Oregon Behavioral Health Quality and Performance Improvement Plan

Semi-Annual Narrative Report September 2021

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Oregon Health Authority

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Acknowledgments

The Oregon Health Authority (OHA) would like to thank Oregon's community providers, Community Mental Health Programs, and Coordinated Care Organizations for their dedicated service to Oregonians with Serious and Persistent Mental Illness. This has been an especially challenging year due to the COVID-19 pandemic and the wildfires of 2020, which interfered with the normal functioning of the behavioral health system. Despite this, Oregon's partners have persevered in providing essential services and supports to this vulnerable population.

OHA staff have also taken on additional duties related to the pandemic while continuing to perform their normal job functions. It is because of their sense of duty and service that OHA is able to carry on its mission to provide the right services for the right amount of time at the right cost.

OHA would especially like to thank all the individuals involved in the preparation of this report:

Hanna Christiansen, Rachel Bradbury, Geralyn Brennan, Brenda Dennis, Cody Gabel, Scott Hillier, Della Hoffman, Lori Kelley, Susan Lind, Michael Oyster, Lisa Peetz and Rick Wilcox. OHA also thanks our consulting attorney for this project, John Dunbar of Dunbar Law LLC.

Executive Summary

This Behavioral Health Quality and Performance Improvement Plan (BHQPIP) is a component of OHA's overall Quality Improvement System, which is the framework OHA uses to ensure compliance with the plan's outcome measures. OHA will seek to ensure the community-based services for civilly committed individuals with Serious and Persistent Mental Illness (SPMI) described in the BHQPIP are offered in accordance with the requirements of the Quality Improvement System.

The BHQPIP monitors and assesses key mental health services provided to adults with SPMI beginning July 1, 2019. It was developed to help adults with SPMI live in the most integrated setting appropriate to their needs, achieve positive outcomes, and are not unnecessarily institutionalized. The plan contains several measures of performance improvement. Currently, these measures are:

- Increase the number of SPMI individuals in Assertive Community Treatment Services (ACT)
- Increase the number of individuals with a SPMI in Supported Housing
- Reduce lengths of stay in the Oregon State hospital
- Reduce readmission to Acute Care Psychiatric facilities (ACPF)
- Reduce utilization of Emergency Department services for mental health reasons
- Reduce Secure Residential Treatment Facility length of stay; and
- Reduce the number of arrests for individuals receiving mental health services

These measures will be used in connection with an approach that includes the following:

- Quality and performance improvement utilizing Six Sigma principles; and
- Data reporting.
- Ongoing quality improvement efforts to improve access to services and treatment outcomes

In future years, the BHQPIP will expand to include other types - of behavioral health services administered by OHA. The current BHQPIP term extends from July 1, 2019, through June 30, 2022.

The report provides FY 2019 baseline data for each of the BHQPIP metrics, the goal for the time period reported, methodology for collecting the data, and the progress toward each goal. At the end of each section, the report describes the activities associated with the metric(s) in that section.

Further information about the metrics is provided in Appendix A. All metrics are summarized in the accompanying Data Report.

As with nearly everywhere in the United States, emergency measures related to the COVID-19 response continued to interfere with normal functioning of Oregon's behavioral health system. This impacted both performance and efforts to improve performance. In many ways, the effects were extremely disruptive. OHA is Oregon's primary COVID-response agency and was forced to redirect resources and efforts to focus on the pandemic. Staff reassignments at OHA and throughout the system, crowded hospitals and Emergency Departments, staffing shortages in the health care system, and reduced civil admissions to Oregon State Hospital all had an influence on the performance measures described in this report. Despite these challenges, OHA's community partners continue to work tirelessly to provide necessary services to Oregonians who need them.

The Federal government provided Oregon with $2.6 billion through the American Rescue Plan Act. At least $350 million has been earmarked to expand community-based behavioral health services.

The first round of expenditures will be approximately $100 million to increase and retain the behavioral health workforce. These efforts will include funding scholarships, providing student loan forgiveness as well as other incentives.

Other planned expenditures include money for housing for persons with behavioral health issues, increases in Community Mental Health Program funding statewide, establishing peer-run respite centers, and creating additional transitional programs at the Junction City hospital to help facilitate OSH discharges. Funding will also be provided to increase Supported Housing and to enhance other community-based alternatives to restrictive environments.

A Word on Data

The narrative in this report describes activities and outcomes taking place during the first half of Fiscal Year (FY) 2021 (7/1/20-12/31/20). Because of OHA's use of a rolling one-year look-back standard for data reporting, many of the charts and graphs contained in this report include data from the second half of the previous fiscal year, FY 2020. ACT and Supported Housing data are only included from July 1, 2020 through December 31, 2020. Data during the second half of FY 2020 is not included due to the suspension of the data reporting requirements for these metrics during the pandemic.

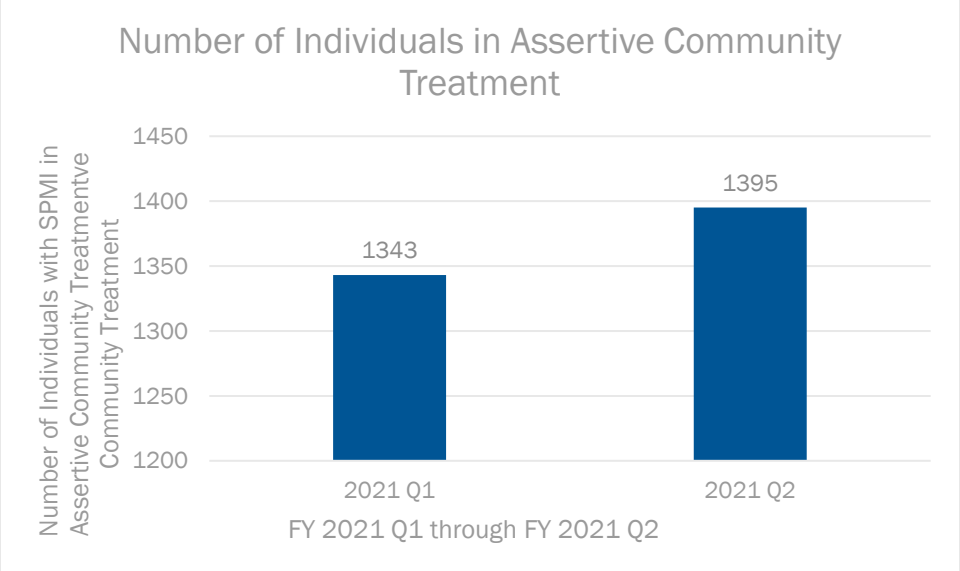
The activities and outcomes for second half of FY 2020 were reported in the previous edition of the BHQPIP, published in March 2021. Data from that time period is included here to provide context and to allow for the reader to make comparisons over the year. The next BHQPIP will be published in February 2022 and will include rolling one-year data from 7/1/20 through 6/30/21, but the narrative report will describe activities and outcomes taking place from 1/1/21-6/30/21.

Assertive Community Treatment (ACT)

#1 Number of Individuals with SPMI Served with ACT

Assertive Community Treatment (ACT) provides evidence-based intensive, community-integrated mental health services. ACT services are provided in the community as opposed to a more restrictive facility-based setting. ACT services are provided by a multi-disciplinary team of individuals that includes licensed medical professionals (Psychiatrist or Psychiatric Mental Health Nurse Practitioner), nurses, substance abuse and mental health professionals, employment specialists, peer support specialists, and various support and administrative staff. ACT teams offer a holistic approach to service provision by addressing Social Determinants of Health Issues such as homelessness and vocational training in addition to behavioral health issues. ACT providers must adhere to rigorous fidelity standards to achieve and maintain certification.

ACT services are often provided outside of the traditional office-based treatment. ACT services are provided in the community, helping individuals develop life skills as well as providing services to address behavioral health issues. ACT services are an effective approach to reducing reliance on higher levels of care, such as psychiatric hospitals and residential facilities, and promote independence and self-reliance. Because of these reasons, increasing the number of individuals in ACT services is a high priority for OHA. The following table shows performance on delivery of ACT services.



Reporting Period: 7/1/20 through 12/31/20. Data Source OCEACT

Baseline (Fiscal Year 2019)

By June 30 2019, the baseline year, ACT was serving 1325 individuals. The goal for FY 2020 was to maintain this number. The goal for FY 2021 is to increase this to 1400. The goal for FY 2022 is 1750.

Comments on Methodology

The Oregon Center of Excellence of ACT (OCEACT)_ resumed regular data reporting beginning the first quarter of FY 2021.

The data regarding ACT services are received through quarterly reports by providers to OCEACT. OCEACT provides the data to OHA. OHA identifies the number of individuals served at the end of each fiscal year to determine if the performance outcome has been achieved.

Due to burdens placed on system partners by the pandemic, including staff reassignments, OHA relieved providers of the need to report various data, including ACT numbers for the first two quarters of FY 2020. OCEACT was able to resume regular reporting data reporting beginning 7/1/20.

ACT enrollment began rising during the first quarter of FY 2021. By 12/31/20, enrollment had increased to 1395 individuals. The goal by the end FY 2021 (6/30/21) is 1400. OHA anticipates it will meet this goal, data will not be available until December 2021.

Comment on Progress

ACT enrollment began rising during the first quarter of FY 2021. By 12/31/20, enrollment had increased to 1395 individuals. The goal for the end of FY 2021 (6/30/21) is 1400. Because 1395 persons had already received services as of the 12/31/20, OHA anticipates it will meet this goal. However, fiscal year-end data will not be available until December 2021.

Activities Associated with Metric

In addition to system pressures caused by the COVID-19 pandemic, additional pressures were placed on the system due to a significant increase in the number of Aid and Assist[1] commitments, and limited workforce resources This impacted services for individuals enrolled in ACT services (both forensic and non-forensic). OHA is working with system partners at all levels to provide additional resources for all individuals who need the service, regardless of their legal status.

Part of this effort includes developing additional Forensic ACT teams (FACT) teams to better serve the forensic population, freeing up needed resources for civilly committed individuals. In April 2021, OHA staff began meeting with providers and Choice contractors to discuss the logistics of developing additional FACT teams. There are currently four FACT teams in the state. These are located in Multnomah, Polk, Yamhill and Deschutes counties.

CCOs and other providers are an important part of the effort to increase ACT services. OHA has contracted with Greater Oregon Behavioral Health (GOBHI) to work with

[1] An Aid and Assist Commitment, also known as a .370 order (after the number of the applicable statute), occurs when an individual is arrested, and there is a question about their competency to stand trial. The statute provides for a narrow scope of treatment in order to achieve stabilization and ensure individuals have the capacity to cooperate with attorneys and participate in their own defense. The increase in Aid and Assist commitments placed a significant strain on system resources.

providers to provide technical assistance to help CCOs and other providers improve processes with regard to ACT programs.

OHA also has instituted requirements intended to drive up the demand for ACT services. CCOs are required to assess members with SPMI to determine eligibility for ACT services. A provider or care coordinator then meets with the member to discuss ACT services and provide information to support the member in making an informed choice regarding participation. This information must include a description of ACT services, how to access ACT services, an explanation of the role of the ACT team, how supports can be individualized based on the member's self-identified need, and ways the ACT team can enhance a members care and support independent community living. CCO members who qualify for and desire ACT services shall be added to a wait list if no program is available in the member's service area. If a CCO lacks capacity to provide ACT, it is the responsibility of the CCO to notify OHA and develop a plan to increase capacity. Lack of capacity may not be a basis for eligible members to be denied ACT services. When a member is denied ACT services, it is the responsibility of the CCO to issue a Notice of Adverse Benefit Determination to the member, detailing steps for the member to file an appeal.

OHA continues to work on a comprehensive guidance document. This work is being performed by Quality Assurance and Contract Oversight Team, as it involves the CCO 2.0 contract. This guidance document will address a number of topics, including procedures regarding Notice of Adverse Benefit Determinations (NOADB), referral processing and other topics. OHA plans to publish this in the fall of 2021.

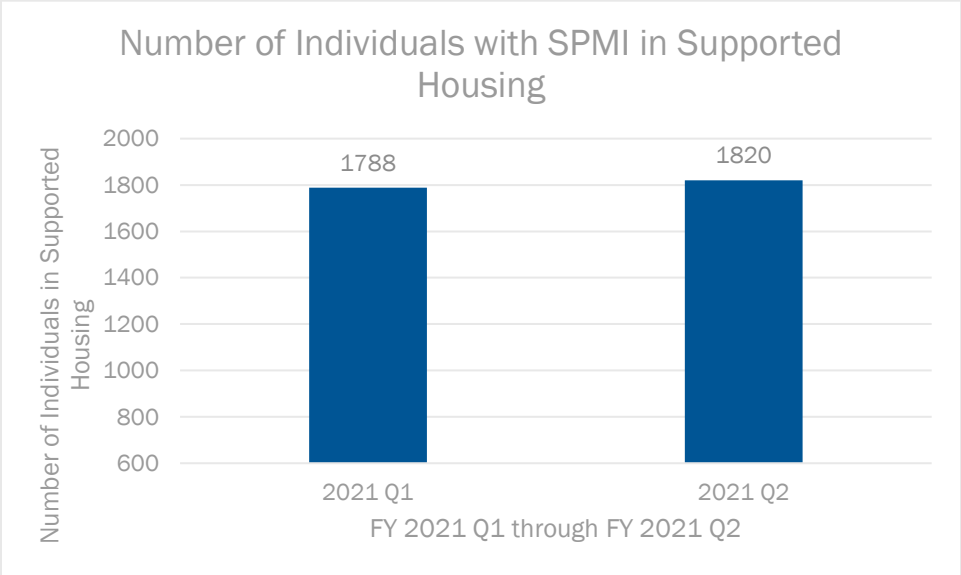
OHA published the first CCO Behavioral Health Report in March 2021. This report contains information on how well the CCOs achieve certain metrics as stipulated in the CCO 2.0 contract. ACT metrics are included in this report. It is available at CCO Behavioral Health Report 2020 (oregon.gov).

Supported Housing

#2 Number of Individuals with SPMI Living in Supported Housing

Supported Housing is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site housing. To be considered supported housing, for buildings with two or three units, no more than one unit may be used to provide supported housing for tenants with SPMI who are referred by OHA or its contractors. For buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for tenants with SPMI who are referred by OHA or its contractors. Supported housing has no more than two people in a given apartment or house, with a private bedroom for each individual. If two

people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported housing does not include housing where providers can reject individuals for placement due to medical needs or substance abuse history. Like ACT, increasing the availability of Supported Housing is an important strategy for reducing reliance on more restrictive level of care. The following chart shows performance on supported housing.



Reporting Period: 7/1/20 through 12/31/20, Data Source Rental Assistance recipient data and OCEACT

Baseline (Fiscal Year 2019)

By the end of the June 30, 2019 baseline, there were 1,903 individuals living in Supported Housing. The goal for FY 2020 was to maintain this number. The BHQPIP goal for FY 2021 (ending June 30, 2021) is 1,925 persons, and the goal for FY 2022 is 2,000 persons.

Comments on Methodology

Supported Housing is calculated using the following:

- Number of Supported Housing units developed, owned and operated by community-based organizations and occupied by individuals with SPMI.
- Number of individuals receiving assistance through OHA's Rental Assistance Program who reside in housing units that meet the definition of Supported Housing.
- Number of individuals in ACT living in Supported Housing not previously counted above; and,
- Number of individuals living in Supported Housing funded through other systems not previously counted above.

Because of the pandemic, OHA relieved providers of the need to report various data, including housing-related information during the last two quarters of FY 2020. Along with ACT data, supported housing data was not provided in the March 2021 report, and OHA

does not have it. Normal reporting resumed in July 2020. The Behavioral Health and Analytics teams are collaborating to develop a new data collection methodology that will eliminate the current time-consuming manual process and help ensure continued compiling of reliable data.

Comment on Progress

By 12/31/20, there were 1820 persons living in Supported Housing. The reported amount reflects of a drop of about 14%. The pandemic taxed both State and local resources. In addition, the wide-spread wildfires in September 2020 added additional burdens to the system by diverting resources, as well as destroying millions of dollars' worth of housing and other real estate. OHA believes that without the hard work and commitment of Oregon's community providers, more individuals would have lost their housing. The moratorium on evictions may have also affected individuals' ability to move into Section 8 housing. Likely causes are the pandemic and wildfires. By 12/31/20, OHA has data indicating that another 1565 individuals with SPMI in Supportive Housing during this reporting period. Suppor*tive* housing is another form of housing with supports, but supportive housing does not meet all of the non-congregate requirements for suppor*ted* housing. Nevertheless, supportive housing is an important source of housing provided in Oregon to persons with SPMI.[2]

Activities Associated with Metric

OHA continues to roll out the 316 units of affordable housing previously funded, including 36 units of Supported Housing and 55 units of supportive housing specifically for individuals with SPMI. As of June 2021, 18 units of Supported Housing located in three affordable housing complexes have been completed. A fourth housing complex that includes 18 Supported Housing units is under construction. Three affordable housing complexes with Supported Housing have been completed and added an additional 42 units. Another complex that includes 13 units is under construction. Occupancy for these housing complexes, which are funded in part by OHA, will be completed by September 2022.

There were a number of efforts to address the significant impact of COVID on residential settings. These included funding of improvements to physical spaces and purchases of equipment and materials for licensed residential providers to increase safety and maintain bed capacity to manage the risk of a COVID outbreak. Forty-two residential homes or facilities serving individuals with a SPMI received more than $1.4 million in grants to address the challenges brought on by COVID.

New laws are also addressing the level of affordable housing. Senate Bill 8 (SB 8) was passed during the 2021 legislative session. (SB8 2021 Regular Session - Oregon Legislative Information System (oregonlegislature.gov). This bill removes barriers to the construction of affordable housing by easing zoning restrictions prohibiting construction on lands not zoned for residential use. This will make developing these sites much easier than in the past. The State of Oregon also continues to implement another new law,

[2] Supportive Housing is similar to Supported Housing. The principal difference between Supportive and Supported Housing is that there are no mandated ratios of disabled to non-disabled tenants, so that Supportive Housing complex may provide a less integrated setting than Supported Housing.

House Bill 2001 (HB 2001), passed during the 2020 session. Under HB 2001, Oregon's medium-sized cities must allow Oregonians to build duplexes in areas zoned for single-family dwellings. By June 30, 2022, cities in the Portland Metro region and Oregon's other largest dozen cities (those over 25,000 population), must allow people to build duplexes, triplexes, fourplexes, cottage clusters, and townhouses in residential areas. Such housing can be more affordable than single-family housing and can meet the housing needs of many younger people, older people, and people who work hard but can't afford a large detached house of their own. (Department of Land Conservation and Development : Housing Choices (House Bill 2001) : Urban Planning : State of Oregon). Both of these laws are intended to address housing shortages, and this should have spillover benefits for those who need affordable housing, including those with behavioral health needs.

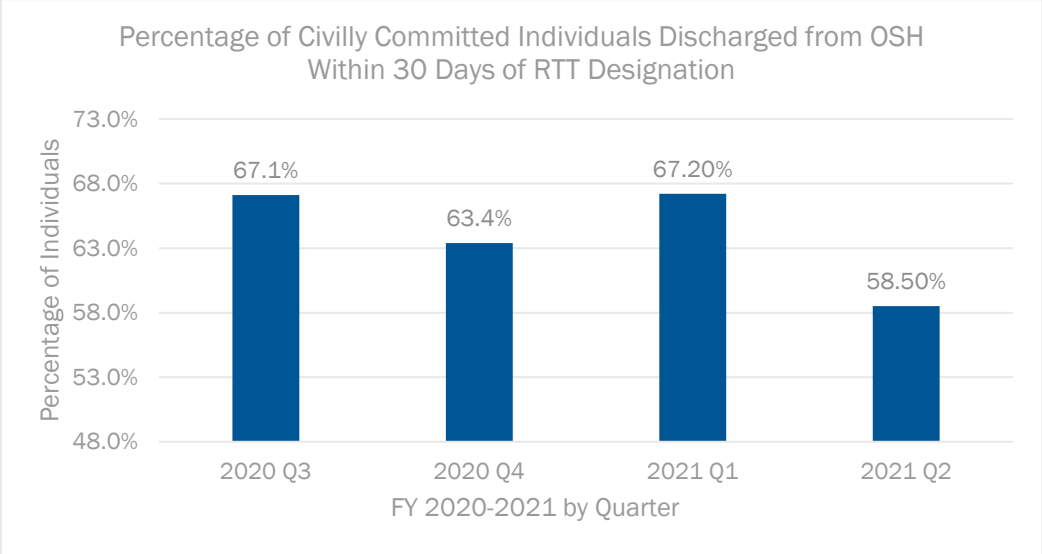
Another law addresses housing for persons with behavioral health issues, House Bill 2316 (HB 2316) was also passed this legislative session. HB 2316 established the Behavioral Health Housing Incentive Fund and transfers interest earned by the Housing for Mental Health Fund to this new fund. The Behavioral Health Housing Incentive Fund is established to provide funding for the development of community-based housing, crisis intervention services, rental subsidies, and other housing related services to help keep individuals with mental illness and individuals with substance use disorders safe and healthy in their communities. (HB2316 2021 Regular Session - Oregon Legislative Information System (oregonlegislature.gov)).. The change was recommended by the Governor's Behavioral Health Advisory Council. This legislation moves the Fund from Oregon Housing and Community Services to the Oregon Health Authority, which has greater expertise in designing housing for individuals living with serious mental illness and/or substance use disorders. It continues formal collaboration between OHA and OHCS and continues to incentivize all types of housing — crisis respite, licensed treatment housing, supportive housing, and independent integrated housing to serve individuals across the spectrum of need.

OHA has also increased its efforts with the state's coordinated care organizations (CCOs) to address social determinants of health (SDOH). A major focus of these efforts has been and will continue to be housing. OHA has developed guidance documents for CCOs regarding the use of Medicaid funding and SDOH. Both the Housing Related Services (HRS) guidance document and SDOH guidance document can be found at Oregon Health Authority : Health-Related Services : Transformation Center : State of Oregon. Under CMS guidance, "room and board" is not a permitted Medicaid expense. Similarly, there currently are no likely scenarios where long-term rental assistance would meet CMS requirements. However, OHA supports a CCO's ability to use health-related services (HRS) for housing assistance that is limited to short-term situations in which housing is a central part of crisis intervention, stabilization and/or transition for a patient, when there is a direct health benefit, and when the assistance meets the criteria to qualify as an HRS (45 CFR 158.150-1).

Oregon State Hospital (OSH)

3.1 Percentage of Persons with SPMI Who Are Civilly Committed Discharged within 30 days of Ready to Transition (RTT) Designation

Ready to Transition (RTT) means that the individual's discharge planning team has determined that a placement in the community is the most integrated setting appropriate for the individual, and that the individual participated in an individualized discharge planning process which took into account the individual's strengths, preferences and needs. Once this determination has been made, waiting for discharge can have a detrimental effect on the individual's recovery. OHA is committed to discharging these individuals within 30 days of the RTT. Performance on this Goal is shown below.



Time Frame: 1/1/20 through 12/31/20. Data Source AVATAR

Baseline (Fiscal Year 2019)

As of June 30, 2019, the baseline percentage of individuals discharged from OSH within 30 days of being designated RTT was 61%. The goal for FY 2020 was to maintain that 61% discharge rate within 30 days for individuals on the RTT list. The goal for FY 2021 is 65%, and the goal for FY 2022 is 75%.

Comments on Methodology

The percentage was calculated based on the number of patients on a civil commitment included in the denominator who had been identified as Ready to Transition (RTT) for 30 days or less divided by the number of patients on a civil commitment discharged who were identified as RTT at the time of discharge.

Comment on Progress

The goal for this metric: The percentage of individuals discharged within 30 days of RTT designation for FY 2020-2021 by quarter, was:

- 2020 Q3- 67.1%
- 2020 Q4- 63.4%
- 2021 Q1- 67.2%
- 2021 Q2- 58.5%

Progress on this metric lagged. Causes of this problem are discussed below in the Activities Associated with Metric for this Goal and in the Comment on Progress for Goal 3.2.

Activities Associated with Metric

The pandemic's impact caused OSH to modify its activities related to BHQPIP Goals 3.1 and 3.2. Admissions for civilly committed persons were suspended beginning in the fourth quarter of FY 2020, as a pandemic emergency measure. Admissions were of civilly committed persons were permitted in exceptional cases, involving patients with greater needs. These changes distorted performance on the metric.

Despite these impacts on performance, OSH has been taking steps to increase the number of discharges within the specified timeframes, as described below.

- The Person Directed Transition Team continues to work to transition patients from the hospital. Due to the reduced number of patients under civil commitment at OSH individuals can receive more individualized attention from this team.
- Despite the decision to generally halt the admission of civilly committed persons at OSH due to the pandemic, some admissions continued in exceptional cases. There were approximately 20 admissions following the decision to halt civil admissions for the remainder of 2020 due to COVID-19 related issues. Discharges continued amid pandemic related challenges to providing services and housing. Most of these patients were admitted prior to this moratorium. Since many of these patients faced multiple challenges, their collective length of stay was higher than average.
- OSH created Expedited Admission Criteria to ensure that civilly committed individuals whose treatment needs require long term care at OSH were still being served. Expedited Admission criteria requires additional documentation of severe aggression and an inability to be safely treated in an ACPF.
- Strategies two, three and four from BHQPIP workplan 3.1[3] have been postponed due to the low civil census. Reporting templates for the notification of CCOs and Choice IDT attendance were created. Choice contractor attendance at IDTs was 93% for the month of November 2020, the only month measured due to low census numbers. CCO notification reports for admission, discharge, and RTT were created but never employed because of the low census.

[3] Strategy two is the creation of a compliance tracking system for IDTs. Strategies three and four described creation of a tracking template for CCOs and Choice contractors and tracked attendance for IDTs. While the templates and other forms were created, they were only in use for a brief period of time. OSH will begin using them again once there is sufficient civil census.

- Process maps and OSH protocols for admission and discharge were updated. Work on new guidance documents has been placed on hold given the small number of civil patients at OSH and given the strains on capacity caused by the pandemic.
- Most counties no longer have civil patients at OSH and stakeholder meetings with CHOICE are more focused on acute care coordination. With the small number of civil patients at OSH, staff can focus energy on discharging these individuals with proper supports.

- In November 2020, OSH developed a guide for clinical leadership and staff to improve the timeliness of the discharge process on the Springs unit.

- OSH developed a Civil Discharge Protocol in March 2021. The protocol describes in detail the various duties performed by OSH staff to ensure case coordination and that all the discharge needs of the individual are addressed.

- Monthly meetings continue to occur between the OSH Social Work Department the Choice Model contract administrator, Multnomah, Clackamas, Lane, Washington, Jackson, and Marion counties, to discuss and problem solve barriers to discharge for specific individuals.

Additionally, to respond to the pandemic, OSH and OHA engaged in additional activities to protect persons with SPMI from the virus and improve services. Examples of those activities include:

- Establishing hospital procedures to prevent exposure to COVID.

- Once COVID-prevention procedures were in place, leadership staff assigned to this work were able to refocus on the BHQPIP during the reporting period.

- OSH initiated work with the Independent Qualified Agent, Comagine, to facilitate person-centered planning interviews via telehealth.

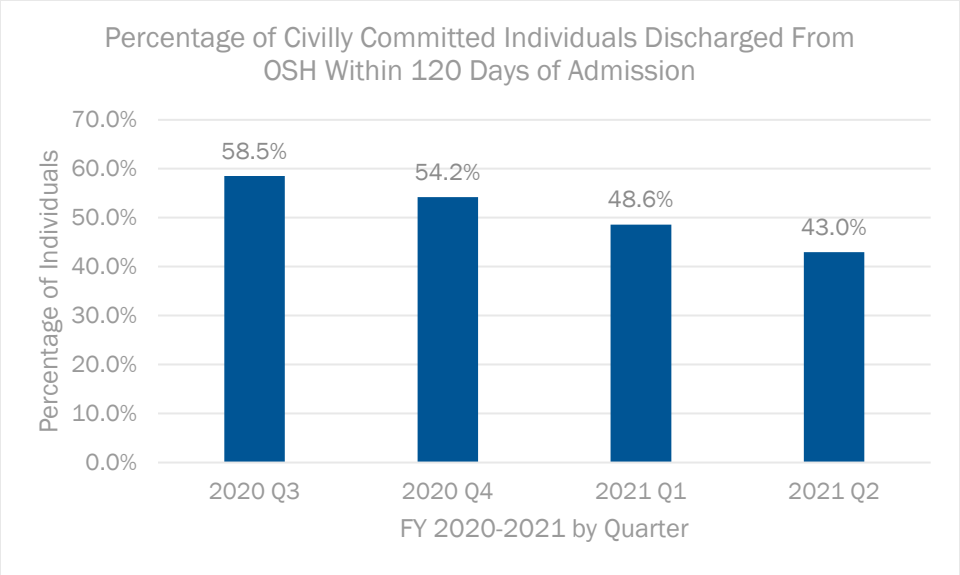
- Civil recommitment procedures were reviewed to make sure only those who need civil commitment were adjudicated.

- OSH reported any COVID-related barriers to discharge to HSD through weekly Ready to Transition review and Multi-population OSH Occupancy and Vacancy Resource Squad (MOOVRS) meetings.

In April 2021 OHA began providing trainings to ACT providers on serving Aid and Assist individuals in ACT programs. Forensic ACT teams could ease the burden on OSH and ACPFs, as well as providing more opportunities for individuals to receive services in the most integrated setting appropriate to their needs.

#3.2 Percentage of Civilly Committed Individuals with SPMI Discharged within 120 Days

Performance on this Goal is shown below.



Time Frame: 1/1/20 through 12/31/20. Data Source AVATAR

Baseline (Fiscal Year 2019)

At the close of FY 2019, the percentage of discharges within 120 days of being admitted to OSH was 61.4%. This was the baseline. The BHQPIP goal for FY 2020 is 61.4%. The goal for FY 2021 is 65%, and the goal for FY 2022 is 70%.

Comments on Methodology

The percentage is calculated taking the number of individuals who were civilly committed and discharged within 120 days of admission, divided by the total number of individuals who were civilly committed and discharged.

Comment on Progress

As compared to the 65% goal, the percentage, by quarter, of individuals discharged from OSH within 120 days is as follows:

- 2020 Q3- 58.5%
- 2020 Q4- 54.2%
- 2021 Q1- 48.6%
- 2021 Q2- 43.0%

The June 30, 2019 baseline of discharges within 120 days of admission was 61.4% (154 of 251 individuals). During the most recent reporting period, OSH encountered difficulties on this Goal and on Goal 3.1. OHA believes a likely cause is that the patient mix changed: there was an increase in the percentage of more complex individuals with lengths of stays longer than 120 days, who were determined to need hospital level of care by the Independent and Qualified Agent (IQA). Aid and Assist admissions also increased and has decreased the number of available beds. In June 2020.[4] The change in the civilly committed population, coupled with COVID-related discharge barriers, contributed to fewer patients being discharged within 120 days, especially in the second quarter of the fiscal year.

> In June 2020, to protect OSH patients from the pandemic, admissions of civilly committed patients were suspended. These population changes, coupled with COVID-related discharge barriers, contributed to fewer patients being discharged within 120 days, especially in the last quarter of the fiscal year.

Finally, the numbers of civilly committed patients were relatively small, which increased the relative impact of patients with higher needs and longer stays. The Average Daily Population (ADP) of civilly committed individuals with SPMI for FY 2020-2021 is as follows:

- 2020 Q3- 68
- 2020 Q4- 44.4
- 2021 Q1- 35.5
- 2021 Q2- 32.8

As stated in the March 2021 report, such a small population can have an outsized impact on metric numbers.

Activities Associated with Metric

OSH is engaged in many activities intended to improve performance on Goal 3.2. A number of activities are summarized above in the discussion of Goal 3.1. OSH continues to assess and work to improve discharge timeliness. OSH is tracking the time on length of stay and RTT to discharge by County, CCO, and Choice Contractor. This information is shared regularly with all system partners to address barriers to discharge at the individual and system levels. These activities include:

- As noted above, monthly meetings continue to occur between the Choice Model Contract Administrator; Multnomah, Clackamas, Lane, Washington, Jackson, Marion Counties; and OSH Social Work representatives to discuss and problem solve barriers to discharge for specific individuals.

[4] Although this had occurred prior to the publication of the March report, it was too soon to realize the full impact of this decision due to data lags and information gathering, as well as being able to assess long term consequences.

- Weekly meetings between system partners continues. Following each meeting, OHA's Health Systems Division follows up with external partners on all external action items and the OSH Social Work leadership follows up on all internal action items.
- The Independent Qualified Agent (IQA)[5] continues to review medical record information to assess if it supports continued need for hospital-level treatment. The OSH Social Work department notifies social work and psychiatry staff, including the director of psychiatry, if the documentation does not support ongoing stay. The patient is then made RTT within three days, unless new clinical information can be presented to the IQA to reverse the determination.
- An important regulatory change has been made. One long standing challenge to reducing overall length of stay at OSH has been the inability to fund individuals with mental health service needs in facilities licensed by Aging and People with Disabilities (APD) and the Office of Developmental Disabilities Services (ODDS). Sometimes individuals may have physical or behavioral healthcare needs in addition to their mental health needs that cannot be met in most mental health facilities. An amendment to Oregon's Medicaid State Plan which took effect in August 2020 now allows Medicaid to pay for treatment in APD and ODDS facilities. This not only promotes shorter lengths of stay at OSH for these individuals, but also allows for flexible person-centered care previously unavailable under the original state plan.

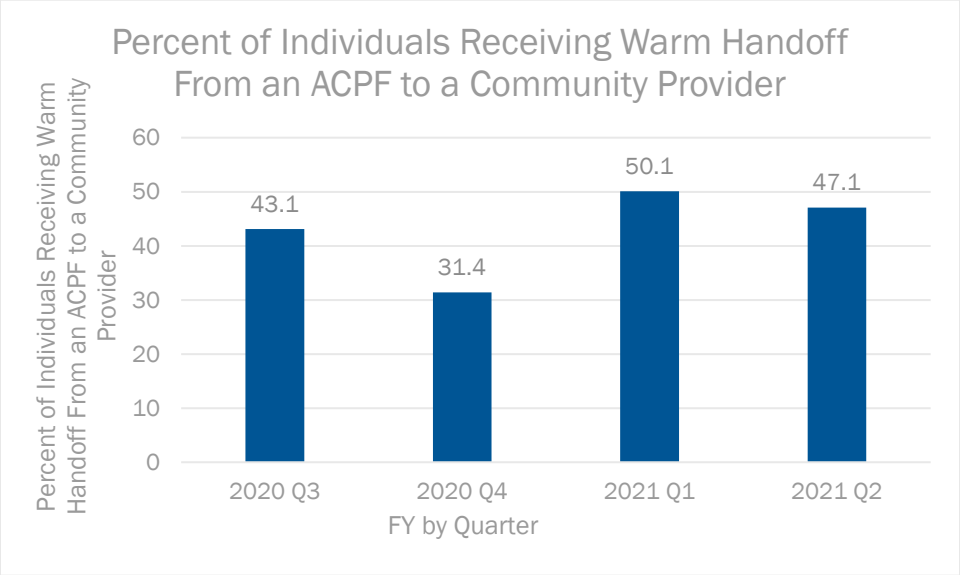
To reduce the burden on OSH and other components of the non-forensic behavioral health system, in April 2021 OHA began opening additional licensed residential beds for the aid and assist population. These new RTF, SRTF, sub-acute and crisis beds will be used to serve these individuals and reduce congestion for non-forensic individuals.

[5] Oregon's Medicaid State Plan directs the state to use an independent qualified agent, known as an IQA, to make clinical decisions regarding coverage. This assures impartiality in Medicaid services coverage decisions.

Acute Psychiatric Care Facilities (ACPF)

#4.1 Percentage of Individuals with SPMI Receiving Warm Handoff

A warm handoff is 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. A warm handoff either including a face-to-face meeting with a community provider and the client, and if possible, hospital staff, or providing a transitional team to support the client, serve as a bridge between the hospital and the community provider, and ensure that the client connects with the community provider. A warm handoff increases the chance of engagement with the community provider and that the individual will continue to be involved in services after discharge. Performance on this Goal is shown below.



Time Frame: 1/1/20 through 12/31/20. Data Source HealthInsight Assure

Baseline (Fiscal Year 2019)

As of the June 30, 2019 baseline, the cumulative average percentage of those who received a warm handoff was 43.3%. The BHQPIP goal for FY 2020 is 43.3%. This was the baseline. The goal for FY 2021 is 50%, and the goal for FY2022 is 60%.

Comments on Methodology

OHA's contractor, Health Insights Assure, gathers data to determine the number of warm handoffs that occurred for individuals with SPMI in Acute Care Psychiatric Facilities (ACPF). The contractor reviews records for all Acute Care discharges within each quarter to determine if a warm handoff was offered and/or occurred. This process also documented individuals' refusals of a warm handoff.

OHA has established a new 12-month contract with Health Insight Assure (now doing business as Comagine). This contract took effect on 6/1/21. OHA is also considering including warm handoff data in

the Compass System Acute Care Reporting (CS-ACR). ACPFs already enter data into this system, and it might prove more efficient than the current process. There have also been discussions regarding having the CCOs report this information directly to OHA, as they are already obligated to monitor this metric as per the CCO contract.

Comment on Progress

During the baseline period ending June 30, 2019, 43.3% of individuals discharging from an ACPF received a warm handoff. The four-quarter average for the previous reporting period was 41.3%. The cumulative average percentage for the current reporting period was 43.1%.

There was a decrease of approximately 12% in warm handoff rates in the fourth quarter of FY 2020 (April-June 2020). This decrease may have been caused by disruptions in the early months of the pandemic, which reduced resources needed for warm handoffs, for example, staff sand readmissions shortages or re-assignments for ACPF staff, Community Mental Health Program (CMHP) staff had reduced ability to meet with patients in person. Also, the ongoing problem of obtaining appropriate technology to facilitate telehealth meetings has also been an issue. During the first two quarters of FY 2021, the cumulative average increased to an average increase of 48.6%. Warm handoff rates for both the third and fourth quarters of FY 2021 began increasing and were above the rates in the first two quarters and are also above the rates in the previous fiscal year. As the system began to adapt to the disruption caused by the pandemic, ACPFs were able to perform warm handoffs at an increasing rate.
COVID

In early 2020, when the COVID Pandemic began, ACPFs had to move quickly to establish policies and procedures based on the direction provided by OHA. The focus was on safety. This reduced in-person Warm Handoffs, which normally occurred prior to COVID. ACPFs and community partners were diligent in building their telehealth capacity; however, this is not an easy solution. With the need for telehealth becoming the norm instead of the exception, more telehealth capacity was needed. Not only do there need to be a sufficient number of devices in a particular facility, there also needs to be available staffing to assist individuals, and there needs to be dedicated space to allow for privacy and confidentiality. The $100 million mentioned in the Executive Summary, some of which will be spent on recruiting and retaining behavioral health employees, should help increase the numbers of staff able to perform this task. Programs are being guided to focus on care coordination, and clearly document any barriers to the warm handoff in their documentation.

As the system began to adapt to the disruption from pandemic mitigation efforts in the first quarter of FY 2021, Bottlenecks began to ease, which made transitions easier throughout the system, including Warm Handoffs. However, over an extended period of time, the cumulative impact of the pandemic is likely degrading overall system performance. It may be some time before OHA has enough information to understand the full impact of COVID on this measure.

Activities Associated with Metric

OHA activities intended to improve warm handoff performance have included efforts to address barriers and to provide guidance and assistance.
During the fall of 2020, the HSD Acute Care Coordinator began holding meetings with ACPFs to discuss warm handoff requirements. Meetings were also held with programs experiencing staff turnover as some of the information about this goal was lost during

staffing transitions. Meetings covered progress and barriers and included discussions regarding the impact of COVID on both warm handoff and the program overall. Despite these disruptions, regular quarterly data was generated and reviewed with ACPFs. Increasing Warm Handoffs continues to be a standing topic at Choice contractor meetings.

The warm handoff guidance document was revised to clarify roles of ACPFs, community partners, and CCOs. In mid-December 2020, it was finalized and uploaded to the BHQPIP website.

OHA's acute care coordinator continues to meet with each of the ACPFs to share their data with them and provide technical assistance. ACPFs continue to receive data on a quarterly basis, and OHA has been clarifying questions regarding the current data collection process. A warm handoff guidance document was recently revised and has been published on OHA's BHQPIP website. It includes additional information regarding the role of the CCOs, CMHPs and community providers in the provision of warm handoffs. This guidance document clarifies the requirement and provides best practice recommendations for each of these groups.

OHA continues to meet with ACPFs to assess where additional follow-up is needed. This includes connecting more regularly with ACPFs where there has been staff turnover to ensure they have a clear understanding of this requirement and continuing to promote consistent documentation with specific references to warm handoff. Additionally, OHA has been asking for feedback regarding the impact of COVID-19 on coordination with community partners. OHA is also continuing to connect with community partners to review their roles in the warm handoff process and where it fits within the discharge coordination process.

#4.2 Acute Care Psychiatric Facility (ACPF) 30-day and 180-day Readmission Rates

Readmissions to ACPHs for adults with SPMI can be an indicator of an increased need for care in community settings. It could also result from barriers to access, lack of services, a need for increased case management, or insufficient engagement with community providers. Improving community services is a good way to reduce readmission rates to ACPHs. Performance on this Goal is shown below for time frame 1/1/2020 through 12/31/2020.

30 and 180-Day Readmission Rates to ACPFs				
Hospital	# of Discharges	Previous Reporting Period data	30 Day Readmit	180 Day Readmit
ASANTE SYSTEM (ROGUE REGIONAL+THREE RIVERS+ASHLAND)	260	30 day-8.0% 180 days-18.0%	8.10%	20.00%
BAY AREA	114	30 day -7.50 180 day-16.50%	6.10%	14.90%
GOOD SAM REGIONAL	118	30 day 11.0% 180 day-20.10%	8.50%	16.10%
UNITY/LEGACY EMMANUEL	966	30 day-12.60% 180 day-26.90%	12.20%	27.60%
PEACE HEALTH SYSTEM	596	30 day- 10.60% 180 day-22.30%	9.90%	22.50%
PROVIDENCE PORTLAND	438	30 day-12.80% 180 day-25.20%	12.80%	27.60%
PROVIDENCE ST VINCENT	721	30 days-10.90% 180 days-24.50%	13.20%	25.50%
SALEM HOSPITAL	327	30 day-5.40% 180 day-16.50%	8.30%	18.30%
ST CHARLES SYSTEM	200	30 day-8.00% 180 day-16.00%	10.00%	20.50%
UBH OF OREGON (CEDAR HILLS)	709	30 day-13.80% 180 day-28.40%	12.40%	24.10%
Total	4,449	30 day- 13.80% 180 days-28.40%	11.30%	24.00%

Time Frame 1/1/20 through 12/31/20. Data Source: MMIS

Baseline (Fiscal Year 2019)

The cumulative 30-day readmission rate to ACPFs for FY 2019 was 10.7%. This was the baseline and is also the BHQPIP goal for FY 2020. The goal for FY 2021 is 10% and the goal for FY 2022 is 9%.

The cumulative 180-day readmission rate to ACPFs for FY 2019 was 22.5%. This was the baseline and is also the BHQPIP goal for FY 2020. The goal for FY2021 is 21.3% and the goal for FY 2022 is 20.5%.

Comments on Methodology

OHA monitors and reports 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 readmission rates by hospital are reported based on the hospital where the first admission occurred. The second admission may have occurred at another hospital. This creates challenges in how the data by hospital is interpreted.

Comment on Progress

The goal for this reporting period is 10% for 30 days and 21.3% for 180 days. As of 12/31/20, halfway through FY 2021, the cumulative average readmission rates to ACPFs was 11.30% at 30 days, compared to a goal of 10%. The rate was 24.00% for 180 days, compared to a goal of 21.3%. Both rates were also higher than baseline. In general, hospitals in more rural areas of Oregon saw slight decreases in their readmission rates, while ACPFs in more populous areas saw slight increases in readmissions.

The increase for this reporting period compared to the last reporting period (7/1/19-12/31/19) was 0.4% for 30 days and 0.6% for 180 days. It's unclear whether COVID is driving this slight rise in readmissions. The pandemic likely had various effects on these numbers, but those effects have not been quantified. For example, it's possible that disruption of community-based services affected the stability of some individuals, leading them to be readmitted to an ACPF.

It is also possible these numbers would have been larger if hospitals were not dealing with overcrowding from COVID, and as a result had to turn away all but the sickest individuals. OHA will continue gather and analyze information to consider how COVID has impacted the healthcare delivery system.

Additionally, another factor contributing to readmissions may have been the impact of the pandemic on individual patients. Whether this played a part in readmission rates is uncertain, but a number of published reports state that the pandemic impacted the mental health of individuals in the general population and those in more vulnerable groups.

Because the rates of COVID-19 infections and hospitalizations also varied by community and region at different times, any analysis of the pandemic's full impact is difficult.

Activities Associated with Metric

In order to reduce the burden on ACPFs and other components of the non-forensic behavioral health system, OHA began opening additional licensed residential beds for the aid and assist population in April 2021. These new RTF, SRTF, sub-acute and crisis beds will be used to serve these individuals and will reduce congestion in the treatment of non-forensic individuals.

Discussions regarding ACPF readmissions are occurring in Choice Team meetings. Those discussions have acknowledged current system challenges (moratorium on civil admissions to OSH, increased demand for residential beds due to the impact of COVID and the increase in Aid and Assist commitments, as well as changes in service delivery or access to natural supports due to COVID). To improve ACPF readmission rates, OHA has been stressing the importance of consistent communication and collaboration between community providers and ACPFs, employing creativity when discharge planning, and utilizing telehealth technologies to facilitate Warm Handoffs and discharge planning. OHA is also reminding providers to be proactive in identifying individuals in the community who may require additional supports that could be wrapped around them to help maintain community placement.

Emergency Departments (ED)

#5.1 Rate of ED Mental Health Visits

A high number of visits by individuals experiencing a SPMI could be an indication that the individual was not receiving or not benefiting from community-based services and supports. The right type(s) of community-based services and supports may prevent crises, allow for earlier intervention to prevent or minimize a crisis situation. A decreased rate of emergency department visits can be an indication that individuals are having their mental health treatment needs met in the community.

Baseline (Fiscal Year 2019)

During FY 2019, the ED utilization rate was 1.88 individuals per 1,000 Oregon Health Plan (OHP) members who visited the ED for psychiatric reasons. The BHQPIP goal for FY 2020 is 1.88. The goal for FY2021 is 1.80, and the goal for FY2022 is 1.60.

Comments on Methodology

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. Impacts due to COVID-19 mitigation measures resulted in data being collected for the entire fiscal year as opposed to quarterly.

Comment on Progress

The goal for the current reporting period was set at 1.80/1,000. The actual performance for this period was 1.57/1,000, which is lower than the final June 30, 2022 goal of 1.60/1,000. Initially, this number is encouraging. However, when considering the demand for ED services due to COVID, it is possible that only the most severely

psychiatrically compromised individuals were seen in EDs, as EDs were full of COVID patients. OHA has no way, at present, to find out how many individuals presenting with mental health issues were turned away from EDs due to overcrowding, or to assess how many persons might have gone to an ED but for their concerns about catching COVID-19. The pandemic has certainly directly or indirectly affected many, if not all the metrics in this report. However, OHA is unable to develop a comprehensive understanding of the specific effects on the healthcare delivery system. In the months to come, HSD and Public Health will conduct further analysis in order to assess the impact of the pandemic on ED utilization rates, but answers may remain elusive.

ED admission rates for mental health reasons by persons with SPMI fell significantly during the reporting period. COVID cases took priority over all but the most urgent psychiatric visits and resulted in community partners finding alternatives to the ED and to ACPFs.

Beginning in FY 2021 Q2 vaccination rates increased and there was a gradual reduction in the number of COVID-related hospitalizations. As of the date of publication, it is unclear what effect the Delta variant will have on this metric. ED admission data for 1/1/21 through 6/30/21 will not be available until December 2021, OHA will work with its community partners to understand how COVID has continued to create challenges for the mental health delivery system.

Implementation of the Case Review Team component has been delayed due to staff being assigned other duties related to the pandemic. OHA is currently reexamining the feasibility of OHA staff doing case reviews in the field, at least until the pandemic eases and staff resume normal duties. Also, the CCOs are required by contract to provide specialized management plans for individuals with two or more psychiatric visits to the ED within a six-month period, as well as providing case coordination and service alignment for all members to visit the ED for mental health reasons. OHA is engaging in discussions with the CCOs to confirm they are performing these functions.

Activities Associated with Metric

OHA is pursuing a number of efforts to improve performance in this area. For example,

Discussions regarding ED utilization occur monthly in Choice Team meetings.

OHA's Acute Care Coordinator continues to meet with Choice contractors, the Metro Acute Care Advisory Council (MACAC), and the Oregon Association of Hospitals and Health Systems (OAHHS) to reinforce OHA's expectations and provide technical assistance to address this metric. The acute care coordinator has also been participating in OHA's internal steering committee regarding Pre-Manage, a database that tracks ED visits.

Premanage is a technology platform utilized by ACPFs to track ED admissions and discharges. Participating in the Premanage Steering Committee has been a principal strategy to promote communication with system partners and to provide technical assistance as needed. The Premanage Steering Committee began cancelling meetings at the beginning of the pandemic due to staff being reassigned staff to COVID response related activities. As of this writing, these meetings have not resumed. When they resume, these meetings will provide an opportunity for CCOs, CMHPs and other

community partners to strategize how best to decrease ED utilization, as well as improve community-based services to reduce reliance on EDs and ACPFs. These meetings will also allow for access to The Emergency Department Information Exchange (EDIE). EDIE provides real-time information for patients, clients or members, to coordinate care and share care recommendations for individuals at high risk. OHA is unable to predict when these meetings will be resumed.

#5.2 Collect data regarding psychiatric boarding in order to develop strategies to address individuals with SPMI who present to the ED for mental health reasons who are in the ED for longer than 23 hours.

Psychiatric Boarding is defined as waiting in the ED for more than 23 hours for admission to an ACPF. ED Boarding is a nationwide problem, and generally indicates a lack of access to treatment. Providing increased access to treatment and increasing the availability of community-based treatment options can reduce ED boarding, getting more timely access to care to individuals.

Baseline (Fiscal Year 2020)

The baseline totals for FY 2020 were 785 individuals statewide who spent longer than 23 hours in an ED, or 22.6% of individuals with SPMI visiting the ED for mental health reasons. The goal for FY 2021 is to continue to collect this data, and identify patterns, trends, and areas for improvement. OHA will collaborate with ACPFs, Choice contractors and Community Mental Health Programs to develop strategies to reduce ED boarding.

Comments on Methodology

OHA Health Analytics has established a contract with Apprise Health Insights to receive ED discharge data. OHA will be pulling data specific to individuals 18 years or older with an SPMI diagnosis who are admitted to the ED for mental health reasons for 23 hours or longer.

Comment on Progress

No goal has yet been set for this metric. As of 12/31/20, the statewide cumulative average was 22.7%, virtually unchanged from the last reporting period number of 22.6%. This number is presented as an aggregate statewide number.

The data for this reporting period, like the previous reporting period, is not consistent with the OSU study in 2016. The 2016 study used different definitions and different parameters for data collection. For these reasons, comparing the two studies is problematic.

Over time, there have been several studies conducted throughout the United States and Canada, each using different definitions for boarding, and each having different methodologies, which makes comparisons difficult. What is clear, however, from a survey of these studies, is that ED boarding for individuals who visit the ED for mental health reasons is an unfortunate reality that needs to be addressed.

The fact that this year's data is nearly identical to last year's data (even with COVID mitigation measures in place) lends credence to its reliability, assuming the pandemic had no effect on the data, One or two additional data collection periods should yield more information OHA can use to develop strategies to reduce ED boarding.

The impact of the pandemic is also difficult to assess. Anecdotally, the pandemic may be impacting the availability of beds in other parts of the system, such as ACPFs.

Activities Associated with Metric

As stated previously, the rise in the Aid and Assist population, coupled with the issues caused by the pandemic have posed significant challenges.

In order to reduce the burden on EDs and other components of the non-forensic behavioral health system, OHA has opened additional licensed residential beds for the aid and assist population. These new RTF, SRTF, sub-acute and crisis beds will be used to serve these individuals and reduce congestion for non-forensic individuals.

ED boarding is also addressed in OHA's CCO contracts. This language includes a requirement for CCOs to develop remediation plans with hospitals with significant numbers of ED stays longer than 23 hours. OHA is developing processes to evaluate CCO compliance. OHA is engaged in discussions with CCOs and CMHPs to share data and to discuss broader system issues; this will result in written guidance and strategies for reducing boarding. OHA currently plans to begin drafting this guidance in the fall of 2021.

The HSD acute care coordinator continues to meet regularly with ACPFs and with Apprise Health Insights to address this issue and to discuss progress and data collection issues. Another requirement that is peripherally related to this metric is the requirement to complete a housing plan and assessment upon discharge. While stable housing may not be directly correlated to ED wait times, it has been proven to contribute to an individual's overall health and stability. Having safe, stable housing increases the chances of treatment engagement in the community and may reduce the need for ED and ACPF visits. The statewide average of housing plans completed dropped slightly during this reporting period to 85.6%. Emergency measures related to COVID 19 mitigation efforts could have played a part in this minor reduction.

OHA is also working with CCOs to determine network adequacy standards statewide for behavioral health services. Providing the correct ratio of a comprehensive array of services has been shown to reduce over reliance on less integrated and more expensive care environments.

The stakeholder workgroup developing the bed registry is currently finalizing the details of the registry. There is one more feedback session prior to a presentation to OHA Leadership. OHA plans to have the bed registry published by September 2021 but given the recent the pandemic surge in Oregon some work may be delayed.

Other steps being taken which address issues related to boarding are:

- 988 Hotline Work continues to launch 988, the National Suicide Prevention emergency number. on the "go live" date remains July 16, 2022, nationwide. OHA hopes to have the basics of the call center in Oregon established by the end of

October 2021. This is only one component of Oregon's plan for a statewide crisis response system. Standards are currently being developed for:

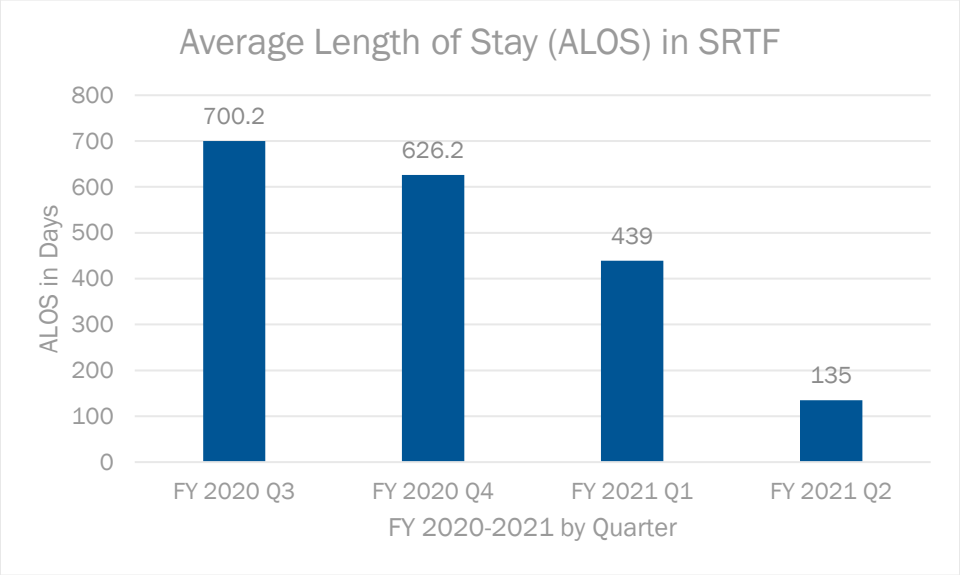
- Mobile Crisis teams and services. While many of the program standards for mobile crisis teams and mobile crisis services have already been developed, OHA will also include standards for dispatch, telehealth and law enforcement and Emergency Medical System collaboration. Due November 2021.
- Crisis Stabilization Centers. Standards are being developed regarding the scope and availability of both mental health and substance use disorder treatment, regionalization, pharmacy access availability, discharge and follow up activities, as well as coordination with an ACPF. Due November 2021.
- Follow Up Services for Individuals Calling 988. Standards will address technology needs, ease of access to behavioral health providers, availability of community-based services, clinical supervision and peer involvement. Due November 2021.
- Other aspects of ongoing work include developing funding and Medicaid reimbursement strategies, addressing needed regulatory and licensure requirements, and developing communication and quality improvement plans.
- Work is still underway to submit a final plan to both Vibrant and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), by Dec. 30, 2021 for additional funding.
- Quantifying and regularly monitoring the extent of boarding.

OHA has regularly communicated with Choice contractors regarding system impacts that could result in ED boarding. Communications regarding such impacts continue.

Secure Residential Treatment (SRTF)

#6 Average Length of Stay (ALOS) in SRTFs for Civilly Committed Individuals with SPMI

A Secure Residential Treatment Facility (SRTF) is any facility or any part of a facility approved by OHA that can restrict an individual's exit from the setting through the use of approved locking devices on individual exit doors, gates, or other closures. SRTFs are the most intensive and restrictive level of care other than hospital level care. In addition to controlling a resident's movement, some SRTFs have curfews, may compel medication, and can utilize seclusion rooms. SRTFs are a necessary level of care intended only for individuals with the most complex needs. SRTFs are intended to further stabilize individuals who may still present with certain risky behaviors that would be difficult to monitor in a more independent setting. OHA is committed to transitioning these individuals into a more integrated, independent setting as soon as they are ready. Lowering the ALOS in these facilities promotes community integration and independence and reduces the likelihood the individual will be re-hospitalized. Performance on this Goal is shown below.



Reporting Period: 1/1/20 through 12/31/20. Data Source MMIS

Baseline (Fiscal Year 2019)

As June 30, 2019, the average length of stay for an individual who was civilly committed to a Secure Residential Treatment Facility (SRTF) was 517 days, which is the BHQPIP goal for FY 2020. The goal for FY 2021 is 491, and the goal for FY 2022 is 467.

Comments on Methodology

OHA calculates ALOS by counting the number of individuals and the length of stay from admission who reside in SRTFs each quarter (to be measured on the 15th day of the last month of the quarter). The average is then calculated to produce ALOS.

Comment on Progress

The BHQPIP goal for FY 2021 is 491 days. The ALOS as of December 15, 2020 was 135 days,

The ALOS for each quarter of the reporting period is as follows:

- FY 2020 Q3- 700.2
- FY 2020 Q4- 626.2
- FY 2021 Q1- 439
- FY 2021 Q2- 135

The data shows the following:

- For the quarter ending December 31, 2020, the point-in-time count of the 38 civilly committed individuals with SPMI residing in SRTFs on December 15, 2020 was as follows:
- Less than 120 days: There were 30 such persons, or 79% of all civilly committed individuals with SPMI, residing in SRTFs on December 15, 2020.
- 120-365 days: There were 4 such persons, or 10.5% of all civilly committed individuals with SPMI, residing in SRTFs on December 15, 2020.
- 366 days to two years: There were 3 such persons, about 8% of all civilly committed individuals with SPMI, residing in SRTFs on December 15, 2020.
- Over two years: There was 1 such person, or about 2.5% of all civilly committed individuals with SPMI, residing in an SRTF on December 15, 2020.

Despite the drop in ALOS, firm conclusions cannot be drawn from the data, even though OHA has instituted several system improvements to reduce ALOS. The previously discussed demands placed on the system of care led to hospital and ED overcrowding, a moratorium on OSH admissions for non-forensic individuals, and workforce shortages. This significantly interfered with day-to-day operations, especially in the residential system. Individuals in crisis who would normally experience eventual admission to OSH did not have that option. Instead, these individuals were admitted to ACPFs until they had attained some stability, and were then referred back to an SRTF, often a different one from which they came when the previous placement denied readmission due to problematic behavior. As a result, a number of stays at SRTFs were short, and this helped drive the average number down. However, as described below, OHA has also taken several steps intended to reduce the average stays in SRTFs, and those steps also should have contributed to the reduction in ALOS.

Because the number of civilly committed persons in SRTFs is relatively small, the ALOS number can be significantly impacted by individual cases. The pandemic also significantly interfered with the normal process of referrals, transition and the normal provision of services, both inpatient and outpatient. Because of these disruptions, it is difficult to analyze the ALOS numbers and draw conclusions from them.

Activities Associated with Metric

OHA has been taking a number of steps to reduce the ALOS in SRTFs.

First, in February 2021, OHA amended administrative rules allowing the State to decline Medicaid reimbursement for individuals who do not meet clinical criteria for SRTF level of care. This had been a long-standing issue that contributed to lengths of stay in SRTFs.

Although rules existed that controlled SRTF admissions for individuals discharging from OSH, no such process existed for civilly committed individuals with SPMI who were admitted to SRTFs from the community. OHA believes this change in Medicaid payment rules will help lower the ALOS in these facilities. It will also ease waiting lists and create more room for individuals who require SRTF services. In many cases, individuals have long lengths of stay in SRTFs due to concerns over safety and assaultive histories. Many of these individuals can have their service and support needs met in less restrictive settings, thereby preventing unnecessary stays that will increase ALOS.

Second, in a related change, OHA also revised the language in its Notice of Adverse Benefit Determination (NOABD). The NOABD is a form issued by the Medicaid payer when a Medicaid reimbursable service does not meet clinical criteria and the service is declined for payment. These revisions more clearly described the individual's appeal and due process rights under Medicaid.

Third, in February 2021, OHA modified the Medicaid payment rules to allow Medicaid to pay for service and treatment costs for individuals with SPMI in facilities licensed by Aging and People with Disabilities (APD) and Oregon Department of Developmental Disability Services (ODDS). This is an important development because many times, an individual may have complex physical or behavioral care needs but does not pose an elopement risk. The rules now allow individuals to receive needed services and supports in a more integrated setting than an SRTF.

Fourth, OHA is working with its contractors, both 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. OHA's oversight in this area can help increase timely discharges, which will help reduce ALOS.

Fifth, the IQA continues to perform prior authorizations for individuals referred to SRTFs from OSH and conducts continued-stay reviews for individuals receiving treatment in an SRTF. OHA continues to review those assessments that recommend transition to a more integrated level of care, a determination that OHA ultimately makes.

Additionally, the Rate Review Committee continued to meet during FY 2020-2021. The committee reviews requests for services provided in SRTFs (and other licensed facilities) that involve proposed charges and services in excess of standardized rates. The committee performs a comprehensive clinical review of the individual's services and works with Medicaid policy analysts to determine appropriate reimbursement for exceptional services. The work of this committee may help reduce the ALOS of civilly committed persons in SRTFs, by declining to authorize services that are no longer needed.

Criminal Justice Diversion (CJD)

#7 Number of Individuals Receiving Mental Health Services and Arrested

Baseline

In March 2020, OHA and the Oregon State Police (OSP) entered into an agreement that provided OHA with baseline information regarding individuals with SPMI who received behavioral health services and were arrested. This agreement covered a three-year period ending June 30, 2019. The cumulative average percentage of individuals in services who were arrested during this three-year period was 2.98%.

OHA and OSP continue in discussions to forge an ongoing agreement to share this data but continue to experience legal restrictions. During the 2021 Legislative Session a proposal (SB 73) was introduced that would have authorized an inter-agency work group to develop a plan that would address the statutory barriers to sharing this information. However, this bill did not come to a vote. OHA leadership is continuing to explore ways to obtain this data.

Activities Associated with Metric

OHA is engaged in numerous activities to address the interaction between persons with SPMI and law enforcement.

Providers continue to utilize the "Sequential Intercept Model" (SIM) and receive technical assistance through the GAINS Center to more effectively deal with mentally ill Individuals who come into contact with law enforcement personnel. Providers use the SIM to identify and intervene upon "points of interception" or opportunities for interventions to prevent Individuals with SPMI from entering or penetrating deeper into the criminal justice system.[6]

The Oregon Center on Behavioral Health & Justice Integration (OCBHJI) is a statewide program that works in partnership with OHA to provide specialized training and technical assistance for behavioral health and justice partners. OCBHJI offers training, tool kits, and other resources to law enforcement, court professionals, and behavioral health professionals who partner with law enforcement, including crisis intervention training. The purpose of this training and technical assistance is to enhance knowledge and improve practices aimed at treating people who, primarily due to symptoms of serious behavioral health or other disabilities, are at risk of becoming incarcerated or are already within the system.

OHA continues to contract with Eastern Oregon Human Services Consortium (EOHSC) for work related to the OCBHJI. EOHSC provides Sequential Intercept Mapping training throughout the state, assists the Department of Publics Safety Standards and Training (DPSST) with Oregon's Crisis Intervention Team (CIT) training program, and works on a variety of other projects. The contract started July 1, 2021, and

[6] The Sequential Intercept Model clarifies five points at which standard processing of crimes can be intervened with community-based actions, so that individuals with mental and psychiatric disorders would not have to further penetrate the criminal justice system. By understanding and using the model, communities can develop a series of strategies to increase diversion of individuals with mental health issues from the criminal justice system and to help them receive proper community-based treatments.

includes Law Enforcement 101 training for providers, which includes training mental health workers to work with law enforcement, and a pilot of Advanced Crisis Intervention Training.

Additionally, OSBHJI is involved in the Oregon Crisis Intervention Teams Center of Excellence (CITCOE). CITCOE was established as a partnership between the DPSST, the state law enforcement licensing agency, and Greater Oregon Behavioral Health, Inc. (GOBHI). CITCOE was formed to broaden the reach of crisis intervention teams across Oregon.

While Oregon is experiencing difficulty in gathering data for this metric, criminal justice diversion activities continue. The most recent quarter (10/1/20-12/31/20) shows promising statewide numbers. 32% of diverted individuals received a pre-arrest diversion, and 68% received those services post-arrest diversion services. This compares to the final reporting period of the Oregon Performance Plan (6/30/19) of 20% pre-arrest diversions and 80% post-arrest diversions.

Pre-arrest diversions can lessen the burden on the criminal justice system. More importantly, they can significantly reduce the trauma of involvement in the criminal justice system for those in mental health services. This can increase the likelihood of the individual's engagement in services and continued personal investment in recovery.

In Conclusion

In Oregon and almost everywhere else in the country, the effects of COVID-19 caused significant disruption in the state's mental health system. OHA took a number of actions to support our community partners in serving their communities, including suspending certain data collection requirements to ease administrative burden. The effects of COVID and subsequent mitigation measures interfered with admissions to OSH and ACPFs, disrupted ACT programs and other outpatient services. Normal legal proceedings, such a civil commitment hearings, were impacted as well. Workforce shortages resulted in diminished access to treatment services. Secondary effects, such as increased isolation, increased substance use, depression and suicidal ideation also impacted Oregon's communities. Despite this, Oregon's providers have continued to faithfully serve some of the state's most vulnerable individuals.

The data collection challenges along with the other stressors on the system make it difficult to thoroughly analyze the information in this report. While OHA is confident in the data, it is too early to understand the many ways COVID (and the wildfires of 2020) influenced the system and metrics outcomes. Since the pandemic appears to be resurging at the time of the publication of this report, it is possible that further emergency measures and alteration of normal processes and practices will be necessary to ensure the health and safety of all Oregonians. OHA will keep working with other agencies and community partners to understand the full effects of COVID on the system and to explore ways to strengthen it moving forward.

Appendix A

Many of the metrics identified refer to a rolling one-year period. Those metrics are identified in the Data Table. A rolling one-year period means the analyst looks at 12 months of data for each semi-annual report.

The publication schedule for the BHQPIP is changing. Due to a six-month data lag and the subsequent time necessary to sort, analyze and prepare the data for publication, it is very difficult to provide sufficiently thorough information and still meet the current publication schedule. Therefore, OHA has decided to adjust the current schedule and publish reports in February and August beginning with the Second Semi-Annual Report.

Report Quarter	Previous Rolling One-Year Period
First Annual Report	July 1, 2019 through June 30 2020
First Semi-Annual Report	July 1, 2020 through Dec. 31. 2020
Second Semi-Annual Report	Jan. 1, 2021 through June 30, 2021
Third Semi-Annual Report	July 1, 2021 through December 31, 2021
Final Semi-Annual Report	Jan. 1, 2022 through June 30, 2022