/31/15)
Section B: General Terms and Conditions		
2. Commitment to Advocate	w/ Oregon Health Policy Board and OHP Quality Metrics Committee	In process
3. Collect and maintain data and records on provisions of the OPP and make records reasonably available to USDOJJ and IC	Keep records re OPP; make available	Most records posted on OHA website
Section C: Funding Limitations		
Make diligent efforts to obtain funding and authority necessary to implement OPP; specific request for funding for housing	Diligent efforts	Additional funding secured over last two biennium; Medicaid expanded; current Legislative session in process
Section D: Performance Outcomes		
1a – b. # SPMI individuals served by ACT Teams	By 6/30/17 – 1,050 By 6/30/18 – 2,000	815
1c. Reduction of waitlist for ACT	After 6/30/18 – if 10 individuals on waitlist >30 days, increase team capacity or add teams	17 ACT teams meeting fidelity; 4 provisional; 6 in development; # on waitlist not available for CY 2015
1d. Waiver of ACT fidelity requirements (rural teams)	Report w/o Targets	No waivers needed
1e – f. Criteria for admission to ACT incorporated into administrative rules	By 7/1/16 – Develop criteria consistent w/ OPP definition & national standards; Incorporate in regs	Criteria developed; interim rule completed; Final rule in process
2. Individuals who need ACT will be admitted to ACT	Develop process to assure admission to ACT	N/A
3.Track denials to ACT teams; corrective action if improperly rejected	Tracking process; corrective action capacity	N/A re denials; corrective action process in development
4a – i. Report data re ACT clients (w/in a quarter)	a. # served b. % homeless c. % housed 6 mos d. % using EDs e. % hospitalized in OSH f. % hospitalized in acute care g. % in jail h. % receiving SE i. % in CIE	a. 815 Other data elements being collected going forward by quarterly reporting from providers
6. Expand mobile crisis services statewide	By 6/30/18 – statewide	N/A
7a – b. # served by mobile crisis	FY2017 – 3,500 FY 2018 – 3,700	3,732
8.Track & report # receiving mobile crisis contact and dispositions	By 6/30/17 – Methodology By 1/1/18 – # admitted to acute care By 6/30/18 – # stabilized in community setting	(See 7 above for baseline # served); Methodology to track dispositions in process

OPP PROVISION NUMBER & TOPIC	TARGETS & ACTIONS IN OPP	BASELINE CY 2015 OHA JAN 2017 RPT IC SPRING 2017 RPT (OHA Data: 1/1/15 – 12/31/15)
9, 10a – b, 11, & 12a. Mobile crisis response times	By 6/30/17 – Other than Rural & Frontier – w/in 1 hr Rural – w/in 2 hrs Frontier – w/in 3 hrs During FY2018 – Review progress & adjust if needed	Data N/A for CY 2015 Reg in process to incorporate requirements
13. Uniform standards for hotline services and county crisis lines	Develop standards and enforce	Standards and reg in process
14a – c. # in supported housing	FY2017 – 835 FY2018 – 1,355 FY2019 – 2,000	442
14. Best efforts to match individual w/ housing needs and choice	Best Efforts	N/A
15. Data re housing stock or inventory available for individuals w/ SPMI; track # in supported housing; use info for budget requests in 2017-2019 budget	Make Inventory Available w/o Targets Advocate for Budget Increases for Housing	53,323 Affordable Housing Units (as of Jan 2017); (See 14 a – c for # in supported housing); Legis session underway
16a – b. # receiving peer delivered services (PDS)	FY2017 – ↑ 20% (3,348) FY2018 – ↑ 20% again (4,018)	2,790
17. Explore better ways to track PDS	Process for improvement w/o targets	In process
20 a – d. % OSH individuals discharged within set # of days after placement on RTT list; track extensions due to holidays/weekends	By 6/30/17 – 75% w/in 30 days By 6/30/18 – 85% w/in 25 days By 6/30/19 – 90% w/in 20 days; Report w/o Targets of # extended due to holiday or weekend	51.7% w/in 30 days 41.6% w/in 25 days 30.1% w/in 20 days 4 extended 1 day due to weekend/holiday
20 e. CCO members discharged consistent with OAR; OHA helping CCOs meet their obligations	Regs and Process Work with CCOs	Regs in process; work with CCOs in process
21. Preference for discharge w/in 72 hrs of RTT	Preference Only; Track w/o Reporting	Tracking
22. Performance-based contracts w/ CMHPs, CCOs, etc., to pursue #s 20 – 21	Contracting	Revised Contracts w/ CMHPs by 7/1/17 and w/ CCOs by 1/1/19
23a. i-ii. Everyone appropriate for ACT receives ACT or evidence-based alternative	Individuals discharged & appropriate for ACT receive ACT or evidence-based alternative (EBA); document efforts to address concerns of those who refuse ACT & offer EBA; data reporting re refusers	Referral criteria and draft universal tracking form in use No data re refusers available for CY 2015
23b. OHS individuals who meet ACT LOC discharged with services appropriate to needs	Services post discharge for individuals with ACT LOC	QPI process for post-discharge services tracking for ACT LOC individuals in discussion
24. % OSH individuals discharged w/in 120 days	By 6/30/17 – 90% w/in 120 days	37.9% (89 of 235)
24 a – f. Clinical review when individual at OSH >90 days & every 45 days thereafter	Clinical review process; Documentation of continued stay justification or appropriate placement; Review best practices annually	Process & documentation in place for reviews at 90 days and every 30 thereafter
25. Discharges to most integrated setting appropriate, consistent with goals, needs, and informed choice; not to SRTF unless clinically necessary and not w/o express approval of Dir of OHA or designee	Appropriateness of discharges documented Discharges to SRTF only w/ Dir or designee approval	Discharge form in use; Documentation in OSH data system; Contract w/ KEPRO to assure appropriate discharge setting

OPP PROVISION NUMBER & TOPIC	TARGETS & ACTIONS IN OPP	BASELINE CY 2015 OHA JAN 2017 RPT IC SPRING 2017 RPT (OHA Data: 1/1/15 – 12/31/15)
26a – e. Interim, short-term, community-based housing for individuals discharged from OSH or SRTF no longer than 2 mo & no more than 5/unit	No more than 20 interim housing slots; # individuals placed in interim housing for no more than 2 mo & no more than 5/unit; By 7/1/19 – Slots converted to long-term integrated housing	No plans to discharge from OSH or SRTFs to interim housing
27. Discharges from acute care psychiatric facilities (ACPF)	All except transfers to OSH have documented linkages to timely, appropriate behavioral & primary health care in community prior to discharge	OAR re linkages and documentation requirement; Working w/ hospitals re data collection process
28. Continue enrolling indigent in Medicaid prior to discharge from ACPF or EDs	Aggressive enrollment efforts	Hospitals have incentive to help enroll in order to bill; proportion of uninsured suggests success
29a – c. % receiving a "warm handoff" from ACPFs	By 6/30/17 – 60% receive warm handoff By 6/30/18 – 75% By 6/30/19 – 85%	N/A for baseline; Methodology under discussion w/ hospitals
29. Individuals refusing a "warm handoff" from an ACPF	Aggregate data by ACPF, quarterly beginning with 2nd Q FY 2017 (Oct 1 to Dec 31, 2016)	Working w/ hospitals re data collection and reporting process
30. # discharged from ACPFs receiving a follow-up visit w/ CMH provider w/in 7 das	Report w/o Targets	2,011 (of 2,534 or 79.36%)
31a. 30 & 180 day rates of readmission, by ACPF	Report w/o Targets	30 days – 6.5% to 13.5% (avg 9.23%) 180 days – 15.3% to 26.9% (avg 21.3%)
31b. Contacting/offering services to individuals w/ 2+ readmissions to ACPF in a 6 mo period, to avoid unnecessary readmissions	Management Plan	Development of plan underway
32. Housing connection for homeless SPMI individuals w/ ≥ 2 readmissions in 6-mo period in ACPF	Identify & connect to housing agency or MH agency w/ access to housing	OAR requiring connection of all individuals discharged to such agencies
33. May use interim housing for individuals in #32	(See #26)	(See #26)
34. Assess housing needs of SPMI individuals in ACPFs	Require ACPFs to consult w/ CCOs in developing assessment & notify individual's community provider re plan for housing	KEPRO contract, CCOs & CMHPs facilitate these efforts
35. Avg length of stay of SPMI individuals in ACPFs; # w/ LOS >20 days	Report w/o Targets	ALOS – 4.98 – 12.43 days (8.89 days avg); # >20 days – 385 (not rptd by facility)
37. Data collection & community strategies re SPMI using EDs for MH reasons	# using EDs; Reasons for staying >23 hrs w/ solutions presented to Legislature & USDOJ; Fall 2016, begin community-based strategies	Report of "psychiatric boarding in EDs" by Oregon State University (OSU) released
38. SPMI individuals connected to services at time of leaving EDs	Initiate strategies to increase # connected; Track data to measure effectiveness	OAR in process; data methodology under discussion w/ hospitals
39, Continue enrolling indigent in Medicaid prior to discharge from EDs	Aggressive enrollment efforts (See # 28)	Hospitals have incentive to aid enrollment in order to bill (see #28)
40a. # SPMI individuals w/ ≥2 readmissions to emergency departments (EDs) in a 6-mo period	Report w/o Targets	1,067
40b. Address needs of SPMI individuals w/ ≥2 readmissions to EDs in 6-mo period	Collaborative efforts w/ CMHPs/CCOs to implement plans & contract amendments w/ CCOs to require ACPFs to develop and implement plans	CMHP contract revisions in process by 6/30/17; CCO contracts to be revised in 2018
41 a – b. Rate of visits by SPMI individuals to general EDs for MH reasons	FY2017 – ↓ 10% (1.39/1,000) FY2018 – ↓ 20% (1.23/1,000)	1.54 / 1,000

OPP PROVISION NUMBER & TOPIC	TARGETS & ACTIONS IN OPP	BASELINE CY 2015 OHA JAN 2017 RPT IC SPRING 2017 RPT (OHA Data: 1/1/15 – 12/31/15)
42. Use of EDs by individuals w/ SPMI	Meet w/ Independent Consultant (IC) to discuss	IC visits to ACPF(s) in planning; Discussions w/ OHA in process
43. Data collection re individuals w/ SPMI in EDs >23 hrs	Work w/ hospitals on data collection strategy; By July 2017 – begin reporting by Q, by region (or by hospital if possible)	Data collection methodology in discussion w/ hospitals; OSU report re "psychiatric boarding" in process (see #37)
45 a – b. # receiving supported employment (SE) services & employed in competitive integrated employment (CIE); # in CIE w/o receiving SE	Report w/o Targets	1,534
46. Improve SE services	Monitor 45a – b data to improve SE services	Data available under consideration; OAR revision re SE in process
49a. Move civilly committed individuals in SRTFs to more appropriate community setting	Move individuals no longer needing SRTFs expeditiously to a community placement in most integrated appropriate setting	KEPRO and Choice provider roles
49b (i – ii). LOS of civilly committed individuals in secure residential treatment facilities (SRTFs)	FY2017 -- ↓ 10% (147.9 days) FY2018 -- ↓ 20% (131.4 days)	164.3 days
49c – 50. # in SRTFs, LOS, & # discharged, to most integrated appropriate setting consistent w/ goals, needs, choices	Report w/o Targets; Beginning 7/1/17 – collect data identifying type of placement at discharge	# in SRTFs not yet available; but 36 discharged (in DSS) Placement Upon Discharge N/A (See #49b for LOS)
51 – 52. Intent to reduce arrests, jail admissions, LOS in jail, & recidivism of SPMI individuals involved w/ law enforcement due to MH	Strategies	Relationship building & strategy development underway
52a. # Individuals receiving jail diversion services; # diversions (pre- and post-arrest)	Report w/o Targets; Include in RFP & contracts requirement to track pre- and post-arrest diversions	1,409 Requirement in 2015 RFP & subsequent contracts
52b. Work w/ OR Sheriffs Association & Association of CMHPs to determine data collection strategies for individuals w/ SPMI entering jails	By July 2016 – Begin work on data collection strategies	Discussions began Summer 2016 w/ OSSA, OACP, & AOCMHP
52c. Expand use of sequential intercept model (SIM)	By July 2016 – Contract with GAINS Center; New funding for jail diversion services will require adoption of SIM	2015 GAINS Center contract; SIM Training Jan 20-21, 2016; SIM Train the Trainers Feb 16-17, 2016; New jail diversion & CMHP contracts require use of SIM; Contracts w/ EOHSC and DPSST re CIT training
52c. Encourage local jurisdictions to adopt interventions in accordance w/ SIM	Encouragement of interventions in accordance w/ SIM	Programs will be asked about use of SIM in IC's Spring visits; how to assess "encouragement" will be determined
52d. # Arrests of individuals w/ SPMI enrolled in services	As of July 2016 – track arrests; Report w/o targets	N/A for baseline
52e – f. Jail diversion program data; prioritize pre-charge diversion activities	Report w/o targets on jail diversion program services, impacts, obstacles, & mapping	N/A for baseline
53. Sharing information w/ jails re MH diagnosis, status, medication regime, & services of incarcerated individuals w/ SPMI	Develop strategies	Discussions & analysis of legal & practical obstacles underway

OPP PROVISION NUMBER & TOPIC	TARGETS & ACTIONS IN OPP	BASELINE CY 2015 OHA JAN 2017 RPT IC SPRING 2017 RPT (OHA Data: 1/1/15 – 12/31/15)
Section E: Quality and Performance Improvement		
1. Develop & implement Q&PI system to ensure compliance w/ OPP	Ensure services in D. are of good quality and sufficient	BH being incorporated into existing QM/QI processes
2. System of accountability for performance outcomes in Section D	Governance structure includes USDOJ Agreement [OPP] Stakeholder Advisory Team, including ≥20% individuals w/ lived experience, to review/comment on progress and advise; Olmstead Plan Stakeholder Team w/ specified membership to review/comment on progress & advise	New OPP Stakeholder Advisory Team underway/meeting; Olmstead Stakeholder Team reconstituting, to meet in May 2017
3. Documentation of groups' (#2) efforts	Minutes, correspondence, reports to USDOJ & IC	Being posted on OHA website
4 a-d. QI system includes data collection & analysis; regulations & performance-based contracts; SE & ACT fidelity reviews annually; and corrective action plans	Data used to: i. identify trends, patterns, strengths, successes, & problems at multiple levels, e.g., service quality, gaps, accessibility, success & obstacles; ii - iii. develop & track efficacy of preventative, corrective, improvement measures; Regs & contracts include expectations of CMHPs/CCOs consistent with OPP; SE/ACT fidelity reviews & TA will continue; OHA will develop corrective action plans for CMHPs or CCOs w/ timelines & oversight	Data collection & analysis underway; Reg & CMHP contract changes underway; COO changes being planned; Fidelity reviews & TA continue; Corrective action plan process under consideration
5. Make public reports re BH QI efforts (See also B.3)	Post on website: semiannual reports re OPP QI efforts; MH outcomes from other QI efforts (Medicaid demo special terms & conditions, OR Metrics & Scoring Committee, CCO external quality reviews)	(See B.3) Timing of semiannual reports re BH under consideration
6. Compliance w/ Section D performance outcomes	Substantial compliance w/ Section D & establishment of Section E QI measures	Compliance TBD; QI measures in process
Section F: Compliance and Reporting		
1. Contract w/ Independent Consultant (IC)	Contract w/ IC	Contract in place as of July 2016
2. Utilization of IC for consultation	At written request, use IC to assist in implementing, including training & TA	Consultation requested & provided re national standards and/or examples
3. Semi-annual reports assessing compliance	IC semi-annual reports assessing compliance provided in draft w/ 30 day review by USDOJ & OHA; final reports made public	Report #1 draft provided for 30 day review 3/19/17; Final IC Report #1 to be posted on OHA website
4. IC access to documents, staff, information	Facilitate IC access; designate contact person	Access to documents, staff, information being facilitated through OPP Project Director
5. Process for replacement of IC if needed	Specified process for replacement IC if needed	N/A
6. Data & reports (See also Section B.3)	OHA to provide data quarterly w/ semi-annual narrative report; contract amendments after 7/1/16 require data reporting quarterly to OHA	OHA data & narrative report provided 1/31/17 (revision in process); Quarterly data report being prepared for April 2017

APPENDIX C
ACT Reporting Template (June 2016)

	Provider Name:	*Agency/Provider Name*													
	Provider Medicaid ID#:	*Agency/Provider Medicaid ID#*													
	Reporting Period:	*Reporting quarters: January - March, April - June, July - September, October - December (Please indicate the year of the reporting quarter e.g. January - March 2016)*													
	Does the Agency use any State General Fund (GF) Dollars to provide ACT services? *(Yes / No)*	*Please type Yes or No here*													
	Number of individuals referred to the program:	*enter the total number of referrals received*			**Number of individuals who were referred, but did not meet program admission criteria:**			*enter number of individuals not admitted to the program - should correspond with the number of denials on the Referral Denial Tracking Sheet (Tab 3)*							
	Participant Last Name	**Participant First Name**	**Participant MOTS ID Number** *(This is most likely the Electronic Health Record (EHR) number)*	**State General Fund (GF) used?** *(Yes / No)*	**ACT Enrollment Date**	**ACT Closure or Discharge Date** *(If Applicable)*	**Reason for Closure or Discharge** *(Transitioned to less intensive service; Higher level of care; Moved; Refused Services; Deceased; Other-specify)*	**Employed in Competitive Employment in the reporting quarter?** *(Yes / No)*	**Admitted to Psychiatric Hospital in the reporting quarter?** *(Includes acute, sub acute, any locked facility (Date(s))*	**Admitted to OSH in the reporting quarter?** *(Date(s))*	**Discharged from Psychiatric Hospital in the reporting quarter?** *(Date(s))*	**Utilized Emergency Room services for psychiatric issues in the reporting quarter?** *(Yes / No)*	**Incarcerated in jail or prison in the reporting quarter?** *(Yes / No)*	**Individual homeless in the reporting quarter?** *(Yes / No)*	
1	Last Name	First Name	This is most likely the Electronic Health Record (EHR) number. It is ***NOT*** the client's SSN or Medicaid ID number.	Enter "Yes" if the client was not enrolled in Medicaid at any point during the reporting period. *Each Agency funds ACT programs differently. Depending on the Agency, every client, including those who are enrolled in Medicaid could utilize State GF.*	This is the date that the client was accepted into the ACT program.	This is the date that the client was transitioned out of the program and is no longer active in the ACT program's caseload.	Enter brief description of reason for discharge	Enter "Yes" if the client has a job that meets the definition of competitive employment during the reporting period. See definition below	See definition below	See definition below	See definition below		Enter "Yes" if the client was "booked" into jail or was in prison at any time during the reporting period. See definition below	Enter "Yes" if the client was homeless at any point (to the best knowledge of the program) during the reporting period. See definition below	
2	Include all clients that are active in the corresponding reporting period. Please include clients that closed or discharged in the quarter if the client received one billable encounter during the reporting period.														
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															

Definitions:	
Booked	An official record of an arrest was made for an individual resulting in confinement in jail.
Competitive Employment	A job that pays at least minimum wage and the wage that others receive performing the same work, based in community settings alongside others without disabilities, and not reserved for people with disabilities. Competitive jobs are not “sheltered work”. Clients must work alongside others without psychiatric disabilities.
Homeless	Adult individual who lacks a fixed, regular, and adequate nighttime residence, including individuals who resided in an emergency shelter or a place not meant for human habitation (e.g. a hallway, a bus station, a lobby or similar places) and who are exiting an institution where he or she temporarily resided.
Incarcerated in Jail or Prison	The client was in jail if he or she was booked into a place of confinement for persons held in lawful custody in a place under the jurisdiction of a government (such as a municipality or county) which is intended to confine persons awaiting trial or those convicted of minor crimes. The client was in prison if he or she was in a place of confinement especially for lawbreakers; specifically: an institution (as one under state jurisdiction) for confinement of persons convicted of serious crimes. **Interaction with law enforcement without being booked is **NOT** considered incarcerated in jail or prison.*
Oregon State Hospital (OSH)	Any Oregon State Hospital campus including the Salem and the Junction City campuses.
Psychiatric Hospital	Acute psychiatric hospital means a psychiatric health facility that is licensed to provide acute inpatient hospital service. This includes psychiatric wards when they are a subunit of a regular hospital that specialize in the treatment of serious mental illnesses, including, but not limited to, clinical depression, schizophrenia, and bipolar disorder.
Report Submission:	
Reporting Periods:	Calendar Quarters: January - March, April - June, July - September, October - December
ACT Quarterly Report Due Dates:	45 days after the reporting period (on the 15th of the second month after the end of the period). If the 15th falls on a weekend or holiday, the report is due on the next business day.
Submission:	All forms must be submitted, by secure e-mail, in electronic to the AMH Contract Administrator Drop-Box at: AMHcontract.Administrator@state.or.us
Submission requirements vary by Agency. Please check with the CMHP for which the ACT Program is affiliated to determine if the ACT Program itself or the CMHP submits the report to OHA.	
Reporting Form Nuances:	

To meet the needs of each reporting Agency and various versions of Excel, the reporting template is no longer "locked".

Please do not alter template form in any way, including, but not limited to:
- Altering the contents of any title cells;
- Changing the formatting of the cells;
- Changing the order of the columns; or
- Changing the "Print Title" settings

The template is set to print up to 225 individuals (about five pages). Changing the printable area is not considered altering the form.
Adding rows to report more individuals is not considered altering the document.

APPENDIX D
Draft ACT Universal Tracking Form

HEALTH SYSTEMS DIVISION
Operations and Contracts Unit

Oregon Health Authority

Assertive Community Treatment (ACT)Universal Tracking Form

Name of person completing this form: _____ Date: _____

Patient name: _____ Date of birth: _____

Home Coordinated Care Organization (CCO): _____

County the patient will be living and receiving ACT services: _____

CCO: _____ Medicaid ID number (*if applicable*): _____

Primary mental health diagnosis: _____

Is the patient currently under the jurisdiction of an Aid and Assist Order?: ☐ Yes ☐ No

Referral source: _____ Referral to: _____

Anticipated date of transition: _____

Was a clinical assessment completed?: ☐ Yes ☐ No

If yes, name of clinician who conducted the assessment: _____

Clinician phone: _____ Clinician email: _____

Please indicate what other services (*separate from ACT*) that are being considered:

OSH only

☐ Patient agrees to referral for ACT services

☐ Patient refuses referral for ACT services

If patient refuses, describe plan to address patient concern(s) regarding ACT Services:

Assertive Community Treatment (ACT) is a specialized model of treatment and service delivery designed to provide comprehensive community-based mental health services to persons with serious and persistent mental illness (SPMI) who are at least 18 years of age, have severe functional impairments, and who have not responded to traditional psychiatric outpatient treatment or less intensive non-standard levels of outpatient mental health treatment. Services are available to individuals with SPMI who have had a history of multiple psychiatric hospitalizations and/or crisis interventions. ACT services are provided over an extended period of time and include clinical, rehabilitation, recovery, supportive and case management services provided directly by a multidisciplinary team in the individual's natural environment. ACT serves as the primary provider of services and is in some cases available 24 hours a day, 7 days a week.

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OHA 9808 (08/2016)

Is the client 18 years or older? ☐ Yes ☐ No

Clients diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (*e.g., schizoaffective disorder*) and bipolar disorder because these illnesses more often cause long-term psychiatric disability.

Is client diagnosed with a severe and persistent mental illness that seriously impairs their function in the community? ☐ Yes ☐ No

Primary diagnosis:_____

Clients with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (*Individuals with a primary diagnosis of a substance abuse disorder or intellectual disabilities are not the intended client group.*)

Does the client have a secondary co-occurring disorder that also affects their ability to function in the community? ☐ Yes ☐ No

Substance abuse disorder: ☐ Yes ☐ No

Describe/supporting documentation found in:_____

Other co-occurring disorder: ☐ Yes ☐ No

Describe/supporting documentation found in:_____

Does the client exhibit significant functional impairment as demonstrated by at least one of the following conditions? ☐ Yes ☐ No

Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (*e.g., caring for personal business affairs; obtaining medical, legal or housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs, maintaining personal hygiene*).

Describe/supporting documentation found in:_____

Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (*e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities*).

Describe/supporting documentation found in:_____

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OHA 9808 (08/2016)

Significant difficulty maintaining a safe living situation (*repeated evictions or loss of housing*)?
Describe/supporting documentation found in:_____

Clients with one or more of the following indicators of continuous high service needs:

- ☐ High use of acute psychiatric hospitals (*two or more admissions per year*) or psychiatric emergency services.
- ☐ Intractable (*i.e., persistent or very recurrent*) severe major mental health symptoms (*affective psychotic, suicidal*).
- ☐ Coexisting substance abuse disorder of significant duration (*greater than six months*).
- ☐ High risk or recent history of criminal justice involvement (*e.g., arrest, incarceration*).
- ☐ Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
- ☐ Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
- ☐ Difficulty effectively using traditional office-based outpatient services.

Evaluator:

Agency:_____ Name:_____

Title:_____ Phone number:_____

_____

Signature Date

ACT services determination:_____ Date of determination:_____

☐ Patient **accepts** ACT services ☐ Patient **refuses** ACT services

☐ ACT Program accepts and agrees the referred patient meets program eligibility criteria

☐ ACT Program denies referral

Specific reason(*s*) for denial:_____

If denial is due to capacity limitations, does the patient elect to be placed on a waiting list? ☐ Yes ☐ No

If denied, please identify recommended alternative community-based services:

_____

Signature:_____ CCO organization:_____

Signature:_____ ACT program representative:_____

Phone:_____ Email:_____

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by Sate Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are *prohibited from making further disclosure without specific written consent of the* persons or as otherwise permitted by law.

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OHA 9808 (08/2016)

APPENDIX E
Mobile Crisis Services Inventory (Fall 2016)

	CMHP:	**Please enter the CMHP responding to this inventory in this space**
1	Does CMHP provide mobile crisis services?	a) Yes or b) No
2	What are the geographic boundaries to which mobile crisis services are provided?	
3	Does the mobile crisis team respond to anywhere in the geographical service area at the location that the crisis is taking place (e.g. school, individual's home, church, etc.)?	a) Yes or b) No
4	What are the hours of operation for mobile crisis services?	
5	Is there a QMHP trained in mental health crisis available for supervision?	a) Yes or b) No
6	What are the CMHP's crisis training requirements, if any?	
7	How the mobile crisis team made aware of the need for crisis services?	
8	Does the CMHP monitor the response time?	a) Yes or b) No
9	If "yes" to #8, how is the response time monitored (e.g. electronic health record)? What starts the clock?	
10	What are the barriers to implementing mobile crisis services as defined above? Please list all barriers that adversely impact your response.	
11	What is the CMHP's approximate annual budget for mobile crisis services by funding source?	State Funding: Federal Grant (by type): County Funding: Managed Care:
12	Please provide a brief, bulleted description of the CMHP's mobile crisis services: (e.g. subcontracted or provided by CMHP staff, agreements with law enforcement for co-response or notification of crisis event, how the client in crisis is engaged for follow-up, etc.)	

APPENDIX F
List of Urban, Rural, and Frontier Counties in Oregon

County	Category	County	Category	County	Category
Benton	Urban	Coos	Rural	Union	Rural
Clackamas	Urban	Crook	Rural	Wasco	Rural
Columbia	Urban	Curry	Rural	Baker	Frontier
Deschutes	Urban	Douglas	Rural	Gilliam	Frontier
Jackson	Urban	Hood River	Rural	Grant	Frontier
Lane	Urban	Jefferson	Rural	Harney	Frontier
Marion	Urban	Josephine	Rural	Lake	Frontier
Multnomah	Urban	Klamath	Rural	Malheur	Frontier
Polk	Urban	Lincoln	Rural	Morrow	Frontier
Washington	Urban	Linn	Rural	Sherman	Frontier
Yamhill	Urban	Tillamook	Rural	Wallowa	Frontier
Clatsop	Rural	Umatilla	Rural	Wheeler	Frontier

APPENDIX G
Supported and Supportive Housing Side-by-Side (Jan 9, 2017)
(Differences highlighted in **bold)**

SUPPORTIVE HOUSING		SUPPORTED HOUSING
Permanent Tenant maintains tenancy as long as meeting occupancy obligations (e.g. pay rent).		Permanent Tenant maintains tenancy as long as meeting occupancy obligations (e.g. pay rent).
Affordable Tenant pays no more than 30% of income for housing costs.		Affordable Tenant pays no more than 30% of income for housing costs.
Integrated Opportunity to interact with non-disabled neighbors readily available.		Integrated Opportunity to interact with non-disabled neighbors readily available.
Access to Services • Participation in support services is voluntary; services cannot be mandated as a condition of obtaining tenancy**;** tenants cannot be evicted for rejecting services. • Tenant**s** are offered choice and range of flexible services that are available as needed, desired; level of services are adaptable as needs may change without losing home. • Services designed to promote recovery, enable tenants to attain and maintain housing. • Provision of housing and provision of services are distinct activities.		Access to Services • Participation in support services is voluntary; services cannot be mandated as a condition of obtaining tenancy; tenants cannot be evicted for rejecting services. • Tenants are offered choice and range of flexible services that are available as needed, desired; level of services are adaptable as needs may change without losing home. • Services designed to promote recovery, enable tenants to attain and maintain housing. • Provision of housing and provision of services are distinct activities**.**
Housing Private and secure with same rights and responsibilities as any other member of community; enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.		Housing Private and secure with same rights and responsibilities as any other member of community; enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.
Siting Number of rental units in any building or complex occupied by individuals with SPMI is not restricted.		Siting • **For a building or complex with 2-3 units, not more than one unit may be used to provide supported housing for tenants with Serious Mental Illness (SMI) who are referred by OHA or its contractors.** • **For buildings or complexes with 4 or more units, no more than 25% of units in a building or complex may be supported housing for tenants with SMI, referred by OHA or its contractors who shall make good faith, best efforts to facilitate the occupancy of those units by individuals with SMI.** • **The remaining housing is available to all individuals in conformance with Fair Housing and other laws.**
Occupancy Comparable to other housing in market; no restrictions or provisions specific to psychiatric disability. Applies to: • Lease provisions; • Lease term with option to renew (as long as in compliance); • Occupancy rules; • Unit options per tenant preferences, range of choices affordable to income level for housing market.		Occupancy Comparable to other housing in market; no restrictions or provisions specific to psychiatric disability. Applies to: • Lease provisions; • Lease term with option to renew (as long as in compliance); • Occupancy rules; • Unit options per tenant preferences, range of choices affordable to income level for housing market. **Additionally:** • **No more than 2 tenants per unit, each with own bedroom.** • **If two tenants in unit, must be able to select roommate.** • **Cannot be rejected for occupancy due to medical needs or substance abuse history.**

Rental Assistance Program

Updated 11-21-2016

***OHA Health Systems Division's Rental Assistance Program* supports individuals with a serious mental illness to live independently by securing affordable rental housing.**

Who is eligible for the Rental Assistance (RA) Program
Individuals with a serious mental illness are eligible if they are homeless, at risk of homelessness, transitioning from a hospital or a licensed facility, or at risk of reentering a hospital or a licensed facility.

How does the RA Program work?
Individuals are eligible to receive move-in assistance costs such as deposits and application fees, as well as monthly rent subsidies. The balance of the rent is paid by the individual.

Individuals work with program staff to comply with their lease, pay their rent and maintain relationships with landlords and neighbors. These services are available to program participants but are not required.

Provide Staff Funding
The RA Program funding supports the employment of 84 Residential Housing Specialists and Peer Support Specialists. Funds awarded to each of the programs allow for the addition of these positions to a contracted provider's existing staff.

These RA Program *Residential Housing Specialists* and *Peer Support Specialists* assist program participants in becoming rent-ready, locating, making application, securing and maintaining a rental unit.

Program Information
Providers began operating Rental Assistance Programs in March 2014. As of October 2016 there are 24 contracted providers operating Rental Assistance Programs throughout the state with 1154 housing slots for Rental Assistance program participants.

Successes to Date
Of the twenty original Rental Assistance programs that began operating in 2014, 87% of these housing slots are filled by eligible program participants as of September 2016.

For further information on the Rental Assistance Program contact;
Shellee Lowery Madden
Housing Development Coordinator
Email; shellee.l.madden@state.or.us
Voice; 503-947-5534

APPENDIX I

OSH Ready to Place [Transition] Form

Oregon State Hospital
Ready to Place Form

DEMOGRAPHIC DATA

Consumer First Name: Last Name:
DOB: / / Gender: Race: Consumer has a Legal Guardian ☐No ☐Yes
Hospital: Living Unit: Admit Date:
County of Residence: Primary Language Spoken:

DISCHARGE READINESS ASSESSMENT

Review Date:
☐ Ready to Place ☐ Continued Stay

The consumer's clinical status has been assessed for substantial risk for imminent harm to self, based on the following:

1. Are there recent deliberate attempts to commit suicide or to cause serious self-inflicted bodily injury? ☐Yes ☐No
2. Is there evidence of substantial suicide risk, as evidenced by a suicide risk assessment or the presence of recent serious threats with a realistic and imminent plan? ☐Yes ☐No
3. Is there evidence of substantial risk of serious harm to self, as evidenced by the presence of recent serious threats to commit deliberate and serious self-inflicted bodily injury with a realistic and imminent plan? ☐Yes ☐No
4. Are there current active threats of dangerous behavior that present a substantial risk to the personal safety and that require 24-hour medical and nursing supervision? ☐Yes ☐No
5. Is there actual violent, impulsive and unpredictable dangerous behavior that presents a substantial risk to personal safety that requires 24-hour medical and nursing supervision? ☐Yes ☐No

If the answer is YES on any of the above listed questions then patient is not ready for placement.

The consumer's clinical status has been assessed for substantial risk for imminent harm to others, based on the following:

6. Are there recent deliberate attempts to cause serious bodily injury to others? ☐Yes ☐No
7. Is there evidence of substantial risk to others, as evidenced by the presence of recent serious threats with a realistic and imminent plan? ☐Yes ☐No
8. Is there evidence of risk of imminent harm to others, as evidenced by the presence of recent threats to commit deliberate and bodily injury to others? ☐Yes ☐No
9. Are there current active threats of dangerous behavior that present a risk to the safety of others and that require 24-hour medical and nursing supervision? ☐Yes ☐No
10. Is there actual violent, impulsive and unpredictable dangerous behavior that presents a risk to the safety of others and that requires 24-hour medical and nursing supervision? ☐Yes ☐No

If the answer is YES on any of the above listed questions then patient is not ready for placement.

ABILITY TO CARE FOR SELF & RECEIVE TREATMENT IN LESS RESTRICTIVE ENVIRONMENT

11. Is the consumer able to perform activities of daily living necessary to basic survival and maintenance of adequate health, either independently, or if necessary community supports were made available? ☐Yes ☐No
12. Has the treatment team assessed that the consumer's condition can safely be treated in a less restrictive level of care? (If No, explain): ☐Yes ☐No
13. Are there other clinical or medical issues not specified above that may preclude community placement? (If Yes, explain): ☐Yes ☐No
14. Is there a need for a safety plan? (If Yes explain): ☐Yes ☐No
15. Does the consumer take their medications regularly? Can occasional non-compliance be handled in the community? ☐Yes ☐No
16. Due to Axis I psychiatric disorder, is hospital level structure and monitoring required to maintain health and safety? ☐Yes ☐No

If the answer is YES to questions 11, 12 and 15 the patient is ready for placement. A YES answer to questions 13, 14 and 16 do not prevent placement planning.

1

CONSUMER OBJECTION

17. Does the consumer have concerns about discharge? ☐Yes ☐No

Explain how the Treatment Team will respond if the answer is Yes to Question 16:

18. Does the consumer have a current forensic legal status? ☐Yes ☐No

Assessment Determination: Ready to Place; Not Ready to Place .

If the patient has a Forensic legal status and has been deemed Ready to Place then the IDT can request conditional release planning through the Forensic Risk Review Board and the Psychiatric Services Review Board. Date conditional release planning begins: .

COMMUNITY TRANSITION PLANNING NEEDED:

19. Recovery Supports (Family, Friends, Community Providers):

20. Medical:

21. Housing:

22. ADL Supports:

23. Psychosocial Rehabilitation:

24. Financial:

25. Legal:

26. Dual Diagnosis

27. Specialized Services (BSP, Incentive Plan, Sex Offender, Trauma, Gambling Addiction):

28. Other Services:

Level of Care identified:

M.D. Signature Date Social Worker Signature Date

3

APPENDIX J
OSH Community Living Assessment and Referral Form

Oregon Health Authority

OREGON STATE HOSPITAL
Community Living Assessment and Referral

ID

Name: _____ **Preferred Name:** _____ **DOB:** _____ **OSH#:** _____ **AVATAR#:** _____

Coordinated Care Organization/Choice Model Partner: _____ **County of Responsibility:** _____

OSH Social Worker: _____ **Phone#:** _____ **Address/Email:**_____

Admit Date: _____ **RTP Date:** _____

Birth Gender: ☐ **F** ☐ **M** **Self-Identified Gender:** _____

Religion or Spiritual Beliefs: _____ **Cultural Identity:** _____

Eligibility for other services: ☐ DD Eligible ☐ DD Applied Date: _____
☐ APD Eligible ☐ APD Applied Date: _____

Remarks: _____

LOCUS SCORE: _____

Placement Grid Recommendation LOC: _____**Clinician Recommended LOC:**_____ **ACLS:**_____

STRENGTHS AND PREFERENCES

Clinician identified patient's strengths and protective factors for consideration in discharge planning: _____

See Personal Preferences Questionnaire for patient identified strengths/dreams/goals.

MOTIVATION

Individual's Engagement in Discharge/Conditional Release Planning:

☐ Highly Motivated
☐ Moderately Motivated
☐ Slightly Motivated
☐ Patient is refusing placement

Remarks: _____

FAMILY

☐ Family/Significant other Involvement
Relationship/contact info: _____

☐ Visits regularly ☐ Visits periodically
☐ Participates in planning ☐ Supportive while in the community

In relation to mental health issues, family/significant other needs:
☐ Mental health education ☐ Support contacts (ex. NAMI)

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are *prohibited from making further disclosure without specific written consent of the* persons or as otherwise permitted by law.

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OREGON STATE HOSPITAL
Community Living Assessment and Referral

LANGUAGE

☐ **Fluent in English** ☐ **Limited English Proficiency**
What is native/primary language: _____

☐ **Hearing Impaired** ☐ **Visual Impairment-Legally Blind/Non-correctable**
☐ **American Sign Language mode of communication**
☐ **Interpreter needed for assessments and treatment planning:**

DIAGNOSIS

Current Diagnosis made by Psychiatrist or Nurse Practitioner

Psychiatric (including addiction):

Medical:

LEGAL

☐ **Guardian:** _____ ☐ **Health Care Representative:**_____ ☐ **Parole/Probation Officer:** _____
Contact Information: _____

Current Legal Status:
☐ Civil Commitment ☐ Vol. by Guardian ☐ GEI/PSRB ☐ .370 End of Commit Date _____
☐ Outstanding Charges ☐ Warrant **Remarks:** _____

☐ Restraining Order

FINANCIAL

☐ SSI $_____ ☐ SSDI $_____ ☐ VA $_____ Tribal: $_____ ☐ Other: _____ $_____
☐ Medicaid#:_____ ☐ Medicare A#:_____ ☐ Medicare B ☐ Medicare D: _____ ☐ Private Insurance: _____
Payee/Conservator: _____ Phone:_____
Address/Email:_____ Fax:_____
Financial Status and Instruction: _____ Forward funds to: _____

CLINICAL SYNOPSIS

Primary Reason for Hospitalization: _____

Progress in treatment: _____

Treatment recommendations and strategies to address discharge barriers: _____

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Community Living Assessment and Referral

COMMUNITY LIVING RECOMMENDATIONS

What was patient's last housing? _____ Patient's county of residence prior to admission: _____

Level of Independence (check as many as apply):

Housing:
- ☐ Independent
- ☐ With Family
- ☐ Supportive Housing (on-site MH)
- ☐ Supported Housing
- ☐ Structured

Staff Support:
- ☐ Independent with Outpatient Mental Health
- ☐ Independent with Multiple MH Contacts per Week (ACT)
- ☐ Daytime Supervision (8am/8pm)
- ☐ 24-Hour Awake Support/Supervision
  - ☐ Danger to Others
  - ☐ Danger to Self
  - ☐ Inability to Care
  - ☐ Medical

Describe: _____

- ☐ History of Arson (legal) Date/Descript: _____
- ☐ History of careless smoking or accidental fire setting Date/Descript: _____
- ☐ History elopement/walk away Date/Descript: _____

APD:
- ☐ Patient's Own Residence
- ☐ AFH
- ☐ ICF (nursing home)
- ☐ ECS/ICF
- ☐ RCF
- ☐ ECS/RCF
- ☐ ECOS

☐ **Community living options reviewed with patient (required field)**

SERVICES:

Rehabilitative Services	**Habilitative Services**
☐ ACT (Assertive Community Treatment) See referral	☐ Vocational Rehabilitation
☐ Intensive Case Management	☐ Supported Employment
☐ Individual Therapy	☐ Activity Therapy
☐ Group Therapy	☐ Community Reintegration Activities
☐ Family Therapy	☐ Psych-Ed and Living Skills Training
☐ Peer Support	
☐ Behavioral Plan/Supports	
☐ Gender Identity Support	
☐ Other: _____	

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OREGON STATE HOSPITAL
Community Living Assessment and Referral

CONTINUING CARE TREATMENT/SERVICES NEEDS:	
Primary Conditions: ☐ Primary Mental Illness ☐ Addiction ☐ Intellectual Disability ☐ TBI/ABI ☐ Inability to Care for Self/ADL Supports ☐ Other Significant Treatment/Service Needs: _____	History of: ☐ Dangerousness Toward Others ☐ Aggression / Current last 30 days ☐ Sexual Safety Concerns ☐ Self –Harm ☐ Arson / Property Destruction ☐ Treatment / Medication Non-Compliance ☐ Polydipsia ☐ Impulsive/Disruptive Behavior ☐ Trauma, Abuse and/or Exploitation

SEX OFFENDER ☐ **N/A**

Sex Offender Treatment/Support: ☐ Recommended

☐ Sex offender treatment ☐ Polygraphs ☐ Plethysmograph

☐ Acknowledges/Agrees to participate in sex offender treatment ☐ Must register with Oregon State Police

SUBSTANCE ABUSE ☐ **N/A**

Substance Abuse Treatment/Support: ☐ Recommended

☐ Relapse Risk *Check all that apply*: ☐ Drugs ☐ Alcohol ☐ Prescription drugs

Date of last use: _____ Pattern of use: _____

☐ Co-occurring groups/education ☐ Residential A&D Treatment
☐ Agrees to attend treatment upon discharge: If No, explain: _____

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OREGON STATE HOSPITAL
Community Living Assessment and Referral

MEDICAL NEEDS

Medical Issues: ☐ Routine Health Maintenance or *RN to Check all that apply:*

☐ Multi-Drug Resistant Organism (ie. MRSA) Type: _____ Site: _____ Date: _____
☐ Requires Insulin ☐ Pregnant ☐ Seizure Disorder ☐ Dysphagia: Diet: _____
☐ Glucose Monitoring ☐ Needs Wheelchair or Walker
☐ Peg tube feeding ☐ Blood pressure monitoring
☐ Catheter placement ☐ Hyponatremia
☐ Fall/Unsteady Gait ☐ Incontinent bowel/bladder
☐ Bowel/bladder training (ex., diapers) ☐ Other (specify) _____

☐ Medical Equipment Needed (specify) _____
☐ Medical Self-Management Training (specify) _____
☐ Dietary needs/restrictions (specify) _____

PPD ☐ Date: _____ Chest Xray ☐ Date: _____ HEP B Pos. ☐ Date: _____ HEP C Pos. ☐ Date: _____

☐ Does not consent or cooperate with medical care: *Explain:* _____

☐ Disabled: Recommended accommodation i.e., service animal, etc.: _____

MEDICATION

RN to Check all that apply:

Medication Adherence Status:
☐ No Medication ☐ Taking medications now
☐ Refusing ☐ Agrees to take medications in the community

Medication Needs:
☐ Routine Medication monitoring
☐ Requires staff to administer meds
☐ Recommend Self Med/Med Ed Program
☐ Training regarding Self Injection of Insulin
☐ Patient on Clozapine (requires a designated pharmacy and assigned psychiatric provider)

ADDRESSOGRAPH

File: Behind Face Sheet
Thin: Do Not Thin
OSH STK: XXXXX 5

OREGON STATE HOSPITAL
Community Living Assessment and Referral

COUNTIES

If other counties will be considered for housing - *Check all that apply as patient's preferences*:

☐ No specific county preferences

☐ Baker	☐ Benton	☐ Clackamas	☐ Clatsop	☐ Columbia
☐ Coos	☐ Crook	☐ Curry	☐ Deschutes	☐ Douglas
☐ Gilliam	☐ Grant	☐ Harney	☐ Hood River	☐ Jackson
☐ Jefferson	☐ Josephine	☐ Klamath	☐ Lake	☐ Lane
☐ Lincoln	☐ Linn	☐ Malheur	☐ Marion	☐ Morrow
☐ Multnomah	☐ Polk	☐ Sherman	☐ Tillamook	☐ Umatilla
☐ Union	☐ Wallowa	☐ Wasco	☐ Washington	☐ Wheeler
☐ Yamhill				

☐ Out of state specify where: _____

☐ Out of country specify where: _____

PERSONAL CARE PLAN/PRELIMINARY

3- Substantial assistance and training to perform skill – (client can perform only a small portion of a task and requires assistance with a majority of the task)
2- Support and training to practice skill – (client is able to perform a majority of a task, but requires some assistance)
1- Prompts or supervision to practice skill – (client is able to perform the tasks independently, but occasionally needs cueing and observation)
0- Practice skill independently – (able to perform tasks independently without supervision)

FUNCTIONAL NEEDS – ADL TASKS	3 2 1 0
Eating/Feeding	☐ ☐ ☐ ☐
Maintain personal hygiene	☐ ☐ ☐ ☐
Self-manage medication	☐ ☐ ☐ ☐
Use and maintain adaptive or medical devices including (change, clean, empty)	☐ ☐ ☐ ☐
Feed self	☐ ☐ ☐ ☐
Ambulate and transfer	☐ ☐ ☐ ☐
Use toilet and care for bowel and bladder	☐ ☐ ☐ ☐
Delegate nursing tasks (see OAR 411-034-0010)	☐ ☐ ☐ ☐

INSTRUMENTAL ACTIVITIES OF DAILY LIVING - IADL TASKS	3 2 1 0
Manage finances and budget	☐ ☐ ☐ ☐
Plan and prepare meals	☐ ☐ ☐ ☐
Clean and maintain residence	☐ ☐ ☐ ☐
Independently access transportation	☐ ☐ ☐ ☐
Manage and attend medical or health appointments	☐ ☐ ☐ ☐
Maintain compliance with court or legal requirements	☐ ☐ ☐ ☐
Plan and participate in social, recreational or community activities	☐ ☐ ☐ ☐

File: Behind Face Sheet
Thin: Do Not Thin
OSH STK: XXXXX 6

ADDRESSOGRAPH

OREGON STATE HOSPITAL
Community Living Assessment and Referral

PSYCHOSOCIAL SKILLS	3 2 1 0
Manage symptoms that pose a physical risk to self	☐ ☐ ☐ ☐
Manage symptoms that pose a physical risk to other	☐ ☐ ☐ ☐
Manage symptoms that reduce ability to control impulses	☐ ☐ ☐ ☐
Manage symptoms of delusional or disorganized thinking	☐ ☐ ☐ ☐
Manage symptoms of emotional excess	☐ ☐ ☐ ☐
Communicate effectively with others	☐ ☐ ☐ ☐
Manage comorbid or co-occurring condition	☐ ☐ ☐ ☐

PERSON-CENTERED SERVICES AND SUPPORT	Number of hours required daily:			
	16 – 24	8 – 15	0 – 7	None
Modified physical environment, program routine or staffing pattern				
Provide line of sight supervision in milieu or community				
Provide 1:1 support, supervision and monitoring				

COMPLETED BY:

_____ _____

Social Worker Nursing

Date: _____ Time: _____

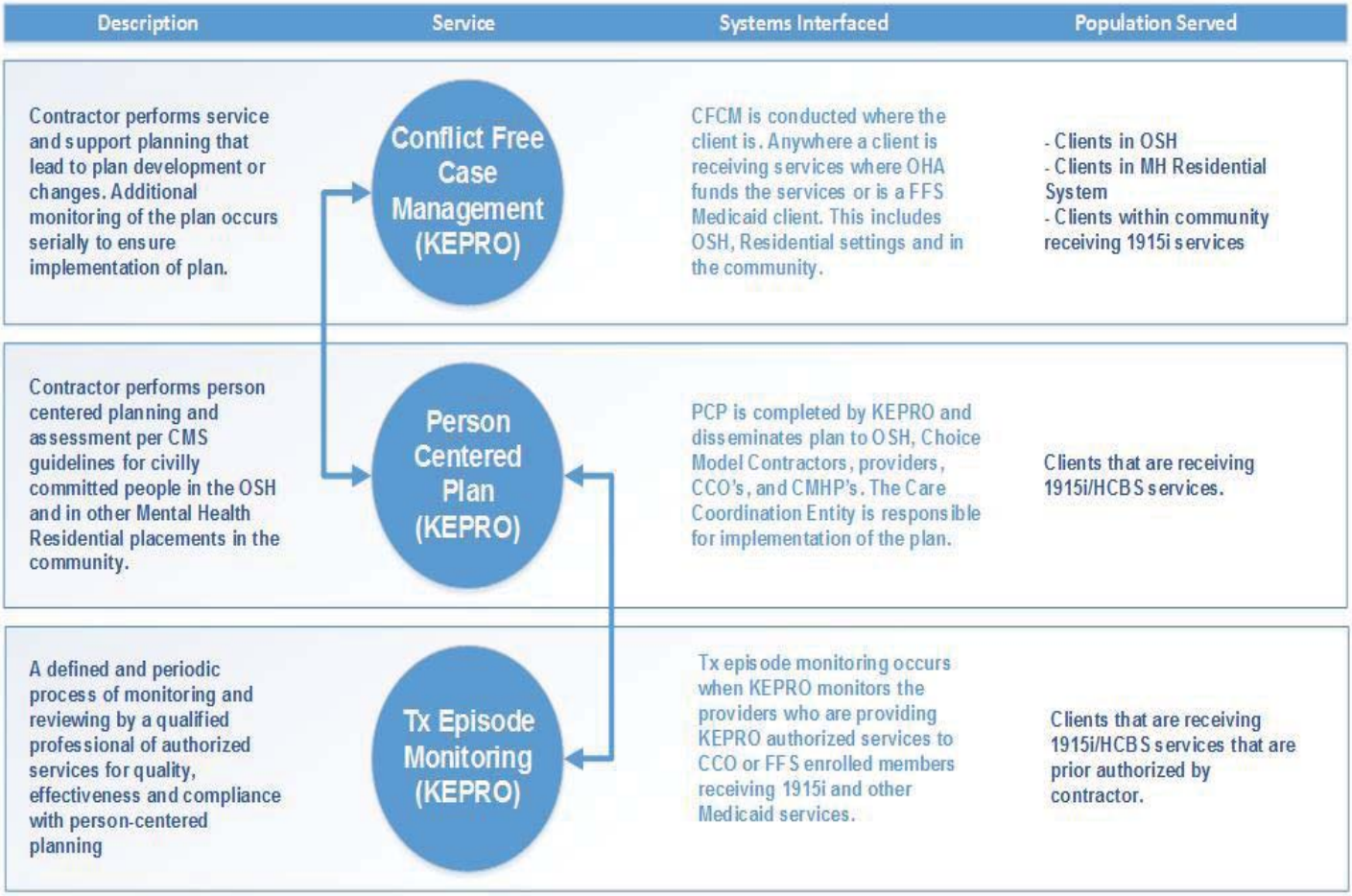
File: Behind Face Sheet
Thin: Do Not Thin
OSH STK: XXXXX 7

ADDRESSOGRAPH

APPENDIX K
Roles of KEPRO, OSH, Choice Contractors, CCOs, and Community Providers

Role	Responsibilities Related to discharge of patients from OSH
KePro	Completes independent assessment of needs supporting a timely discharge for all civil commitment clients. • Complete Person Centered Plan for clients on RTT • Review preauthorization for SRTF services within 10 days • Attend IDT meetings to support Person Centered Plan implementation • Provide utilization management in residential settings • Ensure Medicaid service delivery at discharge
OSH	Provides stabilization and treatment, determines status for ready to transition, and coordinates internal with external partners. Social Workers and Transition Assistants: o Completes community living needs assessment o Coordinates reintegration planning and active engagement by Kepro, Choice and community providers o Requests SRTF approvals o Screens and refers appropriate clients to ACT
Choice Contractors	Identifies, plans, arranges and assist access to home and community based services and supports needed for timely discharge. • Facilitates a planful transition into OSH through community resources and information for stabilization and discharge planning • Single Point of Contact for ACT • Facilitates referrals based the Person Centered Plan to community resources, including o Supported Housing o Peer Delivered Services o Supported Employment
CCO	Care coordinates Medicaid members to assure medical services and equipment for community placement is ready at discharge • Collaborates with OSH & Choice • Funds ACT teams to meet the need of Medicaid recipients
Providers of Service	Provide stabilization services in route to more integrated living • Screen clients for admissions criteria & payment rules • Report census to Kepro monthly

KEPRO's Functions To Support Medicaid 1915i And HCBS Requirements

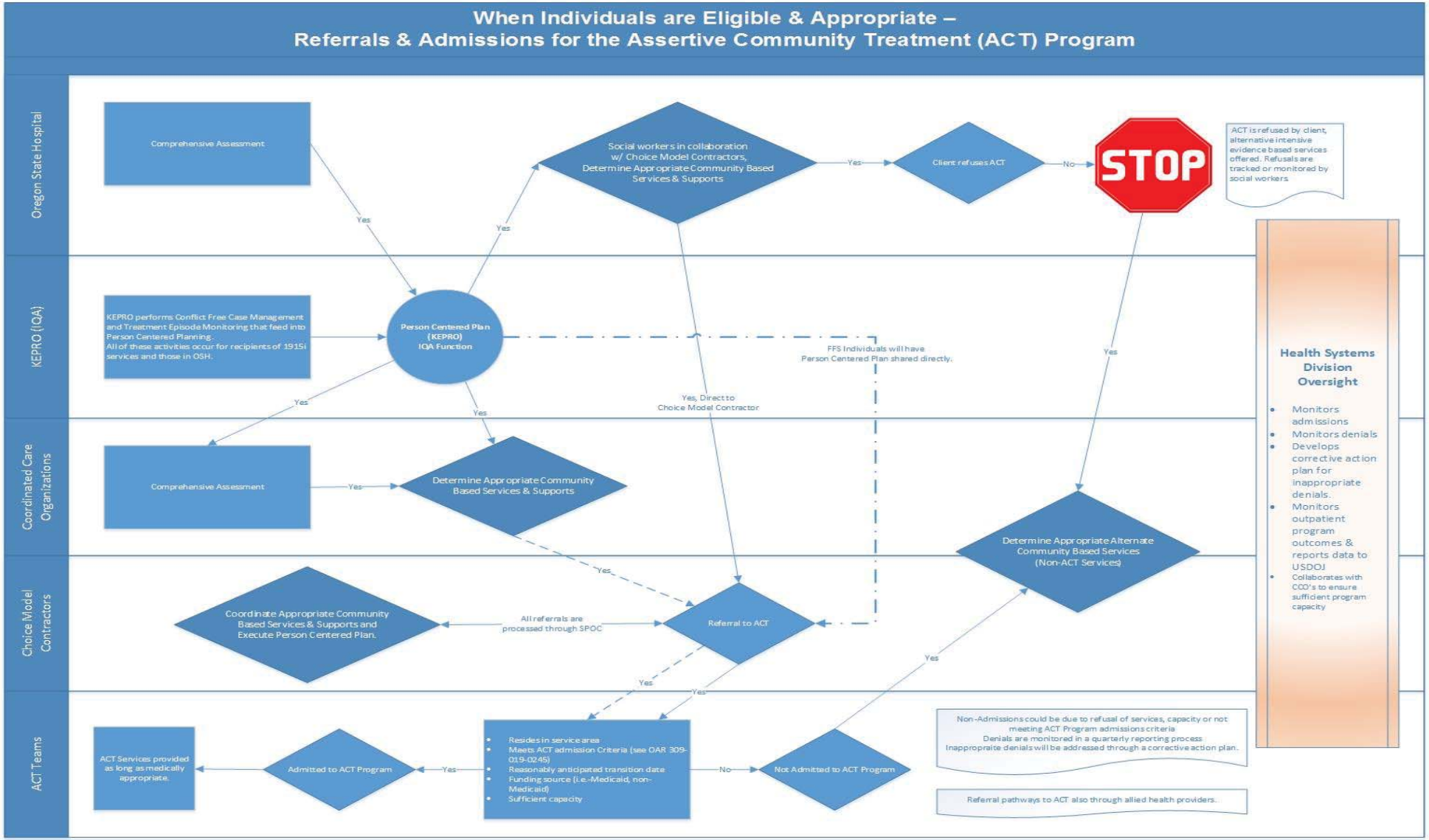


OHA Director's designee for all SRTF admissions is KEPRO.

KEPRO conducts 1915(i) HCBS eligibility determinations defined as the process for:
~Receiving eligibility determination requests for 1915(i) services from providers and advocates, and
~Perform a face to face evaluation and determine eligibility based on the defined 1915(i) HCBS state plan amendment criteria OAR 410-172-0700.

APPENDIX L

Flow Chart of Referrals and Admissions to ACT Services



APPENDIX M
Jail Diversion Reporting Template

Oregon Health Authority
Health Systems Divsion
Adult Mental Health Investments Reporting Workbook

Jail Diversion Reporting:	
Requirement:	**Instructions:**
Reporting Periods:	**Calendar Quarters:** January - March April - June July - September October - December
Jail Diversion Report Due Dates:	45 days after the reporting period (on the 15th of the second month after the end of the period). If the 15th falls on a weekend or holiday, the report is due on the next business day.
Jail Diversion Individual Entry Data Sheet	
Required Information:	**Organization Name**
	Reporting Quarter (include year-see Jail Diversion Tip Sheet for an example)
	Client Unique ID Provider Number, MOTS Person ID Number, and Medicaid ID Number: Client ID: The number that your agency assigns to the client in your data system; this is not a Social Security Number. MOTS Person ID: Person ID (made up of numbers) assigned to a patient who is entered in MOTS (per contract). A formula calculating number of people served counts unique numbers in this column. On the summary, you may use the formula number (to the right) or enter your own number. However, please note that the reporter is responsible for providing accurate information - data clean up is not the responsibility of OHA. Please provide the client's Medicaid ID number, as well.
	Client Name: First and Last
	Date of Birth (DOB): Client's Date of Birth
	Number of Arrests in the Quarter: Per Client's self report **Diversion Type: (drop down menu)** Pre-booking or post-booking
Jail Diversion Report Summary Sheet	
Required Reporting:	
Organization or County Name	
Organization Medicaid ID Number	
Reporting Quarter (include year-see Jail Diversion Tip Sheet for an example)	
Organization Point of Contact:	
The contractor must track and report on the number of individuals whose charges were dropped or dismissed as a result of Jail Diversion Services.	
The Contractor must track and report on the number of individuals who were diverted from 160.370 aid & assist services.	
The Contractor must track and report on the types of charges against the individuals who received post-booking Jail Diversion Services.	
The Contractor must identify if any changes in the Jail Diversion Program within the reporting period.	
The Contractor must identify and report the types of Jail Diversion Services that are new (previously not reported) to their program during the reporting period.	
The Contractor must identify and report any external/internal risks or opportunities that could affect Jail Diversion Services (See Jail Diversion Tip Sheet for examples).	
Please submit all forms by e-mail to the AMH Contract Administrator Drop-Box at: AMHcontract.Administrator@state.or.us	

Oregon Health Authority
Health Systems Division
Jail Diversion Program Tip Sheet

Organization Name:	*Enter the organization's legal name, as it is stated on the contract, here.* *Ex: County Mental Health Program*	
Organization Medicaid ID Number:	*Usually a nine digit number that starts with several zeros*	
Reporting Period:	Enter reporting period here *(e.g. January - March 2014)*	
Organization Point of Contact:	*Please enter the name and contact information for the person who can be reached if there are questions regarding this* *Ex: John Smith, Jail Diversion Coordinator* *Phone: 503-555-5555* *E-mail: John.Smith@somecounty.co.or.us*	
Jail Diversion Services are defined as any service that is provided to divert individuals with mental illness charged with low-level, non-violent misdemeanors from the criminal justice system or commitment to the Oregon State Hospital.		
1)	Report the total number of people that received services designated as pre-booking or post-booking diversion. Break out the following information:	
1a)	Pre-booking diversions do not result in arrest or charges. Pre-booking diversion services include law enforcement diversions that pairs a Jail Diversion Program (JDP) clinician with law enforcement to co-respond to calls with mental health elements. Calls in which JDP clinicians are involved primarily and deliberately involve those individuals thought to be experiencing emotional distress and/or psychiatric symptoms who also may have co-occurring substance use issues. In this model, the police determine whether a person is a candidate for jail diversion. Then, while on site with police, a crisis clinician evaluates the need for hospitalization, makes referrals and can provide follow-up services to monitor treatment compliance, freeing the officers for public safety duties.	determined by formula
1b)	Post-booking Jail Diversion services occur after an arrest is made or charges have been filed. Post-booking services include services delivered post-adjudication (e.g. Jail In-Reach, completion of competency restoration in the community, Forensic Assertive Community Treatment (FACT) service, etc.). Post booking services include the expedited release of the individual from law enforcement custody and/or jail. Post booking services include the expedited release of a 370 from the Oregon State Hospital.	determined by formula
	Total Number Served:	**enter answer from right or your number**
2)	Report the number of incidences where charges were dismissed or dropped as a result of jail diversion services.	Hand count
3)	Report the number of people that were diverted from the Oregon State Hospital for 161.370 aid & assist services.	Hand count
4)	Report the number of crisis consults performed by mental health staff:	Hand count
5)	Report the five (5) most common charges for which people were arrested that received jail diversion services.	
Charges: *Please put the top five charges/crimes that were encountered that received diversion services. See below for example:*		**# of times this charge was encountered:**
Ex: Disorderly Conduct		*13*
Ex: Public Intoxication		*8*
Ex: Unlawful entry to a public transit vehicle		*2*
6)	Provide the five (5) most common jail diversion services that people received in the current reporting period and the number of individuals who received each service.	
Services:		**# of individuals who received services:**
Ex: Jail In-Reach		*21*
Ex: Case Mangement		*13*
Ex: Peer Delivered Services		*4*
7)	Please describe any changes to your Jail diversion program:	
7a)	Provide a detailed description of any new jail diversion service or program created during the current reporting period.	
The response to this question should be a brief description (bulleted format) of changes in services or any new services that were created after your last quarterly report was submitted. Only include changes that have not been previously reported. Your answer to this question can be "N/A" if no new services were provided.		
7b)	Provide information regarding any activities related to jail diversion that involve law enforcement agencies, jails, circuit and municipal courts, community corrections, and local mental health providers that may impact Jail Diversion Services.	
The response to this question is administrative in nature; please provide a brief description (bulleted format) of any activities or events that had an effect on the Jail Diversion Program.		
8)	**Success story (optional): Use the space below to tell a story about a positive outcome as a result of this funding.**	
Any referrence to the recipient of services in this section should be stated as "the client" to protect the recipient's confidentiality. Provide the contact information for the individual(s) (staff members only) who was/were major player(s) in the success story. 1) What happened? 2) Where did it happen? 3) Why was this a success? What was remarkable about this event? 4) How was the funding for this program directly responsible for the positive outcome?		

Revised 3/20/14

Oregon Health Authority
Jail Diversion Individual Data Entry Sheet

Organization Name: 0								
Reporting Period: 0								
	A		**B**	**C.1**	**C.2**	**D.**		**E.**
#	**Client ID**	**MOTS Person ID#**	**Medicaid ID #**	**Client Last Name**	**Client First Name**	**Date of Birth**	**Number of Arrests in the Quarter**	**Pre/Post Booking**
1								
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Revised 3/20/14

Oregon Health Authority
Health Systems Division
Jail Diversion Program Summary Reporting Form

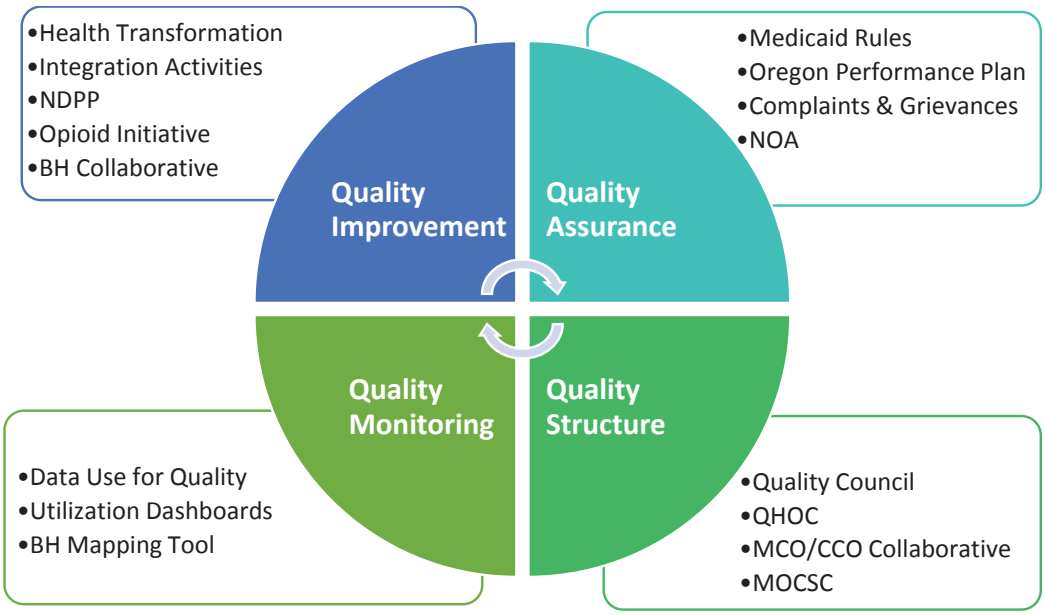
Organization Name:		
Organization Medicaid ID Number:		
Reporting Period:		
Organization Point of Contact:		
Jail Diversion Services are defined as any service that is provided to divert individuals with mental illness charged with low-level, non-violent crimes from the criminal justice system or commitment to the Oregon State Hospital.		
1)	Report the total number of people that received services designated as pre-booking or post-booking diversion. Break out the following information:	
1a)	Report the number of people that received services designated as pre-booking diversion.	0
1b)	Report the number of people that were arrested that received services designated as post-booking diversion.	0
	Total Number Served:	**0**
2)	Report the number of incidences where charges were dismissed or dropped as a result of jail diversion services.	0
3)	Report the number of people that were diverted from the Oregon State Hospital for 161.370 aid & assist services.	0
4)	Report the number of crisis consults performed by mental health staff:	0
5)	Report the five (5) most common charges for which people were arrested that received jail diversion services.	
Charges:		**# of times this charge was encountered:**
6)	Provide the five (5) most common jail diversion services that people received in the current reporting period and the number of individuals who received each service.	
Services:		**# of individuals who received services:**
7)	Please describe any changes to your Jail diversion program:	
7a)	Provide a detailed description of any new jail diversion service or program created during the current reporting period.	
7b)	Provide information regarding any activities related to jail diversion that involve law enforcement agencies, jails, circuit and municipal courts, community corrections, and local mental health providers that may impact Jail Diversion Services.	
8)	**Success story (optional): Use the space below to tell a story about a positive outcome as a result of this funding.**	

APPENDIX N
OHA Quality Management Structure and Activities

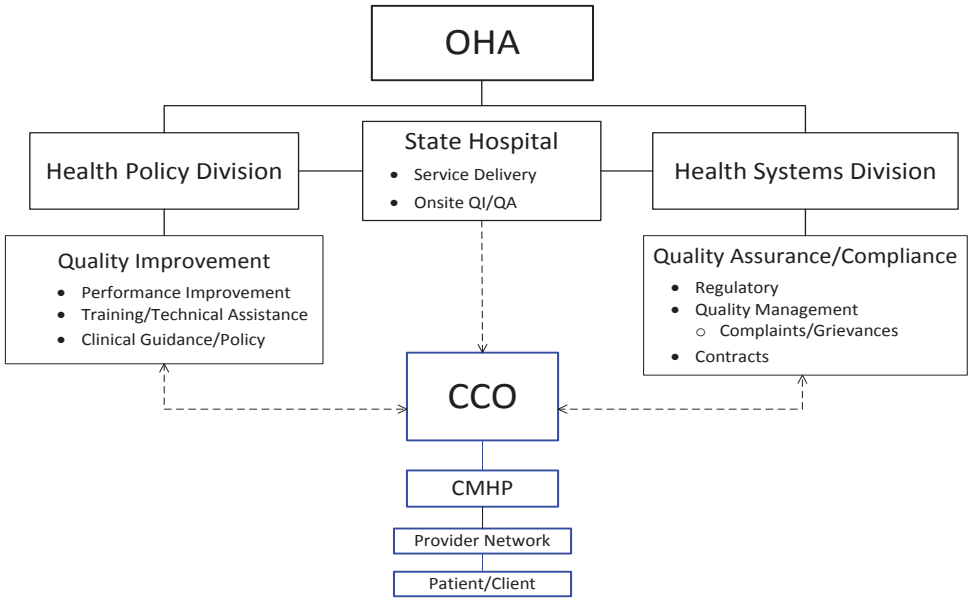
Oregon Health Authority

Quality Management (QM)

QM Activities



Organizational Overview



Quality Initiatives Schedule

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Quality Council	Strategic Planning	Suicide Prevention Common Credentialing	Oral Health Integration	Statewide PIP annual report	Oregon Performance Plan		Mid Year Transformation Report			Oregon Performance Plan		Winter Break
QHOC												
Clinical Directors	Canceled - weather	Transormation report Hep C / LARC	BH Integration Oral Health Road map				Mid Year Transformation Report					Winter Break
Learning Collaborative	Canceled - weather	ABA	PDMP / EDIE		Trauma Informed	TC: Equity??	TC off	TC off	ECU metric		TC	
QI	Canceled - weather	QAPI	Measurement 101 Training	Statewide PIP C&G training			3x3 Learning			QM Plan		
BH Directors	Canceled - weather											
HERC	x		x		x			x		x	x	

Quality Council Potential Topics
Opioid Use - pregnancy
Suicide Prevention
Common Credentialing
Transitions
Special Health Care Needs - MH

QHOC Potential Topics
ABA
Residential Tx
Transgender Services
Oral Health Integration

Learning Collaborative
HIT: Pre Manage / EDIE
Case Management
CAHPS- Client Experience
Health Equity
Trauma Informed Care
Obesity
Kindergarten readiness

HERC Potential Topics
Bariatric Surgery
Tobacco Cessation - Elective Surgery
Genetic testing

Oregon Health Authority
Mission: Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.
Vision: A healthy Oregon
Goals:
- Improve the lifelong health of all Oregonians
- Increase the quality, reliability, and availability of care for all Oregonians
- Lower or contain the cost of care so it is affordable to everyone

as of 1/9/2017