

Oregon Behavioral Health Quality and Performance Improvement Plan

Semi-Annual Narrative Report May 2022

(1/1/21 through 6/30/21)

Publish date
May 10, 2022



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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.

OHA staff are performing additional duties related to the pandemic while performing their normal job functions. It is because of their sense of duty and service that OHA continues 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, Jason Slappe, Brenda Dennis, Cody Gabel, Scott Hillier, Della Hoffman, Susan Lind, Michael Oyster, Patricia Alderson, George Carillo, 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](#) (BHQPPIP) 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 BHQPPIP are offered in accordance with the requirements of the Quality Improvement System.

The BHQPPIP analyzes key mental health services provided to adults with SPMI beginning July 1, 2019. It was developed to help adults experiencing 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 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;
- Data reporting
- Ongoing quality improvement efforts to improve access to services and treatment outcomes

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

The report provides baseline data (FY 2019) for each of the metric, 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](#).

Since OHA declared a Public Health Emergency (PHE) in March 2020, Oregon has reported over 730,000 cases of COVID-19, including over 7,500 deaths. Emergency measures instituted in response to the COVID-19 pandemic have impacted the entire healthcare system, especially the mental health system nationwide, and Oregon is no exception. Staff shortages, over-crowded hospital and emergency departments, and increased demand on services due to secondary impacts, such as increased numbers of individuals experiencing anxiety and depression, social isolation, increased suicidal ideation and other mental health conditions, have stressed the delivery system almost to the breaking point.

The adaptations required to meet the challenges posed by COVID-19 have caused significant disruptions to normal processes and procedures within all areas of the system. It has also affected the progress toward the metrics in this report, as will be covered in the applicable sections.

The Oregon Health Authority (OHA) would like to thank the state's CCOs, Community Mental Health Programs (CMHPs) and community providers for their perseverance and dedication in serving Oregonians with SPMI during these trying times. OHA also acknowledges the hard work and sacrifice of its own employees: Oregon State Hospital (OSH) staff, and OHA office and field staff, many of whom were given additional COVID-19-related duties in addition to their normal workloads. Thank you for all you do. Over 1.2 million Oregon residents had Oregon Health Plan coverage through the CCOs. The impact of COVID-19 presented significant challenges to providing accessible coordinated services across the state. Workforce shortages, overtaxed medical services, quarantines and "lock downs" all played a part in hampering the provision of behavioral health services.

Through the CARES Act, Oregon was able to provide over \$25 million in emergency funds to community behavioral health partners. These flexible funds assisted CMHPs and other contractors in providing services contracted through the CCOs. This helped fund activities like additional Peer Delivered Services, COVID-19 contact tracers, and provided technology to make telehealth more available to members.

Data Collection and COVID-19

The narrative in this report describes activities and outcomes taking place during the second half of Fiscal Year (FY) 2021 (1/1/2021-6/30/2021). 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 first half of the fiscal year,

The next edition of the BHQPIP is scheduled to be published in August/September 2022 and will analyze the period from 7/1/2021 through 12/31/2021. As with previous reports, some rolling year metrics may include figures from the previous reporting period.

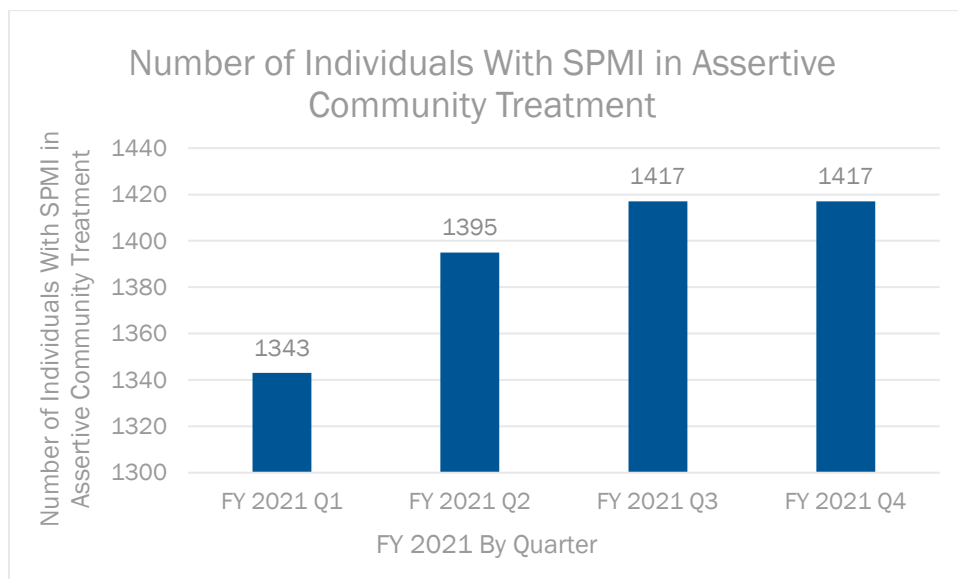
Assertive Community Treatment (ACT)

#1 Number of Individuals with SPMI Served with ACT

Assertive Community Treatment is the most comprehensive community treatment available. Oregon has set a standard statewide of rate for ACT enrollment of 47/100,000 individuals, or 0.47 percent of the general population. OHA believes this is the minimum ratio for ACT enrollment amongst the general population. As of 6/30/2021, the Oregon Center of Excellence for Assertive Community Treatment (OCEACT) estimated the capacity of the 33 ACT programs can serve 1484 individuals statewide. As of 6/30/2021 the ACT enrollment statewide, including non-Medicaid funded individuals, was 1417, slightly over 95% of capacity. Considering the strain placed on the system by COVID-19 mitigation measures, this slight increase in enrollment is a direct reflection on CCOs and other community partners' commitment to providing community integrated services to people experiencing SPMI. Oregon met the goal for FY 2021 of 1400 individuals enrolled in ACT.

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 generally provided outside of the traditional office-based treatment. These 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. The following table shows performance on delivery of ACT services.



Baseline (Fiscal Year 2019)

As of 6/30/2019, there were 1325 individuals in ACT. 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 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.

Comment on Progress

ACT enrollment began rising during the first quarter of FY 2021. By 6/30/2021, enrollment had increased to 1417 individuals. The goal for the end of FY 2021 (6/30/2021) was 1400. Oregon exceeded this goal by 17 individuals.

According to OCEACT, there are currently not enough ACT teams statewide to achieve the goal of 1750 individuals by June 30, 2022.

The \$ 4 million originally slated to be infused into ACT programs was not available. Emergency efforts undertaken to combat the effects of the COVID-19-19 pandemic resulted in diversion of OHA's funding and administrative efforts.

Current funding efforts have been devoted to the staff recruitment and retention crisis, particularly Qualified Mental Health Professionals (QMHP) and Registered Nurses (RN). ACT programs have been unable to fill vacancies, which has resulted in lower fidelity scores for some programs.

Despite these challenges, OHA's contractors and provider still managed to provide services to individuals with SPMI in excess of the goal.

Oregon exceeded the goal of 1400 for FY 2021 with 1417 individuals enrolled in ACT services.

Activities Associated with Metric

OHA staff are exploring short-term (90 day) funding using FEMA COVID-19 funding or from other sources to provide temporary relief for ACT staff who are overwhelmed during staff shortages. The contract administrator is proposing an increase in the OCEACT budget by \$100,000 per year for a two-year minimum. The funds would be used to hire additional staff to provide expanded training in the Recovery Academy.¹

The objective is to train as many ACT program staff as possible and expand this training to staff in residential settings. Improved training resources can improve skills and wellness for staff

¹ Additional information on the Recovery Academy can be found at www.commongroundprogram.com

working in residential settings, thereby helping individuals discharging from OSH attain greater stability in the community.

Other activities include:

- Regular meetings with Pacific Source, GOBHI, CareOregon to discuss referrals and problem solve barriers
- Presentations and discussions involving ACT referrals: Monthly OCEACT presentations during CHOICE² current data regarding referrals by region, including regions which are currently underserving individuals in need of ACT services
- ACT Monthly Technical Assistance Call with all providers
- OCEACT is currently working on a two-year project to improve ACT RN competencies. The project will prepare nurses with appropriate competencies in behavioral health, behavioral health crises and behavioral health medications with associated health concerns. OCEACT contracted with 2 nurse educators and is developing competencies and curricula.

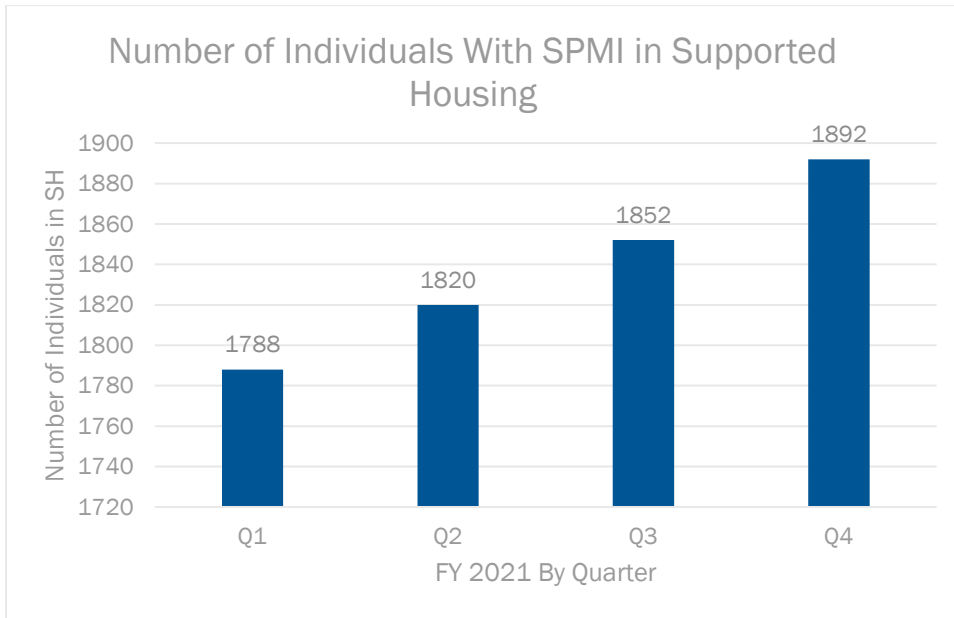
Supported Housing

#2 Number of Individuals with SPMI Living in Supported Housing

Supported housing is an evidenced-based practice that provides permanent housing with support services that enable people to live in their own homes in the community. 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 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 percent 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

² Choice Model Services are designed to promote more effective utilization of current capacity in facility-based treatment settings, increase care coordination, and increase accountability at a local and state level. Choice Model services promote the availability and quality of individualized community-based services and supports for adults with mental illness in the most independent environment possible and minimize the use of long-term institutional care.

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 6/30/21, 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.

Comment on Progress

By 6/30/21 OHA counted 1892 individuals with SPMI living in Supported Housing. Although Oregon did not meet the goal of 1925 individuals, during the Fiscal Year, it was only 33 short of the goal. However, as of 6/30/21,

another 1987 individuals with SPMI were in Supportive Housing. Supportive housing is another form of housing with supports, but supportive housing does not meet the non-congregate requirements for supported housing. Nevertheless, supportive housing is an important source of housing provided in Oregon to persons with SPMI.³

Activities Associated with Metric

The Supported Housing developments described in the previous BHQPIP continue to come on-line on schedule. Two additional projects are scheduled to open in September 2022: Centennial Place, Portland (71 units total, 18 for individuals with SPMI), and Rogue Ridge in Ashland (30 units total with 13 reserved for individuals with SPMI). Yaquina Hall in Salem will provide additional units (50 units total with 20 reserved for individuals with SPMI).

OHA's priorities include being transparent in communication and leading with equity through a model of shared power in planning and decision making with community. It is our goal to demonstrate we are doing things differently and aligning with the core values of this project as we operationalize the plan. Initial funding was provided to community organizations with the acknowledgement and value of community wisdom, and the purpose of supporting community partners in conducting research for Planning Grants intended to inform the need and gaps in services, ultimately guiding our approach as we demonstrate our commitment to centering community.

CCOs are required to coordinate with community partners to ensure members who are homeless and who have had two or more readmissions to an ACPH in a six-month period are connected to a housing agency or behavioral health agency to ensure these members are linked to housing in an integrated setting, consistent with the member's treatment goals, clinical needs and informed choice. The CCO is required to work with OHA and the CMHPs to ensure that members who are discharged from an ACPH are discharged to housing that meets the individuals' immediate need for housing. CCOs are required to work with ACPHs 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 member's 20 CCO Reporting Measures for Adults with Serious and Persistent Mental Illness (SPMI) treatment goals, clinical needs, and informed choice. The CCO is required to notify, or require the ACPH to notify, the community provider to facilitate the implementation of the plan for housing. This measure gauges how effectively the CCOs and other system partners address social determinants of health, specifically housing. This measure identifies the number of members discharged from ACPHs who are homeless, that are connected to a housing provider with an appropriate documented housing assessment, as well as the percentage of such persons among CCO members discharged from ACPHs. For FY 2020, 9,231 individuals, or 89.2% of those discharged had a housing plan upon discharge.

³ 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.

With an influx of additional money, described in the section on ACPFs, and with Supported Housing development financed at the county level, OHA anticipates meeting its final goal of 2,000 individuals in Supported Housing by 6/30/22.

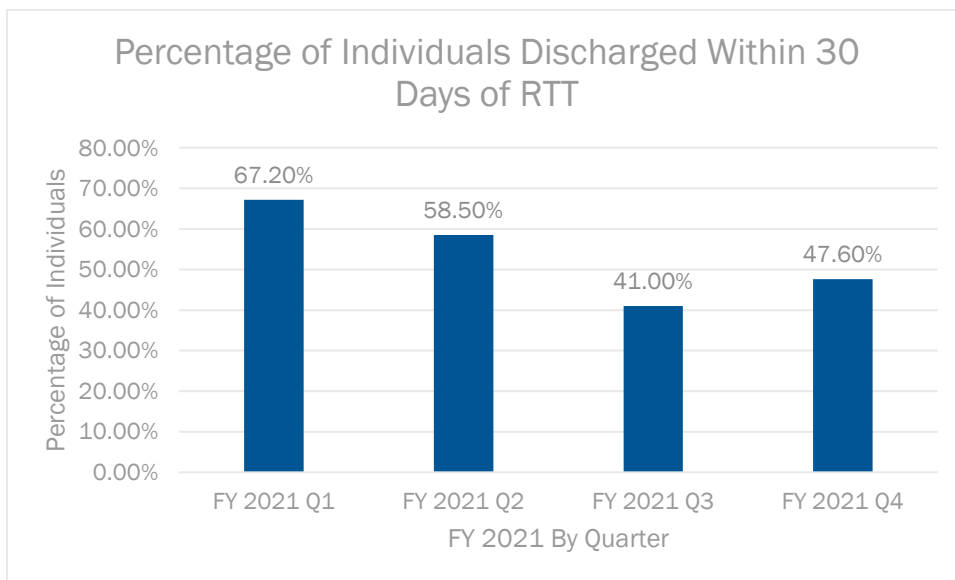
Oregon State Hospital (OSH)

While the data collection methodology used for the OSH metrics remains the same, this report will also include analysis by quarter in addition to cumulative quarterly performance. Because of the low numbers of civil admissions and discharges for the reporting period, additional analysis will allow for a closer examination of the fluidity of the situation during the year. The cumulative quarterly performance is the number by which OHA gauges this metric.

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.



Reporting Period: 7/1/20 through 6/30/21. 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 quarterly cumulative performance for the FY is listed below:

- 2021 Q1-67.2%
- 2021 Q2-58.5%
- 2021 Q3-41%
- 2021 Q4-47.6%

The percentage of individuals discharged within 30 days of RTT designation for FY 2021, using the numbers for the three months of each quarter only, rather than a one-year cumulative number, was:

- 2021 Q1- 50%
- 2021 Q2- 50%
- 2021 Q3- 42.9%
- 2021 Q4- 50.5%

The relevance of these numbers is discussed below.

The cumulative one-year performance numbers appear to have dropped in Q3 and Q4 of 2021, but the three-month performance numbers for the quarter itself show little change over the four quarters. Oregon State Hospital (OSH) has continued to see shifts in the patient population, with a further decrease in civilly committed patients in Q3 and Q4 of FY 2021. Patients ordered to OSH from jail for competency restoration or under the Psychiatric Security Review Board were prioritized for admission. The pandemic also exacerbated the situation. There were only three civil admissions during this period, all qualifying under the Expedited Admission policy, with these patients exhibiting severe aggression that could not be safely treated in an acute care setting.

The overall civil patient average daily population in Q3 was 17.1 patients and in Q4 11.0 patients. The number of civil patients discharged in Q3 was 14 patients, and in Q4 two patients. Reduced civil admissions and the small sample size of discharged patients negatively impacted the metrics of

goals 3.1 and 3.2. Patients discharged were either admitted prior to the pause to civil admissions or were admitted consistent with the Expedited Admission policy.⁴ Discharging many of these patients was difficult. Many were treatment refractory or had co-occurring neurocognitive disorders related to traumatic brain injury. These patients were more likely to have an ongoing need for hospital level of care interventions due to aggression or require specialized placement in the community.

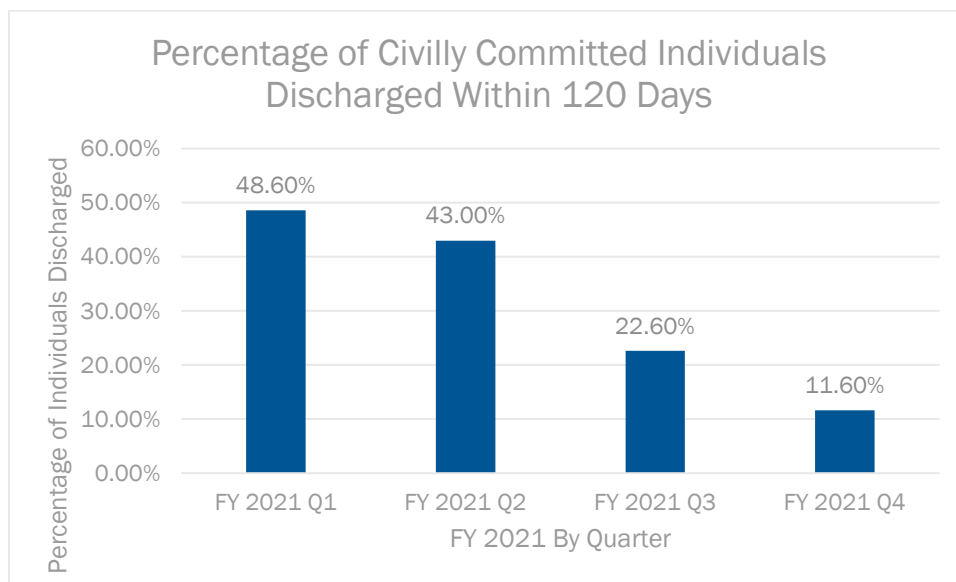
Activities Associated with Metric

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.

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.

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

Performance on this Goal is shown below.



Reporting period: 7/1/20 through 6/30/21. 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%.

⁴ https://www.oregon.gov/oha/OSH/LEGAL/Documents/2021_02-05%20Expedited%20Admissions%20-%20Civil.pdf

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

The quarterly cumulative performance for the FY, is listed below:

2021 Q1-48.6%

2021 Q2-43%

2021 Q3-22.6%

2021 Q4-11.6%

The percentage, by fiscal quarter, of individuals discharged from OSH within 120 days is as follows:

- 2021 Q1-6.3%
- 2021 Q2-18.2%
- 2021 Q3-14.3%
- 2021 Q4-0%

As previously stated, admissions in Q3 and Q4 were limited in number with patients presenting as highly acute and with complex needs, making it more difficult to achieve stabilization and discharge within 120 days, with 2 out of 14 (14.3%) patients discharging within 120 days in Q3 and 0 out of 2 patients (0%) in Q4. Comagine, the Independent Qualified Assessor, continued to assess patients in Q3 and Q4 who were not RTT for the need for hospital level of care. If Comagine's assessment determines a patient that is not RTT does not require hospital level of care, this prompts an administrative review and in-reach to the patient's treatment team to re-assess the patient RTT status.

Oregon State Hospital encountered significant staffing issues within the nursing department during this period due to the COVID-19-19 pandemic. However, OSH remained committed to safe and timely discharges. Only two social workers were re-assigned to nursing during this period, and those that remained were asked to prioritize work related to discharge.

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 2021 is as follows:

- 2021 Q1-35.5
- 2021 Q2-32.8
- 2021 Q3- 17.1

- 2021 Q4-11.0

By contrast, during the baseline year, the ADP of civilly committed persons at OSH was 107.2 persons, almost ten times what it was in the last quarter of FY 2021.

Activities Associated with Metric

The moratorium on civil admissions and the subsequent dwindling numbers of patients made some of the activities associated with these metrics unnecessary. The civil patients who remained or were admitted during this time had more serious symptomology, along with a host of other needs that required continuing treatment at OSH.

Most of these patients require specialized licensed residential settings to meet their complex needs. Prior to the pandemic, these individuals would often travel between acute care psychiatric hospitals and OSH, with brief stays in community residential facilities. These individuals require intensive services regardless of the setting, and OSH staff and community partners have been carefully coordinating and developing care environments to meet their needs and provide them with stable placements.

The \$130 million described in the ED boarding section of this document is expected to result in more residential resources that will ease the current burden on OSH.

- 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.
- 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.

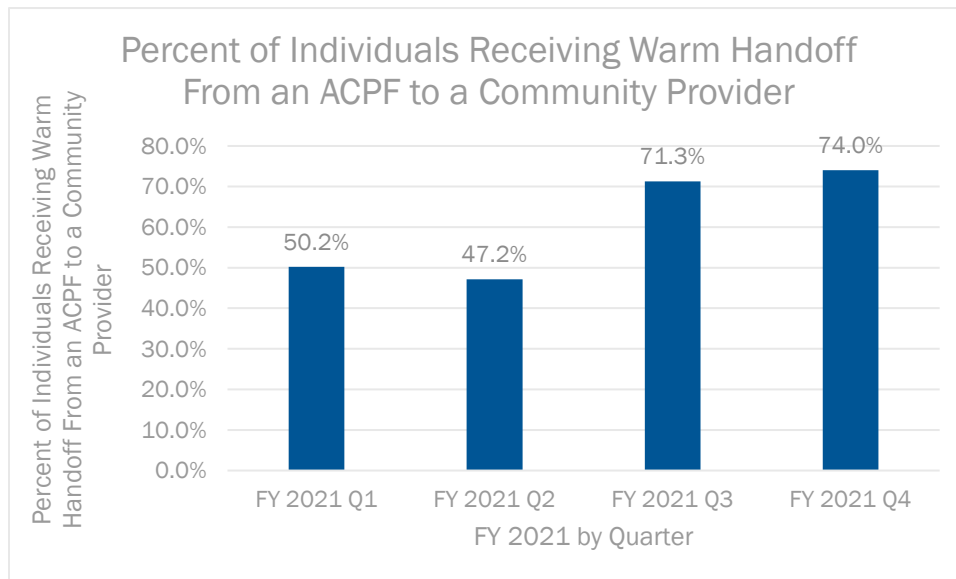
Acute Psychiatric Care Facilities (ACPF)

#4.1 Percentage of Individuals with SPMI Receiving Warm Handoff

A warm handoff is the process of transferring the care of an individual from one provider to another, prior to discharge, which includes face-to-face meeting(s) with the individual, and which coordinates the transfer of responsibility for the person's ongoing care. 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

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.

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: 7/1/20 through 6/30/21. 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, Comagine, 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 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. By 6/30/21, the cumulative percentage of individuals receiving a warm handoff was 74%,

exceeding the final 2022 goal by 14%. Overall, the numbers have continued to improve since that initial dip that occurred during the onset of the pandemic. For Q3 & Q4 of FY 2021, all ACPFs met or exceeded the year two goal of 50% of individuals receiving a warm handoff.

OHA is aware impacts to warm handoff may still occur in relation to the ongoing pandemic and workforce shortages. There is no way to predict whether a dip in data will occur during the onset of the Omicron variant and subsequent hospital surge. The growing workforce issues (can also impact how care coordination is occurring).

While face-to-face contact is a necessary component of a warm handoff, ACPFs have frequently asked “what if we can’t make face-to-face happen?” OHA continues to emphasize the need to clearly document efforts/barriers, and then further emphasize the importance of connecting in some manner during the care coordination (i.e., connecting by telephone is preferable to no connection).

Activities Associated with Metric

The HSD Acute Care Coordinator continues to hold 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-19 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.

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.

OHA continues to send ACPFs quarterly data reports so they can monitor how their program is doing. The OHA Acute Care Coordinator continues to provide technical assistance and additional support when programs experience staffing changes.

Due to the schedule of the data collection process, assessing the impact of change and progress takes time. For example: If OHA provides TA in December 2020 that results in a program implementing changes in January 2021, that quarterly data is not available for several months. (August 2021.)

In addition to sorting the data by ACPF, Comagine is now sorting it by CCO. This allows CCOs to monitor their progress on this metric. OHA plans to work with CCOs regarding activities to increase warm handoffs.

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

Readmissions to ACPFs 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 ACPFs. Performance on this Goal is shown below for time frame 7/1/2020 through 6/30/2021.

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)	278	30 day-8.10%180 days-20.00%	10.10%	20.50%
BAY AREA	95	30 day - 6.10%180 day- 14.90%	8.40%	12.60%
GOOD SAM REGIONAL	108	30 day 8.50%180 day- 16.10%	10.20%	24.10%
UNITY/LEGACY EMMANUEL	887	30 day- 12.20%180 day- 27.60%	12.50%	26.60%
PEACE HEALTH SYSTEM	626	30 day- 9.90%180 day- 22.50%	9.90%	23.20%
PROVIDENCE PORTLAND	448	30 day-12.80% 180 day- 27.60%	13.40%	29.90%
PROVIDENCE ST VINCENT	739	30 days- 13.20%180 days- 25.50%	12.60%	24.80%
SALEM HOSPITAL	324	30 day-8.30% 180 day- 18.30%	8.30%	20.70%
ST CHARLES SYSTEM	216	30 day- 10.00%180 day- 20.50%	10.60%	22.70%
UBH OF OREGON (CEDAR HILLS)	806	30 day- 12.40%180 day- 24.10%	11.80%	24.60%
Total	4,527	30 day- 11.30%180 days- 24.00%	11.40%	24.50%

Time Frame 7/1/20 through 6/30/21. 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 6/30/21, the cumulative average readmission rate to ACPFs was 11.40% at 30 days, compared to a goal of 10%. The rate was 24.50% for 180 days, compared to a goal of 21.3%. Both rates increased only slightly but remain higher than the goals for readmission.

The secondary effects of the pandemic (isolation, anxiety, unemployment, depression and suicidality, etc.,) likely continue to contribute to individuals experiencing behavioral health issues and contributed to readmissions.

Despite this, readmission rates remained relatively stable for the reporting period. The hard work and dedication of Oregon's community providers have most likely contributed to preventing higher rates of readmissions.

Activities Associated with Metric

Care coordination continues to be emphasized in Choice meetings. This includes coordination with the individual and the hospitals. Choice providers are encouraged to check-in on those in the community and, if an individual appears to be struggling, determine what additional services can be wrapped around them to reduce the risk of hospitalization. OHA is also working with hospitals and CMHPs to practice a "Continuous Process Improvement" approach to care coordination.

The ongoing pause of civil admissions to OSH and the strain on community resources have led to an increase in the number of complex case consultations that OHA has been involved in. Additionally, with the hospital use surge (related to the Delta and Omicron variants), the Acute Care Coordinator has provided increased TA and discharge planning for individuals with behavioral health needs in medical beds.

In 2021, the legislature authorized an additional \$175 million to increase behavioral health housing and treatment capacity for the upcoming biennium. Additional funds were approved for

workforce retention and training, as well as a number of other initiatives designed to augment the State's behavioral health services.

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 1.34/1,000. This is a decrease (and an improvement) from the last reporting period and continues to exceed the June 30, 2022, goal of 1.6/1,000.

ED admission rates for mental health reasons by persons with SPMI fell again during this reporting period. COVID-19 cases took priority over all but the most urgent psychiatric visits and resulted in community partners finding alternatives to the ED and to ACPFs.

Workforce shortages are hitting many fields, and this can impact progress on this metric. For example, pharmacies are closing unexpectedly in certain areas. This can impact individuals who are discharged from the ED and attempting to fill medications. If the pharmacy unexpectedly closes this can lead to a delay in obtaining medication and/or lead to an individual returning to the ED for help.

Numbers also may be impacted because of lack of access to physical health care. The pandemic has changed access to physical health care (and dental), with some services being moved to virtual platforms, and other services being

delayed. For example, there have been periods of time where non-life-threatening treatments/surgeries were cancelled to preserve capacity. This is in addition to some individuals being more hesitant to seek out physical health treatment. Unmanaged physical health conditions can lead to exacerbation of mental health symptoms and treatment needs. Also, difficulties in linking an individual to community based medical services can also lead to delays in discharge from hospital settings.

Activities Associated with Metric

Discussions regarding ED utilization continue to 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.

#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 6/30/21, the statewide cumulative average was 25.4%, slightly higher than the previous reporting period.

This number is presented as an aggregate statewide number.

There is general anecdotal evidence that COVID-19 contributed to staff shortages, wait times for ACPF beds and emergency services, and impacted ED wait times. The data for this metric bears this out. Again, without the efforts of Oregon's providers, these numbers would be higher.

Activities Associated with Metric

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.

OHA also received \$130 million (in addition to the \$175 million mentioned previously) from the legislature to increase current capacity in housing and licensed residential facilities for people with behavioral health needs. This is the first time such an amount of funding has been provided to not only address behavioral health needs, but also address the linguistic and cultural needs within services to reduce health inequities. OHA will work under the guidance of those with lived experience and organizations, such as Community Based Organizations (CBOs) and Coordinated Care Organizations (CCOs) to educate leaders on current needs, capacities, and the most appropriate engagement style for this endeavor to be successful. Funding will roll out in phases with oversight at all steps of planning and implementation. Increasing capacity in licensed residential treatment can provide individuals with the treatment, support services and skill building activities to optimally prepare them for more independent living.

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 Comagine 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 continues to work 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.

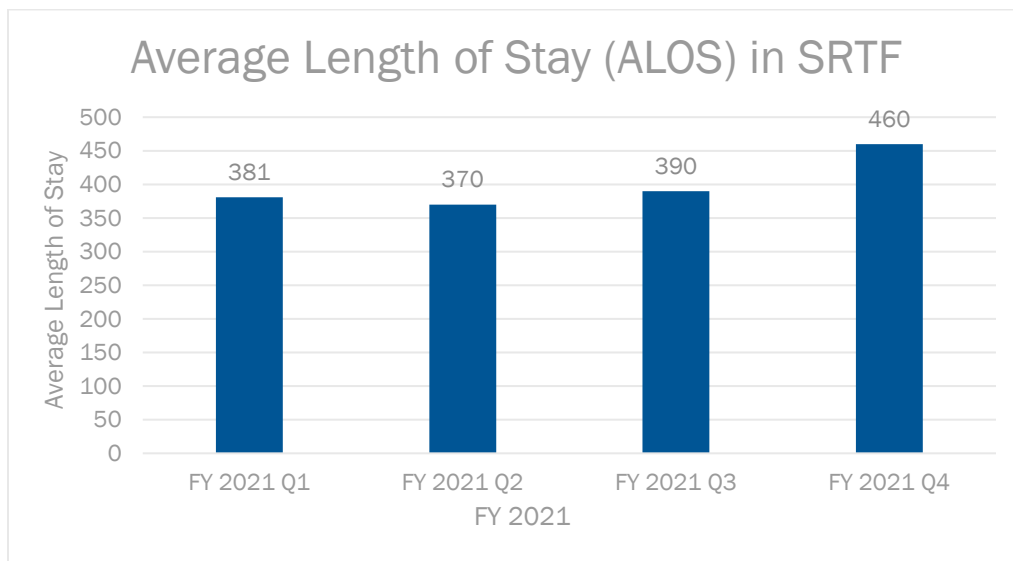
- 988 Hotline Work continues to launch 988, the National Suicide Prevention emergency number. on the “go live” date remains July 16, 2022, nationwide. OHA hopes to have the basics of the call center in Oregon established by the June 2022. This is only one component of Oregon’s plan for a statewide crisis 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. These standards have been identified and currently OHA is in the implementation phase.
- 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. Currently resources are being identified to be able to pilot this component to the system.
- 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. This will be integrated with each component of the crisis system.
- A final plan was submitted to Vibrant and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), by Dec. 30, 2021, for additional funding. A legislative report was also submitted.

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: 7/1/20 through 6/30/21 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.

While the methodology remains unchanged, HSD obtained access to OSH's Avatar database. This access allowed HSD to identify individuals under civil commitment more accurately. This resulted in revising the data from the previous report. The revised data are included in this edition of the report.

OHA will also begin employing a new data platform sometime in early 2023 that will include civil commitment data from the courts. This will be an additional resource to more accurately identify those individuals who are civilly committed and will likely result in another revision of the data.

Comment on Progress

The BHQPIP goal for FY 2021 is 491 days. The ALOS as of June 15, 2021, was 460 days.

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

- FY 2021 Q1- 381
- FY 2021 Q2- 370
- FY 2021 Q3- 390
- FY 2021 Q4- 460

For the quarter ending June 30, 2021, the point-in-time count of the 34 civilly committed individuals with SPMI residing in SRTFs on June 15, 2021, was as follows:

- Less than 120 days: There were 6 such persons, or 18% of all civilly committed individuals with SPMI, residing in SRTFs on June 15, 2021.
- 120-365 days: There were 12 such persons, or 35% of all civilly committed individuals with SPMI, residing in SRTFs on June 15, 2021.
- 366 days to two years: There were 7 such persons, about 21% of all civilly committed individuals with SPMI, residing in SRTFs on June 15, 2021.
- Over two years: There were 9 such persons, or about 26% of all civilly committed individuals with SPMI, residing in an SRTF on June 15, 2021.

Even though OHA has added data from the Avatar data base, which changed the ALOS number, Oregon currently has exceeded the final goal for FY 2022, which will be 467 days. The Data Report spreadsheet shows revised data for the first two fiscal quarters of 2021.

Because of the tremendous disruption to the system of care wrought by the pandemic, it is difficult to thoroughly analyze these data. Because of staff shortages and quarantine protocols, many residential facilities reduced capacity, and slowed normal admissions and discharges.

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 continues to work 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.

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 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.

Activities Associated with Metric

OHA has issued a Request for Proposal (RFP) for a new, integrated data platform. Part of the requirements of the RFP are the contractor’s ability to integrate arrest data for those in services into the platform. However, an agreement between OHA and OSP still needs to be undertaken. Measures to combat COVID-19 and still provide necessary services and supports have forced OHA to pursue other initiatives. OHA will renew its efforts to forge an agreement after the PHE is over.

In Conclusion

COVID-19 continued to present extraordinary challenges to Oregon’s behavioral healthcare system. Despite staff shortages, capacity issues due to quarantines and program closures, Oregon met 50% of the metrics for the reporting period. The goals that were not met either missed by a small margin or were impossible to accurately track due to the pandemic or were beyond OHA’s ability to influence.

The PHE caused by the pandemic concluded on May 1, 2022. The additional spending on system workforce, infrastructure, and services should help Oregon achieve the goals in this plan and help more individuals with SPMI live in the most integrated setting possible.

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
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