Oregon Performance Plan
Semi-Annual Narrative Report
January 2019

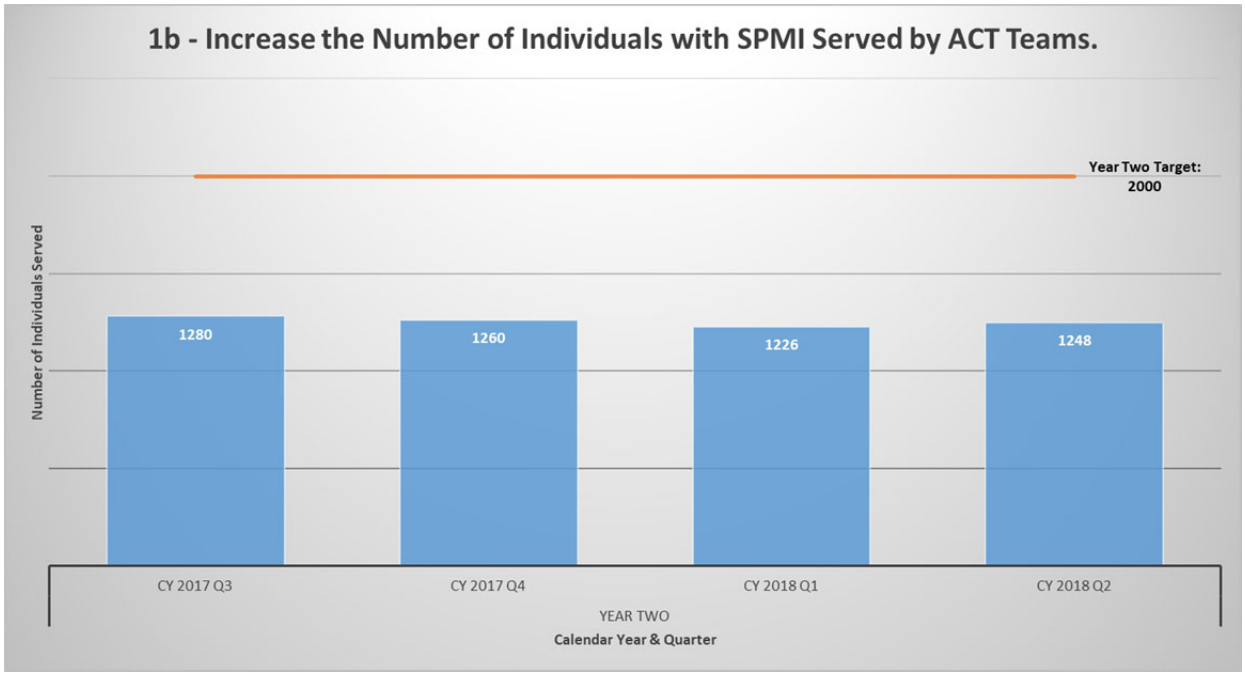
The Oregon Performance Plan (OPP) requires that Oregon Health Authority (OHA) provide data to USDOJ on a quarterly basis and a narrative report about the data every six months. This is the fourth semi-annual report about data.

For each of the data metrics, this report will describe the calendar year 2015 Baseline Data (if applicable and available), the target for the time period reported (if applicable), the methodology for collecting the data, and the progress of each metric for the quarter ending 06/30/18. At the end of each section, this report will describe the activities associated with the metric(s) in that section. This report does not review or discuss requirements related to OHA's implementation of various processes. However, those processes may be referenced if related to the data metrics. Some of the metrics in the OPP require baselines to be established since there are percentage improvement targets. The other metrics have baselines to inform the review of progress, and numeric annual targets are provided for a number of the metrics. While OHA has detailed implementation plans associated with the OPP, only some of the implementation activities are highlighted in this report.

This report includes graphs for those metrics that have established targets. Further information about the metrics is provided in Appendix A. All metrics are summarized in the attached Data Report in Appendix B.

Assertive Community Treatment (ACT)

#1 (a-b) Number Served with ACT



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, 815 individuals were being served by ACT.

Comments on Methodology
The data regarding ACT services is received via quarterly reports from providers, via the Oregon Center of Excellence for ACT (OCEACT). OHA will identify the number of individuals served at the end of each fiscal year to determine if the performance outcome has been achieved.

Comment on Progress
Pursuant to the OPP, OHA will increase the number of individuals with SPMI served by ACT teams. OHA will provide ACT services to everyone who is referred to and eligible for ACT and will meet a metric so that 2,000 individuals will be served by the end of fiscal year two (June 30, 2018). As of 6/30/18, a total of 1,248 individuals were being served by ACT, an increase of 50% over the baseline year, but short of the year two target by 752. Growth in ACT numbers has remained level for the last four quarters of reporting.

Activities Associated with Metric

OHA has taken several steps to address growth in ACT numbers. OHA is partnering with OCEACT to ensure individuals eligible for ACT services receive ACT services.

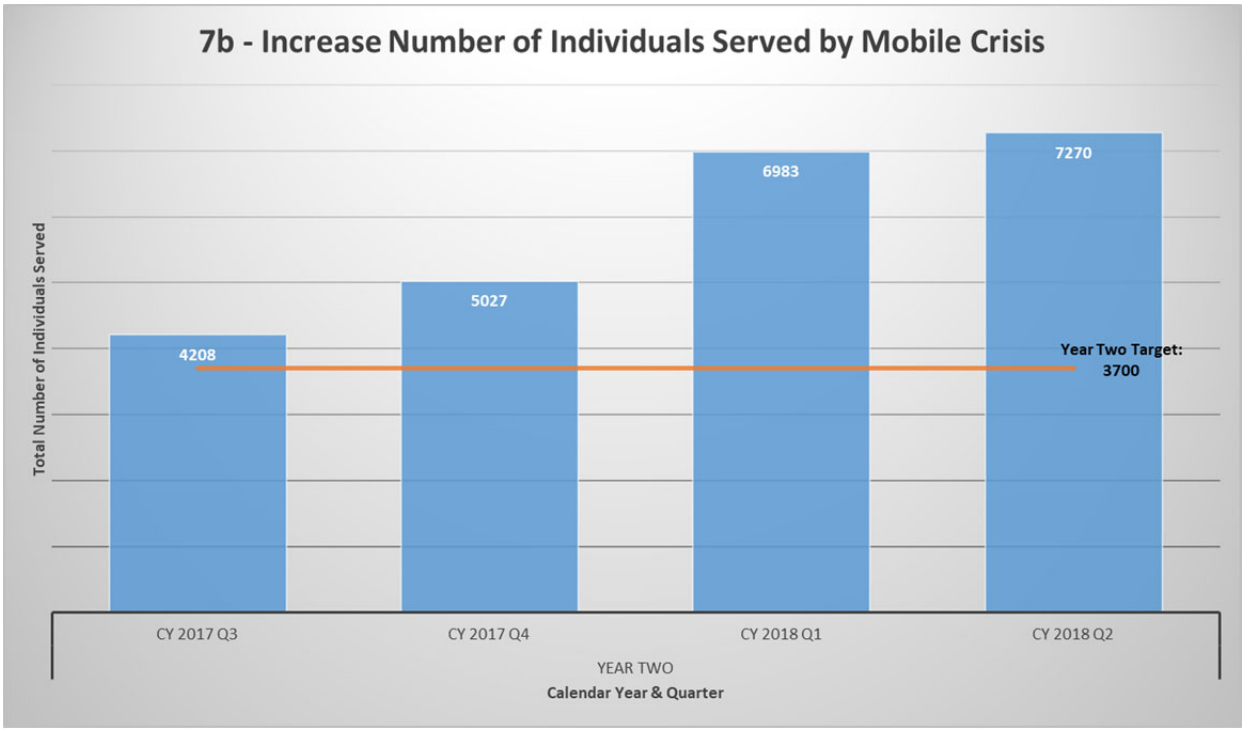
The Coordinated Care Organization 2019 Contract, effective January 1, 2019, better identifies CCO responsibilities regarding providing ACT to all eligible individuals. It reads:

> *Contractor shall:*
> *(1) Ensure Members with SPMI are assessed to determine eligibility for ACT.*
> *(2) Ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services. Related provisions: OAR 309-019-0105 and 309-019-0225 through 309-019-0255.*
> *(3) Ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed. When ten (10) or more of Contractor's adult Members with SPMI in Contractor's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Contractor solutions, additional capacity may be created by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams. If contractor lacks qualified providers to provide ACT services, Contractor shall consult with OHA and develop a plan to develop additional qualified providers.*
> *(4) Ensure all denials of ACT services for all adult Members with SPMI are based on established criteria and are recorded and compiled in a manner that allows denials to be accurately reported out.*
> *(5) Follow the Notice of Adverse Benefit Determination process for all denials of ACT services for adult Members with SPMI.*

OHA has worked with the CCOs in understanding this responsibility by revising Oregon Administrative Rules, speaking specifically about ACT at the Rules Advisory Committee which included CCOs, and discussion during the CCO Behavioral Health Directors quarterly meeting. OHA will continue to work with CCOs and will be providing additional guidance documents in the coming weeks.

Crisis Services

#7 (a-b) Number Served with Mobile Crisis



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, a total of 3,150 individuals received mobile crisis services.

Comments on Methodology
OHA captured mobile crisis services through 3/31/1/, utilizing the Measures and Outcomes Tracking System (MOTS). Beginning 4/1/18, OHA is collecting data for mobile crisis via a quarterly reporting template. This allows for tracking response times and dispositions. This also ensures we are counting only the data for mobile crisis responses that occur in the community and not in Emergency Departments (ED) or other settings not considered to be a mobile response. The number of individuals receiving these services in both methodologies is unduplicated. For instance, if the same individual received mobile crisis services multiple times through the year, they are still only counted as one. The metric for individuals receiving mobile crisis services is based on a rolling 12 month period, whereas the response times and dispositions are reported quarterly.

Comment on Progress

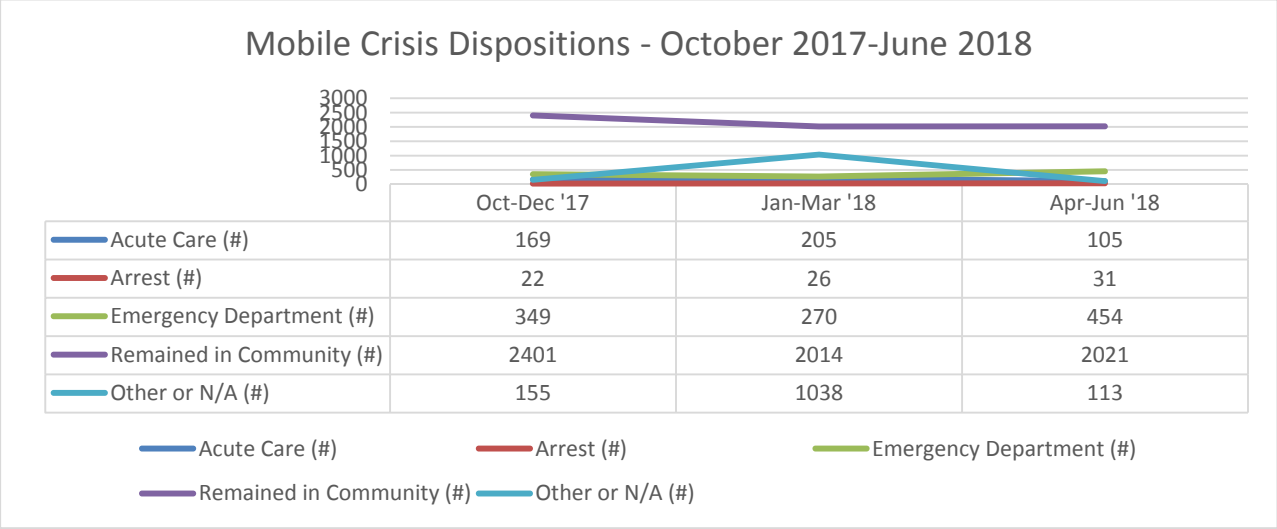
Pursuant to the OPP, OHA will increase the number of individuals served with mobile crisis services, so that during fiscal year two (July l, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis. There were 7,270 individuals who received mobile crisis services during the quarter ending 6/30/18. This is 3,570 over the target of 3,700.

Activities Associated with Metric

The 2017 Legislature allocated $15 million to OHA to address the goals of the Oregon Performance Plan. OHA utilized $10 million of the $15 million to increase mobile crisis services to address statewide coverage. The funding has been allocated through the County Financial Assistance Agreement (CFAA). All counties now have mobile crisis programs in place.

#8 (c) The Number of Dispositions resulting in Stabilization in a Community Setting Rather than Arrest, ED, or Admission to Acute Care

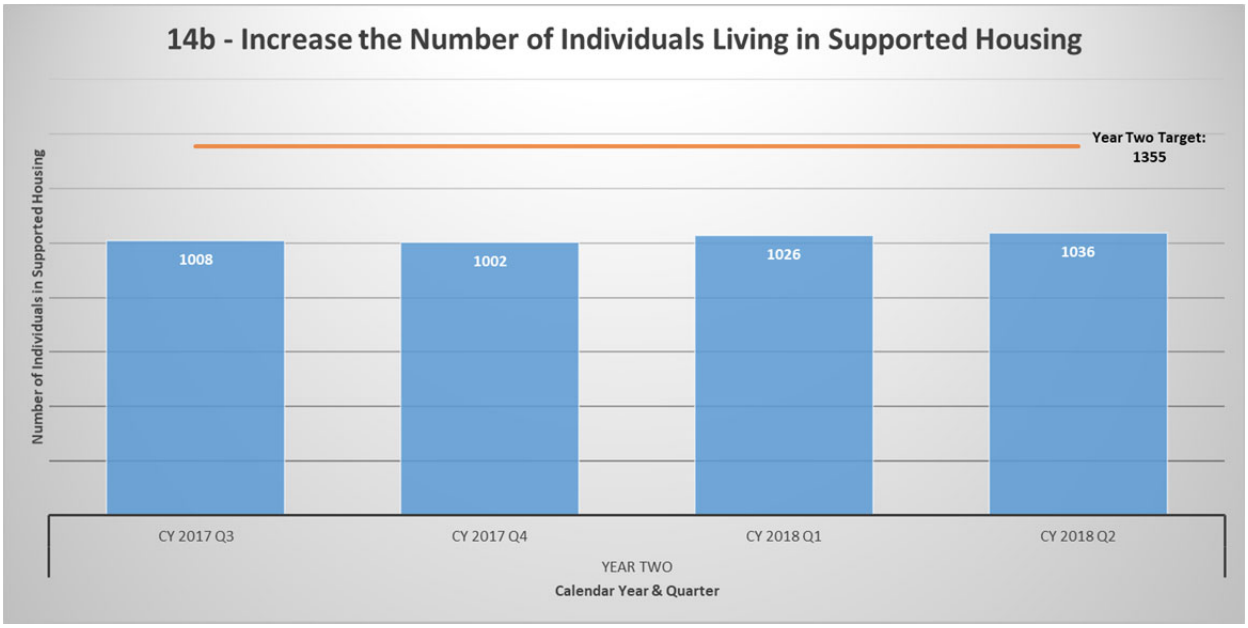
Dispositions following a mobile crisis response for October 2017 through June 2018 are indicated in the graph below. The graph indicates a majority of individuals are stabilized and remain in the community following a mobile crisis service.



	Oct-Dec '17	Jan-Mar '18	Apr-Jun '18
Acute Care (#)	169	205	105
Arrest (#)	22	26	31
Emergency Department (#)	349	270	454
Remained in Community (#)	2401	2014	2021
Other or N/A (#)	155	1038	113

Supported Housing

#14 (a-c) Number Living in Supported Housing



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, there were 442 individuals living in Supported Housing.

Comments on Methodology
Supported Housing is calculated using a combination of Supported Housing units developed and occupied and individuals receiving rental assistance in existing affordable housing units that meet the definition of Supported Housing. The Rental Assistance provider reporting requirements were enhanced this year to distinguish individuals in Supported Housing and those in Supportive Housing. For the Rental Assistance Program, although data are collected on both Supported and Supportive Housing, only the Supported Housing is counted. This is then combined with additional units of Supported Housing that have been developed and in which adults with SPMI are living for a combined overall count.

Comments on Progress
Pursuant to the OPP, OHA's housing efforts will include an increase in the number of individuals with SPMI in Supported Housing, in fiscal year two (July 1, 2017 to June 30, 2018), so that at least 1,355 individuals will live in Supported Housing.

As of 6/30/18 there were 1,036 individuals residing in Supported Housing. OHA is 319 short of the goal.

OHA also tracks the number of individuals with SPMI receiving Supportive Housing, applying the definition for that term found in the November 2012 letter of agreement with USDOJ. Supportive Housing is another form of housing support provided for the SPMI population. As of 6/30/19, there were 1,415 individuals with SPMI living in Supportive Housing in addition to those living in Supported Housing.

OHA is also maintaining an inventory of affordable housing statewide, available at http://www.oregon.gov/oha/amh/Pages/affordable_housing.aspx. As of the end of calendar year 2018, there were 54.691 units of affordable housing throughout Oregon.

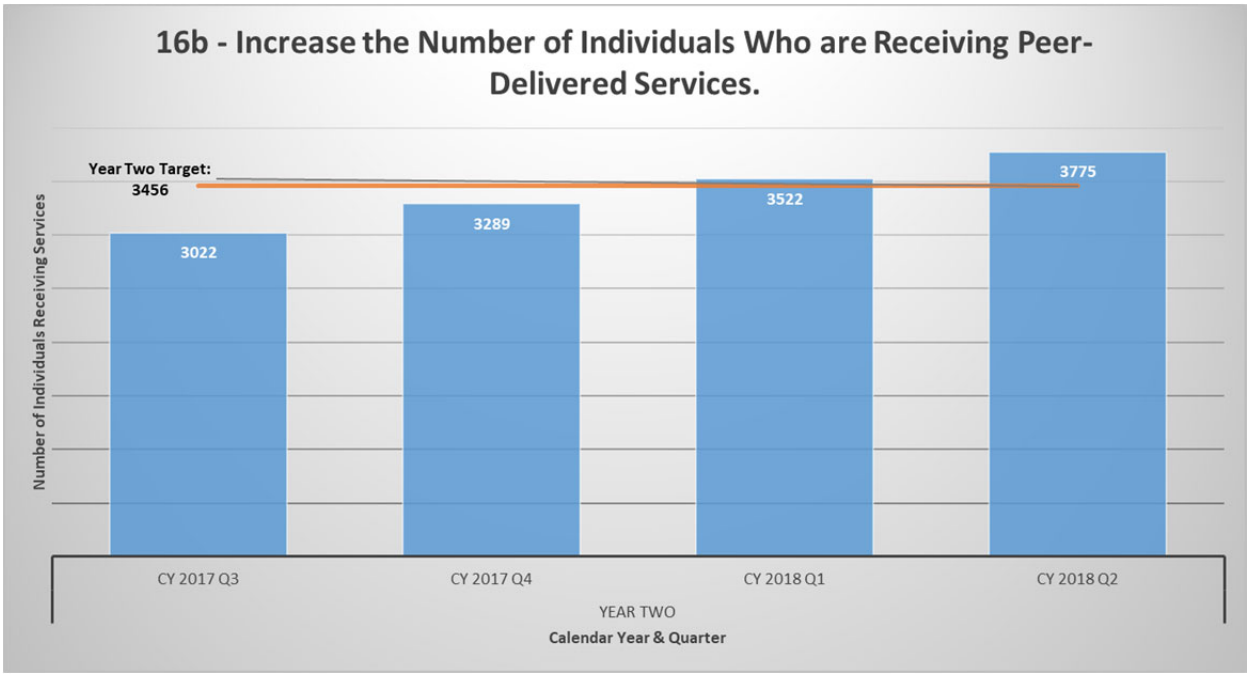
Activities Associated with Metric(s)

OHA continues to work with Oregon Housing and Community Services (OHCS) to increase Supported and Supportive Housing opportunities for both individuals with SPMI and individuals with substance use disorder (SUD). Using competitive funding rounds, as of July 2018, OHCS in collaboration with OHA has obligated a total of $13.2 million of the $20 million provided to OHCS by the 2015 Legislature for development of Supported and Supportive Housing. The most recent round of Notice of Funding Availability was veteran focused. OHCS Mental Health Housing Funds (MHHF) totaling $700,000 were awarded to three SUD projects serving Veterans. However, no applications for projects to serve Veterans with SPMI were submitted for consideration.

Additionally, OHA and OHCS brokered an agreement to braid $2.5 million of OHCS's MHHF into OHA's Community Mental Health Housing Trust Funds and Mental Health Services Funds to increase the supply of Supported and Supportive Housing. OHA released two applications with the combined OHCS and OHA funds in May 2018. A combined total of $5,060,000 was made available in two separate applications, one for rental housing to serve individuals with SUD and one for rental housing to serve people with SPMI. This application described the importance of integrated (Supported) housing and incented it over Supportive Housing by awarding a higher unit subsidy. In September 2018, OHA made awards to eight housing development projects serving individuals with SPMI that will offer 91 rental units. Awards were also made to three housing development projects serving individuals with SUD that will offer ten rental units.

Peer Delivered Services (PDS)

#16 (a-b) Number Served with Peer Delivered Services



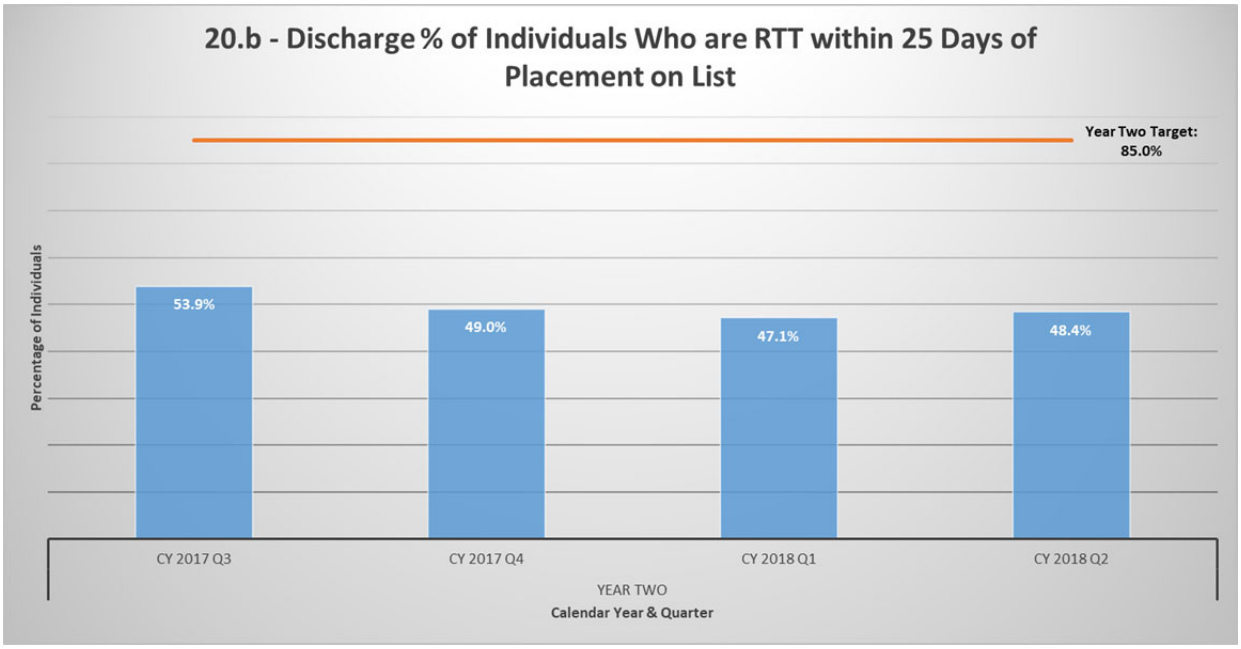
Baseline (Calendar Year 2015)
A total of 2,156 individuals received Peer Delivered Services (PDS) in the calendar year 2015.

Comments on Methodology
OHA continues to capture PDS utilizing the Medicaid Management Information System (MMIS) as agreed upon with USDOJ, and stated in the OPP.
Comments on Progress
Pursuant to the OPP, OHA will increase the availability of PDS, in that by the end of fiscal year two (June 30, 2018), OHA will increase the number of individuals who are receiving PDS by an additional 20% more than the actual number at the end of fiscal year one, that is, the higher number of 3,456 individuals. As of 6/30/18, there were 3,775 individuals who received PDS. OHA has exceeded the year two target by 319.

Activities Associated with Metric(s)
OHA continues to work across stakeholder groups to increase opportunities for education regarding PDS and its outcomes.

Oregon State Hospital (OSH)

#20 (a-b) Percentage Discharged within Target of Ready to Transition



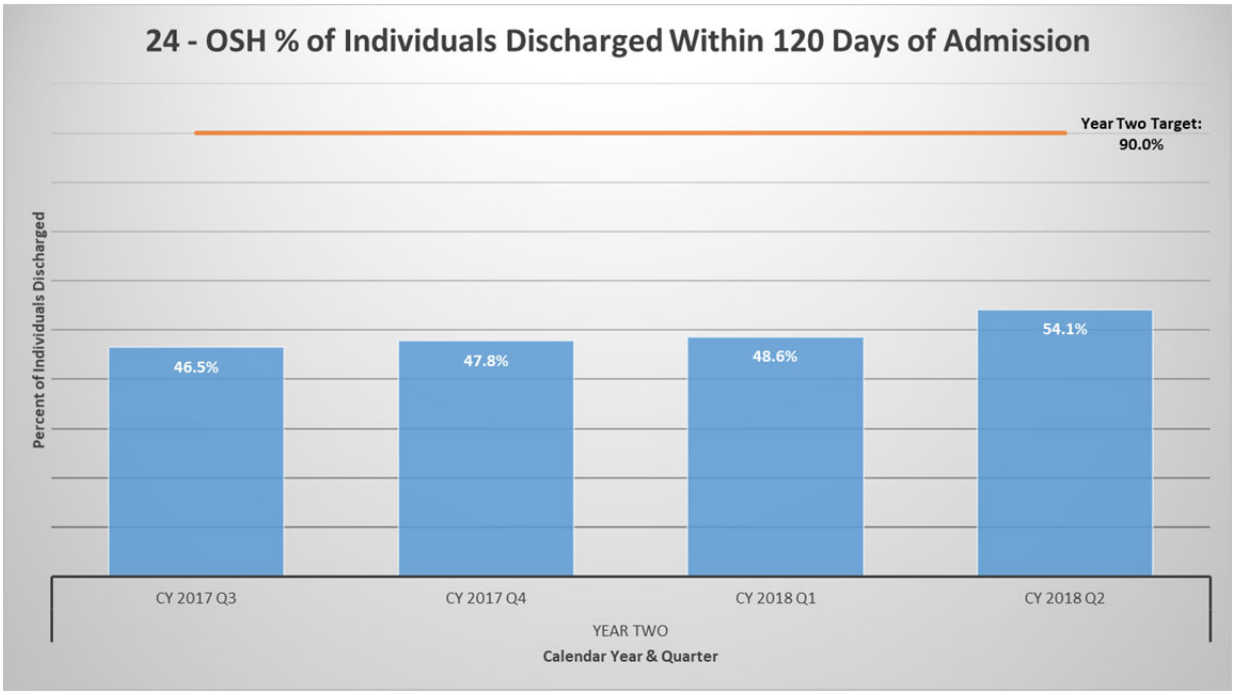
Baseline (Calendar Year 2015)
The cumulative percentage of civilly committed patients discharged within 30 days of being placed on the Ready to Transition (RTT) list was 51.7% for the 12-month period ending December 31, 2015. This includes one individual who was discharged shortly after the 30 days due to a weekend/holiday.

Comments on Methodology
In order to provide the most accurate RTT data possible, a new tracking system was developed and implemented as part of the OSH Electronic Health Record (Avatar) on July 1, 2016.

Comments on Progress
The OPP goal is that by the end of fiscal year two (June 30, 2018), 85% of individuals who are RTT will be discharged within 25 calendar days of placement on that list. As of 6/30/18, the cumulative percentage of those discharged within 25 days of being placed on the RTT list was 48.4%.
Efforts to address the shortfall on OSH metrics are addressed below, in the section "Activities Associated with Metric(s)."

There was one discharge that was extended to, and occurred on, the business day following a weekend day or holiday.

#24 Percentage Discharged within 120 Days



Baseline (Calendar Year 2015)
For calendar year 2015, the percentage of discharges within 120 days of being admitted to OSH was 37.9%.

Comments on Methodology
The percentage is calculated taking the number of individuals who are civilly committed, pursuant to the OPP, who were discharged within 120 days of admission, divided by the total number of individuals who are civilly committed and were discharged.

Comments on Progress
As of 6/30/18, the cumulative percentage of discharges within 120 days of admission was 54.1%.

Activities Associated with Metric(s)
OHA is taking many steps to address discharges.

On 01/04/19, OHA filed temporary Oregon Administrative Rules 309-091-0000 through 309-091-0050, State Hospital Admissions and Discharges. These rules will ensure consistency in the application of criteria for admissions and discharges.

OSH and Health Systems Division (HSD) have been meeting directly with Acute Care Hospitals since 11/08/18 to provide training on these rules. Specifically, to assure the community and the hospital understand an OSH stay is an episode of care only and that discharge is to be planned from the beginning, and the community remains responsible for the individual's care and discharge.

To date, there have been eight trainings across Portland, Salem, Eugene, and Corvallis. There is another training scheduled for the end of February.

The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities related to individuals at OSH. It reads:

> *Contractor shall:*
> *(1) Coordinate with applicable Choice Contractors as needed regarding Oregon State Hospital discharges for all adult Members with SPMI.*
> *(2) Coordinate care for members receiving behavioral health treatment while admitted to the State hospital during discharge planning for the return to Home CCO when the patient has been deemed ready to transition.*
> *(3) Provide access to evidence-based intensive services for adult Members with SPMI discharged from Oregon State Hospital who refuse ACT services.*

OHA is currently revising the Choice contract for the 2019-2021 biennium to include the OPP fiscal year three metric which reads 90% of individuals who are RTT will be discharged within 20 calendar days of placement on that list.

As was provided in the January 2017 report, OHA is providing a "Point in Time" count of all civilly committed individuals with SPMI residing in OSH on June 15, 2018. The breakdown for the number of days in OSH for the 97 individuals in residence on June 15, 2018 is as follows:

- Less than 120 days: 56 persons, or 57.7% of all civilly committed individuals residing at OSH on June 15, 2018.
- 120-365 days: 27 persons, or 27.8% of all civilly committed individuals residing at OSH on June 15, 2018.
- 366 days to two years: 9 persons, or 9.3% of all civilly committed individuals residing at OSH on June 15, 2018.
- Over two years: 5 persons, or 5.2% of all civilly committed individuals residing at OSH on June 15, 2018.

OHA is consulting with Pam Hyde, the Independent Consultant to examine the OSH metrics and look for opportunities to impact OSH utilization.

Acute Psychiatric Care

#29 Percentage Receiving Warm Handoff

Baseline (Calendar Year 2015)
This is a new process and metric, therefore there is no baseline information available for calendar year 2015.

Comments on Methodology
OHA has contracted with Health Insights to gather data to determine the number of warm handoffs that are occurring for individuals with SPMI in Acute Care. The contractor is reviewing records for all Acute Care discharges within each quarter to determine if a warm handoff occurred. This process will also identify any refusals for a warm handoff.

Comments on Progress
Pursuant to the OPP, by the end of fiscal year two (June 30, 2018), 75% of individuals discharged from an Acute Care Psychiatric Facility will receive a warm handoff to a community case manager, peer bridger, or other community provider. As of 6/30/18, the cumulative percentage of those who received a warm handoff was 27.7%. The hospital association believes the numbers are low due to documentation issues and that there are actually more warm handoffs occurring. OHA is below the year two percentage for this metric. Steps being taken to address

this are described below in the section for "Activities Associated with Metric(s)."

#30 Percentage Receiving Follow-up within 7 Days of Discharge

Baseline (Calendar Year 2015)
For calendar year 2015, the percentage of follow up visits within seven days of discharge was 79.4%.

Comments on Methodology
The methodology to collect this data aligns with the methodology for reporting on other Coordinated Care Organizations (CCO) metrics.

Comments on Progress
The OPP provides that OHA will continue to require that individuals receive a follow-up visit with a Community Mental Health Provider within seven days of discharge, and that OHA will report this data. As of 6/30/18, the percent of individuals receiving follow up within seven days was 76.7%. Oregon continues to do well as compared to other states. According to the 2015 Benchmarks and Thresholds Report by the National Center for Quality Assurance (NCQA), the Medicaid national 90th percentile was 70%. Oregon's numbers continue to be above the 90th percentile.

#31 (a) Readmission Rates

Baseline (Calendar Year 2015)
The cumulative 30-day readmission rate to Acute Care Psychiatric Facilities for calendar year 2015 was 9.23%. The cumulative 180-day readmission rate to Acute Care Psychiatric Facilities for calendar year 2015 was 21.35%.

Comments on Methodology
Pursuant to the OPP, OHA will monitor and report the percentages of discharges with readmissions to Acute Psychiatric Care hospitals within 30 and 180 days of discharge from hospitalizations for a psychiatric reason. The Data Specification Sheet has been updated to provide the methodology for collecting the readmission rate data by hospital. The readmission rate by hospital was reported based on the hospital where the first admission occurred. The second admission may have actually occurred at another hospital. This creates challenges in how the data by hospital is interpreted.

Comments on Progress
As of 6/30/18, the cumulative percentage rates of readmission at 30 and 180 days were 12.2% and 24.0% respectively. See Appendix C for the breakout by hospital.

#35 Average Length of Stay

Baseline (Calendar Year 2015)
The cumulative average length of stay for Acute Psychiatric Care Facilities, for calendar year 2015, is 8.89 days. For calendar year 2015, there were 4,431 discharges; 385 (8.7%) of them exceeded 20 days.

Comments on Methodology
The OPP provides that OHA will provide the cumulative average length of stay of individuals with SPMI for all hospitals, as well as the average length of stay by hospital. OHA will also provide a count of the number of individuals with a length of stay longer than 20 days.

Comments on Progress
As of 6/30/18, the cumulative average length of stay of individuals with SPMI discharged from Acute Care Psychiatric Facilities was 11.16 days. When broken down by hospital, the range of length of stays at the Acute Care Psychiatric Facilities (see Appendix D ranges from 8.0 to 15.1 days. Of the 3,907 discharges, the length of stay for 518 (13.3%) exceeded 20 days. Of the 518 individuals, 138 were on the OSH Waitlist. See Appendix D for the detail by hospital.

Activities Associated with Metric(s)
OHA continues to work with the Oregon Association of Hospitals and Health Systems (OAHHS) to assure performance of warm handoffs and documentation of any warm handoff activity improves over time.

The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities regarding Acute Care, including warm handoffs and links to housing agencies. It reads:

> *Contractor shall:*
> *(1) Ensure all adult Members with SPMI discharged from Acute Care Psychiatric Hospitals are provided access to a Warm Handoff to a community case manager, peer bridger, or other community provider prior to discharge.*
> *(2) Ensure that all Members discharged from Acute Care*

Psychiatric Hospitals have documentation of linkages to timely, appropriate behavioral and primary health care in the community prior to discharge. Related OAR provision: 309-032-0850 through 309-032-0870.

(3) Ensure all adult Members with SPMI receive a follow-up visit with a community mental health provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital.

(4) Reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals.

(5) Work with system partners to ensure adult Members with SPMI who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these adult Members are linked to housing in an integrated setting, consistent with the individual's treatment goal, clinical needs and the individual's informed choice.

(6) Work with OHA and the CMHPs to ensure that adult Members with SPMI who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and shall work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the individual's treatment goals, clinical needs, and the individual's informed choice. Contractor shall notify, or have the Acute Care Psychiatric Hospital notify, the community provider to facilitate the implementation of the plan for housing.

(7) Develop and upon request, provide to OHA a management plan for contacting and offering services to each adult Member with SPMI who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period. The management plan will describe how it will assist the Member in avoiding unnecessary readmissions to acute care hospitals.

OHA is engaging with Health Insights, the contractor determining if warm handoffs are occurring, to better understand the barriers. OHA has developed guidance documents regarding warm handoffs. They will be distributed to system partners in the coming weeks.

Emergency Departments (ED)

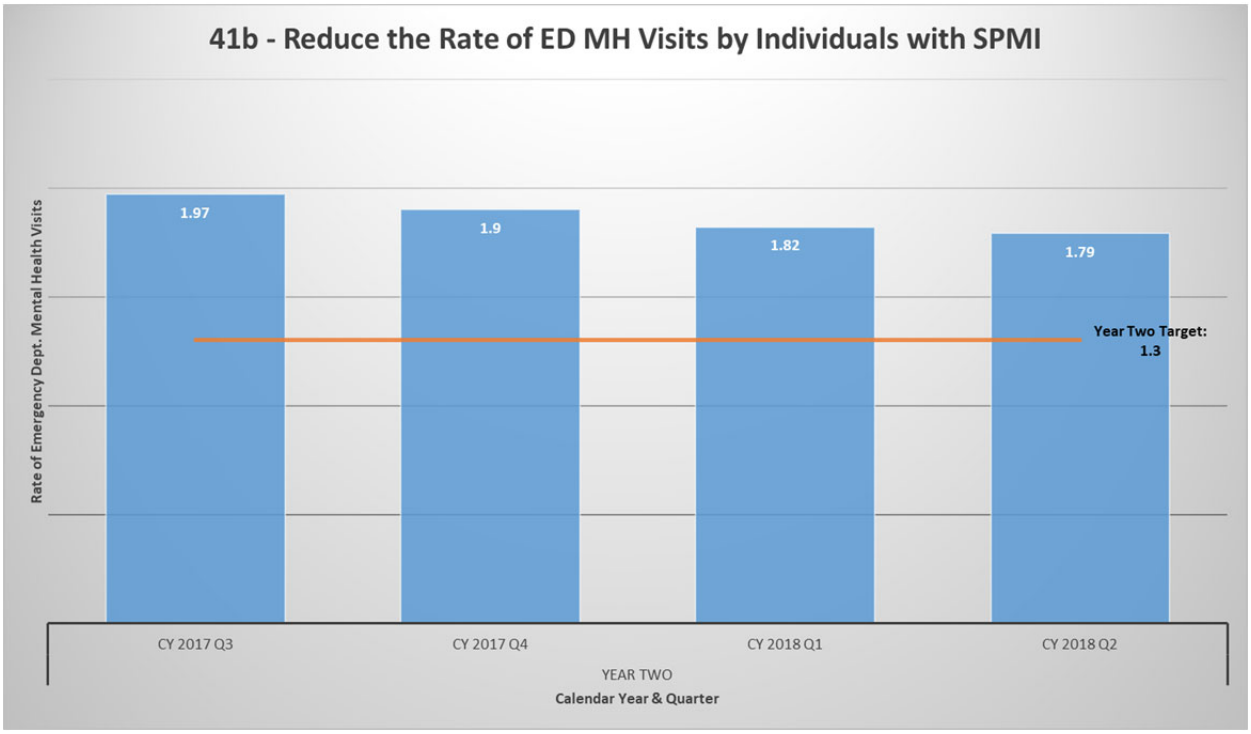
#40 (a) Number Readmitted Two or More Times within 6 Months

Baseline (Calendar Year 2015)
During calendar year 2015, 1,067 individuals with SPMI were re-admitted to an emergency department (ED) two or more times in a six-month period.

Comments on Methodology
The OPP provides that OHA will count individuals with three or more visits (admissions) to an ED (which is equal to two readmissions) within a six-month period of time. As previously discussed with Pam Hyde, the Independent Consultant, and as discussed with USDOJ during the November 2, 2017 meeting, OHA is providing this breakout by CCO. See Appendix E for the detail by CCO.

Comments on Progress
As of 6/30/18, a total of 622 individuals with SPMI were readmitted to an ED two or more times in a six-month period. There is no target associated with this metric, although the data is relatively unchanged over the last four quarters.

#41(a-b) Rate of ED Mental Health Visits



Baseline (Calendar Year 2015)
During calendar year 2015, the rate was 1.54 persons per 1000 Oregon Health Plan (OHP) members who visited the ED for psychiatric reasons.

Comments on Methodology
The OPP provides that OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, and that by the end of fiscal year two (June 30, 2018), there will be a 20% reduction from the baseline. The rate of ED visits for mental health reasons is the number of individuals with SPMI who had an ED visit for psychiatric reasons per 1,000 persons enrolled in Medicaid. The MMIS system does not have diagnostic information for everyone enrolled in Medicaid. However, OHA will review the methodology for possible narrowing of the patients in the denominator to individuals with SPMI.

Comments on Progress
As of 6/30/18, 1.79 individuals per 1,000 OHP members with SPMI visited the ED for mental health reasons. This rate has been trending down over this second fiscal year.

Activities Associated with Metric(s)
Steps taken by OHA to address the rate of ED visits include contract modifications. The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities regarding providing a management plan for individuals with 2 or more readmissions to an emergency department in a six-month period. It reads:

> *Contractor shall develop a management plan for contacting and offering services to each adult Member with SPMI who has two (2) or more readmissions to an emergency department in a six-month period. The management plan will describe how it will assist Members in avoiding unnecessary readmissions. Contractor shall collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in less institutional community settings and to reduce recidivism to emergency departments for mental health reasons.*

OHA will continue to monitor the other services in the OPP that affect the rate of ED utilization.

Supported Employment

#45 (a-b) Individuals Served with Supported Employment

Baseline (Calendar Year 2015)
The two Supported Employment data points being collected regarding Supported Employment are new data points; therefore, baseline data is not available.

Comments on Methodology
The data regarding Supported Employment services is received via quarterly reports. OHA will identify the number of individuals receiving Supported Employment who are employed in Competitive Integrated Employment (CIE), and the number of individuals who no longer receive Supported Employment services and are employed in CIE without receiving supportive services from a Supported Employment specialist at discharge.

Comments on Progress
Pursuant to the OPP, OHA will report the number of persons receiving Supported Employment who are employed in CIE and the number of individuals who no longer receive Supported Employment and are employed in CIE. As of 6/30/18, a total of 762 individuals were receiving Supported Employment services and employed in CIE. There were 137 individuals who no longer receive Supported Employment and are employed in CIE without currently receiving supportive services from a Supported Employment specialist. The number of individuals receiving SE services as well as the number of individuals employed in CIE without receiving supportive services has increased since the end of year one (6/30/17).

Activities Associated with Metric(s)
OHA will continue to work with the Oregon Supported Employment Center of Excellence to monitor fidelity and provide technical assistance.

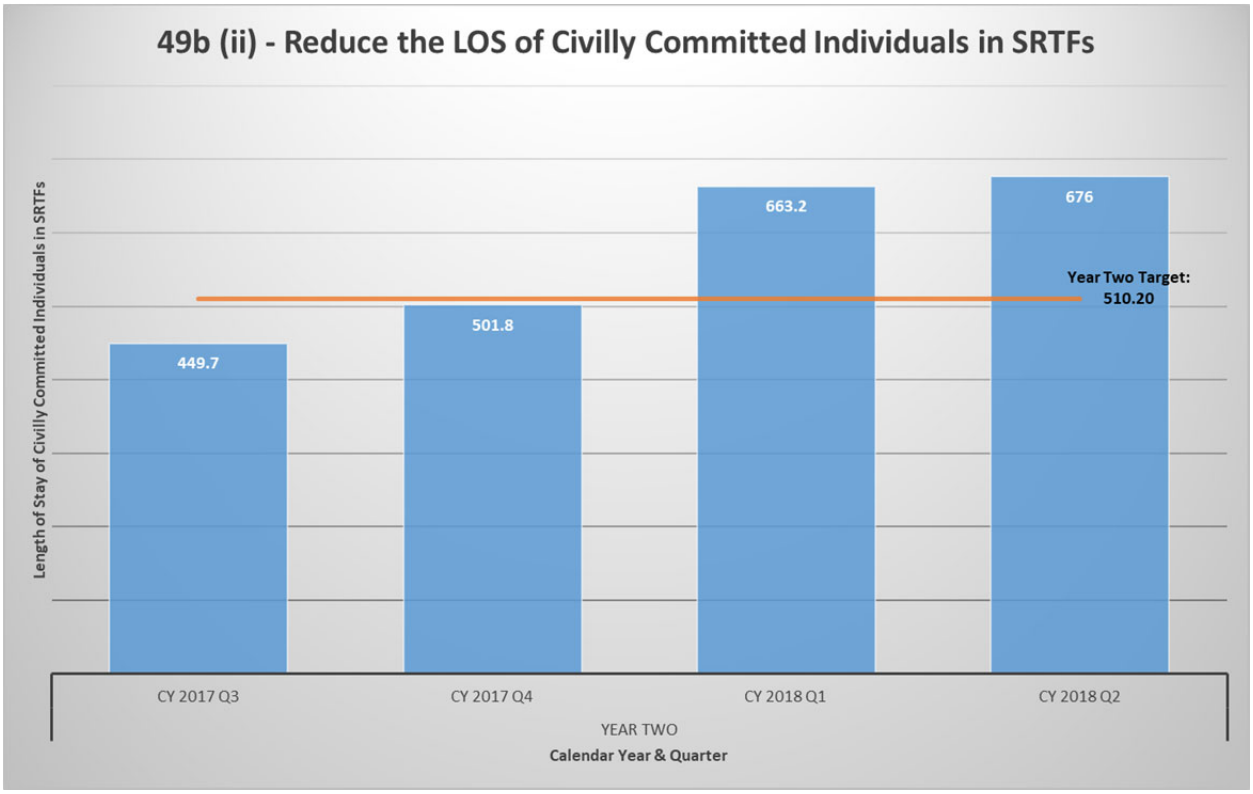
The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities regarding Supported Employment. It reads:

> *Contractor shall ensure access to supported employment services for all adult Members with SPMI seeking these services, in accordance with OAR 309-019-0275 through 309-019-0295. "Supported employment services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR*

309-019-0225.

Secure Residential Treatment (SRTF)

#49 (b) (i-ii) Average Length of Stay in SRTFs



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, the average length of stay for an individual who was civilly committed and in a Secure Residential Treatment Facility (SRTF) was 638 days.

Comments on Methodology
The baseline data is calculated by dividing the total days by the number of individuals with SPMI civilly committed who have been discharged from SRTFs.

Comments on Progress
Pursuant to the OPP, OHA will seek to reduce the length of stay of civilly committed individuals in SRTFs, in that by the end of fiscal year two (June 30, 2018), there will be a 20% reduction from the baseline. As of 6/30/18, the average

length of stay for an individual who was civilly committed and discharged from an SRTF was 676 days. While the length of stay based on discharge has increased, it is still significantly below baseline.

This increase may in part reflect efforts to assure that those who can be served in more integrated settings have been transitioned to other settings or are no longer being admitted to SRTFs. That is, individuals now being admitted to SRTFs may have higher or more intense needs on average than before.

The other factor resulting in an increase is that in CY 2018 Q1, there were discharges of individuals with longer lengths of stay. The data represents a rolling 12 month reporting period, so it will take some time for the average to level back out.

The 15 discharges occurred within the following timeframes:

- Less than one year: two individuals discharged
- 366 days to two years: 3 individuals discharged
- Two plus to three years: four individuals discharged
- Three plus to four years: one individual discharged
- Four plus to five years: one individual discharged
- Five plus to six years: one individual discharged
- Six plus to seven years: one individual discharged
- Seven plus to eight years: two individuals discharged

Activities Associated with Metric(s)

The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities regarding SRTFs. It reads:

> *Contractor shall work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a community placement in the most integrated setting appropriate for that person.*

OHA's contractor (KEPRO) continues to perform prior authorizations for individuals referred to SRTFs from OSH as well as the continued stay reviews for individuals receiving treatment in an SRTF. OHA is working with its contractors to assure only those who need this intensive level of care are admitted and to promote timely discharge from SRTFs for those who can transition safely to more integrated settings.

As was provided in the January 2017 report, OHA is providing a "Point in Time" count of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2018. The breakdown for the number of days in SRTFs for the 53 individuals in residence on June 15, 2018 is as follows*:

- Less than 120 days: 19 persons or 35% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2018.
- 120-365 days: 10 persons or 19% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2018.
- 366 days to two years: 11 persons or 20% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2018
- Over two years: 13 persons or 24% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2018.

*The percentage only adds up to 98% due to decimal rounding.

Criminal Justice Diversion (CJD)

#52 (a) Numbers Served with Jail Diversion

Baseline (Calendar Year 2015)
In the last quarter of calendar year 2015, there were 1,409 individuals who received Jail Diversion services. The number of individuals reported by jail diversion contractors as receiving services pre-arrest was 499 and the number post-arrest was 910.

Comments on Methodology
The data regarding Jail Diversion services is received via Quarterly Reports from jail diversion contractors. OHA will identify the number of individuals receiving Jail Diversion services as well as the number that were pre-arrest and post-arrest.

Comments on Progress
Pursuant to the OPP, OHA will continue to report the number of individuals with SPMI receiving Jail Diversion services and the number of reported diversions. As of 6/30/18, a total of 2,086 individuals received Jail Diversion services, an increase over the baseline year of 677 individuals. Of these 2,086 individuals, 502 were pre-booking and 1,574 were post-booking.

#52 (d) Number of Individuals Receiving Mental Health Services and Arrested

OHA has been keeping Pam Hyde, the Independent Consultant apprised of the challenges in collecting this data. During the November 2017 annual meeting between OHA and USDOJ, OHA shared the challenges in collecting the data directly with USDOJ. The collection of this data is a complex process requiring data from both OHA and the Criminal Justice Commission (CJC). OHA continues to work with Oregon DOJ regarding establishing a partnership between OHA and the CJC so that data can be shared. OHA is encountering new barriers in obtaining this information.

Based on data and through Pam Hyde, the Independent Consultant's June 2018 Site Visit, we are assured that there is a great deal of work occurring to divert individuals with SPMI from being arrested. There is a lot of diversion occurring in the Mobile Crisis services rather than just in the Criminal Justice Diversion programs.

<u>Activities Associated with Metric(s)</u>
The CCO 2019 Contract, effective 1/1/19, better identifies CCO responsibilities regarding Criminal Justice. It reads:

> *Contractor shall work with local law enforcement and jail staff to develop strategies to reduce contacts between adult Members with SPMI and law enforcement due to mental health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism. Contractor will work with local jurisdictions to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of adult Members with SPMI who are incarcerated.*

APPENDIX A

Many of the metrics identified refer to a rolling one-year period. This information is identified in the Data Table in Appendix B – see the footnote marked with an asterisk (*). A rolling one-year period means the analyst looks at 12 months of data for each quarterly report. In the current report, three quarters of data from the previous report are included along with one new quarter for a full 12 months of data. Doing this ensures adequate sample size for analysis, especially when there are small samples. The table below shows a rolling one-year schedule with a six-month lag period to ensure complete data submission.

Report Quarter	Previous Rolling One-Year Period
Q1 (January)	July 1 to June 30 of the previous year
Q2 (April)	October 1 to September 30 of the previous year
Q3 (July)	January 1 to December 31 of the previous year
Q4 (October)	April 1 to March 31 of the previous year

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACT*	1a	OHA will increase the number of individuals with SPMI served by ACT teams.	1,050 individuals will be served by the end of year one (June 30, 2017).	815	1,050		1,098	1,120	1,140	1,170
	1b		2,000 individuals will be served by the end of year two (June 30, 2018).			2,000	1,280	1,260	1,226	1,248
Crisis	7a	OHA will increase the number of individuals with mobile crisis services, as follows:	During year one (July 1, 2016 to June 30, 2017), 3,500 people will be served by mobile crisis.	3,150	3,500		3,587	3,472	3,564	3,832
	7b		During year two (July 1, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis.			3,700	4,208	5,027	6,983	7,270
Crisis*	8c	OHA will track and report the number of individuals receiving a mobile crisis contact.	By the end of year two (June 30, 2018), Oregon will report the number of individuals whose dispositions after contact with mobile crisis result in:							
			stabilization in a community setting rather than arrest				*n/a*	2,401	2,041	2021
			presentation to an emergency department				*n/a*	349	270	454
			admission to an acute care psychiatric facility				*n/a*	169	205	105
SH*	14a	OHA's housing efforts will include an increase in the number of individuals with SPMI in supported housing, as follows:	In year one (July 1, 2016 to June 30, 2017), at least 835 individuals will live in supported housing.	442	835		767	834	876	966
	14b		In year two (July 1, 2017 to June 30, 2018), at least 1,355 individuals will live in supported housing.			1,355	1,008	1,002	1,026	1,036
	14c		In year three (July 1, 2018 to June 30, 2019), at least 2,000 individuals will live in supported housing.	*Year Three Deliverable*						
PDS	16a	OHA will increase the availability of peer-delivered services, as follows:	By the end of year one (June 30, 2017), OHA will increase the number of individuals who are receiving peer-delivered services by 20%.	2,156	2,587		2,434	2,461	2,538	2,880
	16b		By the end of year two (June 30, 2018), OHA will increase the number of individuals who are receiving peer-delivered services by an additional			3,456	3,022	3,289	3,522	3,775

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
OSH	20a	Discharge from OSH will occur as soon as an individual is ready to return to the community, as follows:	By the end of year one (June 30, 2017), 75% of individuals who are Ready to Place/Ready to Transition will be discharged within 30 calendar days of placement on that list.	51.7%	75.0%		55.4%	59.6%	61.6%	61.3%
	20b		By the end of year two (June 30, 2018), 85% of individuals who are Ready to Place/Ready to Transition will be discharged within 25 calendar days of placement on that list.	61.3%	*n/a*	85.0%	53.9%	49.0%	47.1%	48.4%
	20c		By the end of year three (June 30, 2019), 90% of individuals who are Ready to Place/Ready to Transition will be discharged within 20 calendar days of placement on that list.	57.7%			*Year Three Deliverable*			
	20e		OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday. (FY1)	*Baseline Not Applicable*	*Measure without Target*		0	1	1	1
			OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday. (FY2)				5	2	3	3
OSH	24		At the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission.(FY1)	37.8%	90.0%		41.5%	41.7%	46.4%	46.9%
			At the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission.(FY2)			90.0%	46.5%	47.8%	48.6%	54.1%
ACUTE	29a		By the end of year one, (June 30, 2017), 60% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Baseline Not Applicable*	60%		*Not Available*			
	29b		By the end of year two, (June 30, 2018), 75% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.			75.0%	21.4%	27.7%	29.6%	27.7%
	29c		By the end of year three, (June 30, 2019), 85% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Year Three Deliverable*						

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACUTE	30		OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge, and OHA will report this data. (FY1)	79.4%	*Measure without Target*		71.5%	72.0%	73.0%	74.20%
			OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge, and OHA will report this data. (FY2)	*n/a*	*n/a*	*Measure without Target*	75.7%	77.8%	77.2%	76.7%
ACUTE	31a		OHA will monitor and report the 30 day rates of readmission, by acute care psychiatric facility. (FY1)	9.2%	*Measure without Target*		10.9%	11.1%	10.3%	10.60%
			OHA will monitor and report the 30 day rates of readmission, by acute care psychiatric facility. (FY2)			*Measure without Target*	11.0%	10.8%	11.8%	12.2%
			OHA will monitor and report the 180 day rates of readmission, by acute care psychiatric facility. (FY1)	21.3%	*Measure without Target*		22.6%	22.6%	22.7%	22.80%
			OHA will monitor and report the 180 day rates of readmission, by acute care psychiatric facility. (FY2)			*Measure without Target*	23.8%	22.9%	23.4%	24.0%
ACUTE	31b 32		Two or more readmissions to acute care psychiatric hospital in a six month period. (FY1)	*Baseline Not Applicable*	*Data for Process Measure*		*n/a*	346	280	284
			Two or more readmissions to acute care psychiatric hospital in a six month period. (FY2)			*Data for Process Measure*	305	314	291	302

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACUTE	35		OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital. (FY1)	8.9	*Measure without Target*		9.6	9.6	11.0	11.24
			OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital. (FY2)	*n/a*	*n/a*	*Measure without Target*	11.5	11.4	11.2	11.16
	35		OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. (FY1)	385	*Measure without Target*		435	423	459	475
			OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. (FY2)			*Measure without Target*	534	529	509	518
ED	40a	OHA will reduce recidivism to emergency departments for the psychiatric purposes, by taking the following steps:	OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, by CCO (previously stated by hospital). (FY1)	1,067	*Measure without Target*		924	919	865	834
			OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, by CCO (previously stated by hospital). (FY2)	*n/a*	*n/a*	*Measure without Target*	828	935	838	622
ED	41a	OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, as follows: (excludes Unity)	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline.	1.5	1.4		2.0	2.1	2.0	2.0
	41b		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.			1.3	1.97	1.9	1.82	1.79
ED	43	OHA is working with hospitals to determine a strategy for collecting data regarding individuals with SPMI who are in emergency departments for longer than 23 hours.	OHA will begin reporting this information in July 2017, and will provide data by quarter thereafter. OHA will report this information by region. OHA will pursue efforts to encourage reporting on a hospital-by-hospital basis.	*Not Available*						

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
SE*	45a		The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment… (FY1)	*Baseline Not Applicable*	*Measure without Target*		680	697	628	757
			The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment… (FY2)			*Measure without Target*	749	756	731	762
SE*	45b		The number of individuals with SPMI who no longer receive supported employment services and are employed without currently receiving supportive services from a supported employment specialist (but who may rely upon natural and other supports). (FY1)	*Baseline Not Applicable*	*Measure without Target*		114	115	164	110
			The number of individuals with SPMI who no longer receive supported employment services and are employed without currently receiving supportive services from a supported employment specialist (but who may rely upon natural and other supports). (FY2)			*Measure without Target*	121	127	139	137
SRTF	49b (i)	OHA will seek to reduce the length of stay of civilly committed individuals in secure residential treatment facilities, as follows:	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline. (Mean)	638.0	574.2		409.1	552.8	543.5	553
	49b (ii)		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.			510.2	449.7	501.8	663.2	676.0
SRTF	49c	OHA will regularly report on the number of civilly committed individuals in SRTFs, their lengths of stay, and the number of individuals who are discharged.	Starting with year two of this Plan (July 1, 2017), OHA will collect data identifying the type of, and the placement to which they are discharged.	*Not Available*						

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix B
Oregon Performance Plan
January 2019 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
CJD*	52a	OHA will work to decrease the number of individuals with serious and persistent mental illness who are arrested or admitted to jail based on a mental health reason, by engaging in the following strategies:	OHA will continue to report the number of individuals with SPMI receiving jail diversion services. (FY1)	*Baseline Not Applicable*	*Measure without Target*		1,553	1,610	1,736	2,499
			OHA will continue to report the number of individuals with SPMI receiving jail diversion services. (FY2)	*n/a*	*n/a*	*Measure without Target*	1,822	1,766	1,884	2,086
	52a		OHA will continue to report the number of reported diversions. (Pre-Booking) (FY1)	*Baseline Not Applicable*	*Measure without Target*		284	385	346	515
			OHA will continue to report the number of reported diversions. (Pre-Booking) (FY2)	*n/a*	*n/a*	*Measure without Target*	356	350	393	502
	52a		OHA will continue to report the number of reported diversions. (Post-Booking) (FY1)	*Baseline Not Applicable*	*Measure without Target*		1,269	1,225	1,390	1,984
			OHA will continue to report the number of reported diversions. (Post-Booking) (FY2)	*n/a*	*n/a*	*Measure without Target*	1,466	1,416	1,491	1,574
	52d		As of July 2016, OHA will track arrests of individuals with SPMI who are enrolled in services and will provide data by quarter thereafter.	*Baseline Not Applicable*			*Data Not Available*			

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix C

Rates of Readmission by Acute Care Facility (31a-b)

2018 Q2 (July 1, 2017 – June 30, 2018)

Acute Care Psychiatric Hospital	Location	30-day	180-day
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	12.0%	21.9%
Bay Area Hospital	Coos Bay	13.9%	25.2%
Good Samaritan Regional Medical Center	Corvallis	6.7%	15.8%
Unity/Legacy Emmanuel Medical Center	Portland	13.9%	27.3%
Peace Health - Sacred Heart Medical Center	Eugene	12.3%	24.9%
Providence Portland Medical Center	Portland	13.4%	24.4%
Providence St. Vincent Medical Center	Portland	12.0%	26.0%
Salem Hospital	Salem	11.6%	20.5%
St Charles Health System Sage View	Bend	10.3%	19.4%
UBH of Oregon (Cedar Hills)	Portland	10.2%	22.3%
	Total:	12.2%	24.0%

Appendix D

Average Length of Stay in Acute Care Facilities, by Facility (35)

2018 Q2 (July 1, 2017 – June 30, 2018)

Acute Care Psychiatric Hospital	Location	Average Length of Stay	Number of Individuals whose Length of Stay exceeds 20 days
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	9.2	29
Bay Area Hospital	Coos Bay	8.0	17
Good Samaritan Regional Medical Center	Corvallis	15.1	48
Unity/Legacy Emmanuel Medical Center	Portland	12.1	180
Peace Health - Sacred Heart Medical Center	Eugene	11.9	62
Providence Portland Medical Center	Portland	13.0	67
Providence St. Vincent Medical Center	Portland	9.8	36
Salem Hospital	Salem	12.3	43
St Charles Health System Sage View	Bend	8.0	16
UBH of Oregon (Cedar Hills)	Portland	9.5	20
	Total:	11.2	518

Appendix E

Count of Individuals with 2+ Readmissions to ED in 6 Months (40a)

2018 Q2 (July 1, 2017 – June 30, 2018)

Coordinated Care Organization	2+ Readmissions within a Six Month Period
AllCare CCO Inc	18
Cascade Health Alliance LLC	4
Columbia Pacific CCO LLC	10
Eastern Oregon CCO LLC	10
FamilyCare CCO	59
Health Share of Oregon	178
Intercommunity Health Network	21
Jackson Care Connect	15
PacificSource Community Solutions Gorge	0
PacificSource Community Solutions Inc	17
PrimaryHealth Josephine County CCO	4
Trillium Community Health Plan	61
Umpqua Health Alliance DCIPA	17
Western Oregon Advanced Health	6
Willamette Valley Community Health	31
Yamhill Community Care	13
Fee-for-Service	136
Total	600