

***INDEPENDENT CONSULTANT
REPORT #5***

***OREGON HEALTH AUTHORITY
ACTIVITIES TO IMPLEMENT
THE OREGON PERFORMANCE PLAN***

***Acute Psychiatric Care
Emergency Departments
Secure Residential Treatment Facilities***

***Submitted by Pamela S. Hyde, J.D.
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August 2019

ACKNOWLEDGEMENTS

Many Oregon Health Authority (OHA)¹ staff and Oregon behavioral health system stakeholders continue to help me and the Oregon behavioral health system improve and report on the status of various activities to implement the "Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness" (OPP). During the last few months, not only OHA staff, but program staff and leaders throughout Oregon helped me understand programs and review charts of individuals served. These individuals shared information, challenges, and materials to help me learn about the efforts underway throughout the state to improve the lives of adults with serious and persistent mental illness (SPMI).

In addition to Cissie Bollinger, Michael Morris, Jon Collins, Margie Stanton, and Patrick Allen, other OHA staff helped advise and provide me with information and perspective. These staff include Alisa Campbell, Brandy Hemsley, Michael Oyster, Lisa Peetz, and Elaine Sweet, among others. And a special thanks to Steve Allen, the state's new Behavioral Health Director as of early April 2019. Oregon State Hospital (OSH) Superintendent Dolly Matteucci, along with Arthur Tolan, and Tyler St. Clair also continue to help me understand changes underway at OSH and how these affect individuals being admitted to and discharged from OSH.

Stakeholders too numerous to name – especially those in the Association of Oregon Community Mental Health Programs (AOCMHPs); Coordinated Care Organizations (CCOs) Behavioral Health Directors; Oregon Association of Hospitals and Health Systems (OAHHS); Tri-County Behavioral Health Association; Health Insights; and local providers of acute care psychiatric facilities (ACPFs), emergency departments (EDs), secure residential treatment facilities (SRTFs), and community behavioral health services – allowed me to visit their programs and look at records and/or spend time with me in person or by phone. All welcomed my inquiries, provided input and materials, and identified challenges and areas for improvement locally and statewide. OHA's Independent and Qualified Agent (IQA) contractor (KEPRO) during the OPP timeframe (July 1, 2016 – June 30, 2019), also met with me more than once and provided input and access to their records as I looked at how their reviews and services impacted admission and/or discharge from various Oregon treatment facilities. I appreciate all of these entities' and individuals' cooperation and assistance. The openness and commitment of all these Oregon staff and stakeholders bodes well for the state's residents as Oregon continues to work to implement the OPP.

Finally, a continuing note of thanks to attorneys representing OHA, namely John Dunbar, Allison Banwarth, and Kailana Piimauna, and to attorneys for the United States Department of Justice (USDOJ) on this project, namely Richard Farano in Washington, D.C. and Adrian Brown in Portland, OR. Their consultation and input continue to make a significant difference for me and for those adults with SPMI receiving publicly-funded services in Oregon.

Respectfully and with continuing gratitude,

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¹ See Appendix A for a list of acronyms used in this and other Independent Consultant reports.

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INTRODUCTION

Context – Prior IC Reports

This is the fifth report of the Independent Consultant (IC) regarding the Oregon Performance Plan (OPP) for Mental Health Services for Adults with Serious and Persistent Mental Illness (SPMI). The context of the development of the OPP and the commitments by the State of Oregon represented in the provisions of the OPP were described in IC Report #1, dated March 2017.² Contract and regulatory implications of the OPP were discussed in IC Report #2, dated October 2017. IC Report #3, dated April 2018, reviewed efforts and the status of the State of Oregon's compliance with four services utilizing year one data and process information about the State's efforts to comply with provisions regarding peer-delivered services, supported employment, Oregon State Hospital (OSH), and Assertive Community Treatment (ACT). IC Report #4, dated September 2018, described Oregon's work to implement OPP commitments regarding mobile crisis services, criminal justice diversion, discharges from OSH, and supported housing, as of the end of calendar year (CY) 2017, or half-way through the three years of the OPP.

Scope of IC Report #5 and IC Report #6 to Come

This IC Report #5 describes the State's efforts to implement OPP commitments regarding acute psychiatric care, emergency departments, and secure residential treatment facilities serving adults with SPMI. This Report describes Oregon's efforts through July 2019. However, Appendix B to this report summarizes the status of the State's efforts toward compliance with OPP commitments in these three areas utilizing data as of the end CY 2018 or December 31, 2018 which is halfway through the third year of the OPP timeframe.³

IC Report #6 – to be released in 2020 after the Oregon Health Authority's (OHA's) final narrative and data report is released – will address the Quality and Performance Improvement commitments in OPP Section E, as well as compliance overall with all provisions of the OPP.

² All IC Reports as well as other materials related to the OPP, can be found on OHA's website at <https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx>

³ The OPP is a document with a three-year timeframe, from July 1, 2016 through June 30, 2019 (Fiscal Years 2017, 2018, and 2019). The Oregon Health Authority (OHA) often provides data based on Calendar Year as the data is reported in quarters or for a year's time which is a rolling 12-month timeframe. See OHA's data and narrative reports found at the website noted in Footnote 2 above for further description of this data reporting process. Also, the data are provided with a six-month lag because data are often reported by service providers on specialized hard copy forms that are provided after the quarter has ended or through billing systems that allow several months before data is required to be reported. These time allowances are also consistent with federal allowances for time periods for billing Medicaid.

As required by Subsection F.3 of the OPP,⁴ USDOJ and OHA were provided a draft of this Report and had 30 days in which to comment. However, the August date of this report is based on the date it was drafted by the IC rather than the date it was finalized after the 30-day review. This report is the IC's work product and represents my judgments as IC. It has been revised to reflect comments of USDOJ and OHA determined by me to be appropriate to improve the accuracy of the report, with the intent of all involved to aid in the resolution of this matter, as directed in the OPP.

ACUTE PSYCHIATRIC CARE

Acute Care Psychiatric Facilities (ACPFs) (or Acute Care Psychiatric Hospitals) are defined in Subsection B.6.a. of the OPP as:

". . . a hospital that provides 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 and older with severe psychiatric disabilities."

Such facilities are licensed or certified by the State and are regulated by Oregon Administrative Rule (O.A.R.)⁵ and are critical to the infrastructure serving civilly committed adults with SPMI as such individuals in need of inpatient care must be served first in a local ACPF before they will be considered for admission to Oregon State Hospital (OSH).⁶

Subsections D.27. through 36. of the OPP describe the State of Oregon's commitment to assure:

- All individuals with SPMI who are discharged from ACPFs (not including OSH) will have documentation of linkages to appropriate behavioral and primary health care in the community prior to discharge (D.27);
- OHA shall continue with its process to enroll all or substantially all indigent individuals with SPMI not yet enrolled in Medicaid prior to discharge from ACPFs (or emergency departments), consistent with state law (D.28);
- All individuals discharged from an ACPF will be presented a "warm handoff" to a community case manager, peer bridger, or other community provider prior to discharge and OHA shall require ACPFs to report to OHA all individuals who refused a warm handoff on a quarterly basis, and shall report this information to USDOJ beginning October 1, 2016, by ACPF(D.29)⁷;
- OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge, and OHA will report this data (D.30);
- OHS will reduce recidivism to ACPFs and will monitor and report the 30 and 180 day rates of readmission, by ACPF, as well as provide a management plan for contacting and offering services to individuals with two or more readmissions to an ACPF in a six-month period designed to assist the individual to avoid unnecessary readmission in acute care hospitalization (D.31);
- OHA will identify individuals with SPMI who are homeless and who have had two or more readmissions to an ACPF in a six-month period, and either directly or through another system participant will connect these individuals to a housing agency or mental health agency with

⁴ All references in this report to Subsections are to the OPP unless otherwise noted in the text.

⁵ O.A.R. 309-032-0800, et seq.; and 309-033-0700, et seq. It should be noted there are other acute inpatient units for those with geropsychiatric issues, that is, mostly cognitive perhaps with some behavioral aspects (e.g., dementia). Generally, individuals served in such facilities would not meet the definition of SPMI, with a primary diagnosis of such, although may have some underlying behavioral health issues and/or diagnoses. These units are not considered or reported as part of the acute care facilities available for persons with SPMI pursuant to the OPP.

⁶ O.A.R. 309-091-0000, et seq.

⁷ This Subsection goes on to define the warm handoff process, which is discussed later in this Report.

access to housing in order to work to ensure such individuals are linked to integrated housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice (D.32);

- OHA will work with ACPFs, CCOs, and CMHPs to seek to ensure that individuals with SPMI discharged from ACPFs are discharged to housing that meets a particular individual's immediate need for housing, including establishing requirements for ACPFs to assess the housing needs of individuals with SPMI and require that, for all individuals with SPMI who are CCO members, ACPFs shall consult with the individual's CCO in developing the assessment which will be documented in a plan for integrated housing that is part of the individual's discharge plan and the ACPF will notify the individual's community provider regarding that housing plan in order for the provider to facilitate the implementation of that plan for housing (D.34); and
- OHA will measure the average length of stay of individuals with SPMI in ACPFs, by hospital and report the number of individuals with SPMI in each ACPF whose length of stay exceeds 20 days (D.35).⁸

Each of these commitments and the status of the quantitative and qualitative goals related to each are discussed below.

Quantitative Commitments re Acute Psychiatric Care – Progress as of December 31, 2018

The OPP includes four types of quantitative commitments about acute psychiatric care: 1) to ‘present’ all individuals discharged from an ACPF a “warm handoff” (with specific measurable goals); 2) to require and report that individuals receive a follow-up visit with a community mental health provider within 7 days of discharge; 3) to monitor and report rates of readmission; and 4) to measure and report average length of stay (ALOS) by hospital, and the number of individuals with SPMI whose length of stay exceeds 20 days. (Subsections D.29. – 31., and 35.). Progress on these commitments is described below.

Number of Discharged Individuals Presented and Receiving a Warm Handoff: Warm handoffs are described in detail in Subsection D.29. They must be with a community case manager, peer bridger, or other community provider *prior* to discharge or with a team that will be assisting the individual with their transition to the community. A warm handoff is the process of transferring a client from one provider to another, “*prior to discharge*,” and 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.” [Emphases added]. This Subsection goes on to make it clear “a warm handoff shall either (a) include a face-to-face meeting with the community provider and the client, and if possible, hospital staff, or (b) provide 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.” For the latter, “the transitional team shall meet face-to-face with the client, and if possible, hospital staff, prior to discharge.” This Subsection goes on to indicate “*face-to-face in person* [emphasis added] meetings are preferable for warm handoffs. However, a face-to-face meeting may be accomplished through technological solutions that provide two-way video-like communication on a secure line (“telehealth”), when either distance is a barrier or individualized clinical criteria support the use of telehealth.”

In this Subsection, OHA commits to achieving a goal of 60% of individuals discharged receiving a warm handoff by the end of year one (June 30, 2017); 75% by the end of year two (June 30, 2018); and 85% by the end of year three (June 30, 2019). Neither of these goals for years one and two have been met at this point although it is still possible the State could be in compliance by the end of year three. However, Oregon is ***not in compliance*** with this part of the OPP at this time. These data have not been collected in

⁸ Two other Subsections comment on the use of interim housing described elsewhere in the OPP (D.33 and D.26) and on the use of Medicaid claims and State general fund services to track the services to be reported in these Subsections regarding ACPFs (D.36). The latter is a consistent Subsection in many Subsections of Section D of the OPP regarding Performance Outcomes. And, as indicated in IC Report #4, OHA has indicated they do not now and do not intend to utilize interim housing for adults with SPMI.

the past so there is no baseline to compare to see whether changes have occurred even if the goals have not yet been fully met. During the OPP timeline, OHA expanded an existing contract with Health Insights⁹ to review, collect, and report these data from nine ACPFs licensed to provide psychiatric acute care in Oregon.¹⁰ The data reported by Health Insights for year two did show improvement from the first quarter data (21.4% receiving a warm handoff) to the fourth quarter data (27.7% receiving a warm handoff), and this improvement has continued into the second quarter (through December 2018) of OPP year three (30% receiving a warm handoff).¹¹ The percentages for the nine ACPFs included in the Health Insights report range from 16.5% to 35.2%, so some of the facilities are clearly doing better than others, but all of Oregon's ACPFs are performing well below the levels committed to in the OPP.¹²

However, both OHA and many of the State's ACPFs are working to improve these outcomes as described further later in this Report. Others are not clear what is expected or consider this an impossible goal to meet. All clear ACPFs cannot meet these goals alone. By definition, the cooperation and assistance of community providers are necessary for the State as a whole to increase performance on this metric. As a consequence of both the numbers and the collaborative approach required, I interviewed a number of the ACPFs and some key community providers to obtain their perspectives on the challenges in meeting these goals. These challenges (as described by the entities interviewed¹³) include the following:

1. Many ACPFs and community providers' representatives still lack knowledge and/or understanding of the requirements, expectations, and process required to present a discharging individual with the opportunity to have a warm handoff as described and defined in the OPP. This is the case even though OHA and the IC have met with some hospital representatives regarding this process, early in the OPP timeframe and again during year two. Some indicate the State made this commitment regarding warm handoffs without consultation with them and if such consultation had occurred, they feel they could have explained why the requirement and/or the numeric goals for *face-to-face* (as opposed to telephonic) pre-discharge meetings may be unachievable. Others mistake or confuse the requirements of including lay caregivers in a person's care, treatment, and discharge planning¹⁴ with the OPP expectation of a warm handoff with community providers.
2. Confusion and/or inconsistency among payers and responsible managing entities (CCOs, CMHPs, Choice providers/ENCCs, etc.) make it difficult for ACPFs to always know in a timely manner who will be the community connection for an individual being discharged;

⁹ OHA is continuing Health Insights' role in data collection and reporting of data through June 30, 2019 and beyond. Reports for the final two quarters of year three of the OPP will be released by OHA in the fall of 2019 and in early 2020.

¹⁰ The list of the 10 facilities included in the attachments to OHA's data reports can be found at <https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx>. Health Insights includes all of these except UBH (Cedar Hills) in its data reports about warm handoffs and discharge planning because previously UBH (Cedar Hills) did not bill Medicaid since it is a free-standing psychiatric hospital. However, with federal regulatory changes allowing some Medicaid billing in such a facility, UBH's (Cedar Hills') length of stay and readmission data have begun to be reported. Therefore, OHA indicates it will be working with Health Insights to begin looking at Cedar Hills discharge data and records going forward.

¹¹ It should be noted that this gain was experienced after a small decline in the first quarter – down to 26%.

¹² While no quantitative goal is included in the OPP for the number refusing a warm handoff, OHA did commit to tracking this number and reporting it to USDOJ. However, this tracking and reporting effort did not begin until year two even though the commitment was to begin reporting it for the second quarter of year one. [Given the OPP commitment for OHA and the Independent Consultant (IC) to meet to determine the underlying reasons why a given outcome measure was not achieved and whether adjustments to the measure or the timeline need to be made (Subsection A.8.), I have taken the position that so long as OHA is making a good faith effort to work toward the goal and is making progress, the timeline can be flexible.] Health Insights' report for the second quarter of year three indicates only 4.1% of those presented a warm handoff refused, but the percentages range from 0.0% or no refusals to 7.4% refusing the warm handoff. It is unclear why this range exists in the percentage of refusals by facility.

¹³ These reported challenges by stakeholders do not necessarily represent this IC's conclusions.

¹⁴ See HB 2023 and 3378 from the Oregon 2015 Legislative Session.

3. Community providers indicate they do not always get good information in a timely manner about who has been admitted to an inpatient unit or when “their” clients are being discharged;
4. As is the case in many areas of the country, community behavioral health workforce services are limited and insufficient to meet Oregon’s needs. In addition, those interviewed indicated there are insufficient community-based services to meet the need. As a result, those interviewed reported providers cannot or simply do not participate in person at the ACPF before an individual is discharged, especially if the community provider is located a significant distance from the ACPF from which the individual is being discharged – travel time is prohibitive and community practitioners are limited, so the trip would take practitioners away from other individuals needing critical services;
5. Discharges occur all hours of the day and night, depending on when the court determines the individual does not meet the criteria for civil commitment or when the individual wants to be released. Therefore, once a discharge is determined to be imminent, especially if after hours or on the weekend, the availability of community practitioners or peer bridgers is often limited and therefore a warm handoff may not be possible before discharge. After hours or weekend availability is reported to be generally only for those individuals served by ACT teams or in some cases a crisis team follow-up worker;
6. Some ACPFs feel more warm handoffs are being offered and provided than are being documented, especially when the individual is being discharged from an inpatient unit to a community provider that has close ties with or is operated within the same organizational umbrella as the ACPF – in these cases, interviewees felt this process happens organically and naturally so may not be noted in the discharge plans or other client/patient records; in other cases, ACPFs indicated electronic health records (EHRs) systems are often not set up to remind or even allow documentation of such interactions;
7. Discharge planning is often done by phone between the ACPF staff and the community staff and in some cases with the individual being discharged, but not as much in-person or face-to face; staff indicate they work to assure the individual gets a face-to-face meeting with a peer, a case manager, or other clinical practitioner within a short time after discharge (see below discussion of 7-day follow-up appointments), and they feel this is the best way to assure the individual makes an appropriate connection for follow-up care;
8. Community-based housing for individuals being released from a psychiatric inpatient unit is extremely limited so discharge efforts focus on connection to safe and stable housing or access to a residential service setting more than anything (see discussion below re housing plans upon discharge); and
9. Lack of telehealth capacity at ACPFs and community providers, and related lack of understanding or differences in understanding of confidentiality requirements (especially HIPAA), means telehealth face-to-face warm handoffs are utilized infrequently, even though this technology would decrease the travel time and increase community providers’ capacity to participate; stakeholders also report telehealth is expensive, requiring a clinician or staff person to be available on both ends of the telehealth connection and it is difficult to get Medicaid to cover both these costs.

While these data and the performance on this metric statewide show the State is ***not in compliance*** with this OPP commitment, OHA and local providers are taking several steps to increase the number of warm handoffs offered and provided. Specifically:

1. OHA has included this warm handoff requirement in its regulatory¹⁵ and contractual requirements for CCOs,¹⁶ and is evaluating whether to add this requirement to County Financial Assistance Award (CFAA) document which is the funding agreement with CMHPs;¹⁷ however, the regulations regarding acute psychiatric care – in which warm handoffs are required – are referenced in the CFAA agreement;
2. OHA has revised and plans to release and post in early August updated guidance for ACPFs as well as for CMHPs, CCOs, and community providers about the necessity to provide and how ACPFs should document warm handoffs (original guidance dated February 13, 2019);¹⁸ this updated guidance will clarify what counts and does not count as a warm handoff to assist ACPFs in documenting these efforts; this guidance will also clarify a warm handoff needs to occur any time before discharge and not just immediately preceding discharge thereby providing more options and opportunities for ACPFs and community providers to make these connections with patients; OHA's new acute care liaison is also now meeting with each ACPF to discuss expectations and requirements;
3. OHA has prepared a draft toolkit and offered a training for the field on privacy/confidentiality (including HIPAA) requirements¹⁹ and has requested input and suggestions from the field to improve and finalize the toolkit; I have also provided feedback on the draft toolkit indicating what would help to assure consistency in understanding of privacy and confidentiality via telehealth technology to help support and encourage use of this approach;
4. OHA is working to assure the data collection and reporting effort will continue past the OPP timeframe by: a) extending work currently done by Health Insights to continue its data collection process; b) including goals, action steps, and timelines about warm handoffs and discharge planning in its Behavioral Health Quality and Performance Improvement Plan (BHQPIP) which OHA committed to in Subsection E. of the OPP;²⁰ and c) filling a critical staff position specifically focused on overseeing and directing inpatient facilities and services;
5. Some ACPFs have worked to change their EHRs, produce brochures for patients and family members, or retrain staff about the warm handoff expectation and/or documentation requirements; and
6. Associations of hospitals and community providers have invited me to talk with them about this OPP commitment and what they might do to increase the numbers and performance in this area.

While all of these efforts are admirable, they are likely insufficient to move the currently available numbers to even the year one goal of 60%, much less the year three goal of 85%. In addition to the efforts above,

¹⁵ O.A.R. 309-032-0860 and - 0870 includes the OPP warm handoff and discharge planning definitions and requirements for individuals with SPMI.

¹⁶ 2019 CCO Contract Extension, Exhibits B and M; CCO 2.0 Sample Contract for 2020-2024 (Appendix B, Exhibit M) found at <https://www.oregon.gov/oha/OHPB/CCODocuments/Reference-Documents/CCO-RFA-4690-7-Appendix-B-Sample-Contract-Final-Clean-Version.pdf>

¹⁷ This lack of reference in the CFAA with CMHPs is because CMHPs do not generally pay for inpatient care. However, CMHPs and other community providers need to understand expectations about warm handoffs and the necessity of their role in these face-to-face handoffs; hence OHA will need to determine how to reference this expectation in upcoming CFAAs.

¹⁸ While this guidance was clearly helpful, from my interviews it appears the guidance documents have not gotten to all levels of facility/provider leadership or frontline staff. Many were unaware of the February 13 memo and guidance document or who within their organization had seen it. The updated guidance document also reflects my discussion with OHA and the agreement made regarding how ACPFs should document discharges to homeless shelters, as Health Insights is now reporting pursuant to this agreement.

¹⁹ While this is a good first step, the July 12th webinar was offered to anyone who was interested rather than to a specific group, namely those (often lawyers) who are interpreting HIPAA inconsistently and advising clients inconsistently across the state.

²⁰ The Behavioral Health Quality and Performance Improvement Plan (BHQPIP) for this effort is in development by OHA and will be reported on in my IC Report #6, to be released in the Spring of 2020.

in order to increase the percentages of those receiving warm handoffs, OHA should at least consider taking actions such as the following:

1. Incorporate warm handoff descriptions and expectations in CMHP CFAA agreements, and engage local providers to understand their role in the warm handoff process;
2. Work with ACPFs, community providers, and payers to be clear about the expectation of offering and providing a warm handoff (including after hours and on weekends) and exactly how to do it and document it, including how to communicate with and engage partners in knowing about individuals admitted to and being discharged from inpatient facilities (using EDIE or other standardized communication tools); OHA will need to disseminate the updated guidance document widely and assure all who need it get it or know where to get access to it; OHA will also need to widely disseminate warm handoff expectations regarding roles and performance goals for both ACPFs and community providers through trainings, conferences, group discussions, and workgroups that include key representatives from ACPFs, community providers, CCOs, and CMHPs, (including Choice providers as appropriate);
3. Incentivize the presentation and conducting of warm handoffs by setting collective numeric goals for all involved entities (for example, in a given location) and assuring payments are withheld or reduced for entities (facilities, community providers, and payers) who do not meet those goals, or at the very least by publicly publishing performance on this metric by each entity so it is clear who is meeting expectations and who is not; provide recognition for those meeting goals and express concerns directly to and about those not meeting set goals;
4. Determine who is providing inconsistent guidance to ACPFs and others regarding confidentiality and privacy requirements (likely lawyers and policy leaders for ACPFs) and create training and guidance required to be attended by these individuals to create a common and statewide understanding about how to manage these requirements in the context of the warm handoff process;
5. Identify ways to incentivize development or revision and use of EHRs that remind and provide opportunity to document warm handoffs; and
6. Provide guidance and funding for telehealth infrastructure and sufficient reimbursement when two staff persons are involved in order to encourage face-to-face meetings with patients and providers from a distance.

Percentage Receiving a Follow-up Visit Within 7 Days: Subsection D.30. commits OHA to continuing to require individuals receive a follow-up visit with a community mental health provider within 7 days of discharge, and to report these data. OHA does continue this requirement in regulations and elsewhere.²¹ However, at the second annual meeting with USDOJ, OHA staff indicated since this requirement continues to be well met, it will likely not be continued in the financial incentive pool for CCOs in 2020 and beyond. If so, this is concerning since the data show erratic performance on this measure with an overall decline since 2015 baseline in the percentage of those receiving such a follow-up visit. This measure will be continued in the performance metrics for CCOs so performance can be tracked over time.

OHA reports the percentage receiving such a follow-up visit was 79.4% during the baseline year (CY 2015). However, this percentage dropped to 71.5% the first quarter of year one (FY 2017) of the OPP and then rose again each successive quarter to end year one at 74.2%. In year two (FY 2018), the percentage increased further for the first two quarters and then declined again the last two quarters to end the year at 76.7%, an increase over the end of year one. The first two quarters of year three (FY

²¹ O.A.R. 309-032-0870 and CCO 2.0 Sample Contract Exhibit M, Section 3.f.(5). It should be noted OHA proposes to go beyond the requirement of follow-up within 7 days for any CCO Member involved in Intensive Care Coordination, requiring such individuals receive a follow-up visit within 3 days. Exhibit M, Section 3.f.(7).

2019, through December 2018) saw a decrease each quarter to 74.1%, a decrease from the end of year one and year two. All of these percentages are less than baseline.

While OHA states in its narrative report these percentages still place Oregon well ahead of national averages for this measure and within the 95th percentile nationwide (an improvement from prior quarters), according to the 2018 Benchmarks and Thresholds Report by the National Center for Quality Assurance (NCQA). This national measure suggests the entire country declined in the percentage of individuals being seen within seven days of discharge in 2017. However, national decline in this area does not make it acceptable for Oregon's rates to decline. If Oregon's performance had shown steady progress or at least kept even with its baseline percentage, this argument might carry more weight. As it is, Oregon's current performance on this measure is concerning. However, there is no quantitative goal in the OPP about this metric other than continuing the requirement and reporting these data, which OHA is doing. Therefore, the State is ***in compliance*** with this commitment. However, the concerns expressed above indicate Oregon needs to consider how to incentivize increasing or at least maintaining performance on this metric.

Rates of Readmission: In Subsection D.31.a. OHA commits to reduce recidivism to ACPFs and to monitor and report the 30- and 180-day rates of readmission by ACPF. No specific quantitative goals are included in the OPP for this area but OHA did commit to "reduce recidivism to ACPFs . . ." Given this overall commitment, the data regarding rates of readmission should be decreasing. The rate of readmission within 30 days has been increasing rather than decreasing, with the baseline for CY 2015 at 9.2% and the rate as of the second quarter of year three (December 2018) at 11.6%. While this rate is down from the last three quarters, it still shows an overall increase from the baseline and even from year one and on into the second quarter of year two, rather than a decrease. Therefore, the State is ***not in compliance*** with this commitment at this time.²²

Similarly, the 180-day rate of readmission has gone up and down over the ten quarters of the OPP timeframe, but the data in all ten quarters show rates over the baseline rate of 21.3%. While the rate of 180-day readmissions for the second quarter of year three is the same as the first quarter (23.5%) and somewhat lower than the fourth quarter of year two (24.0%), this currently reported rate is still higher than the middle two quarters of year two and remains higher than at baseline in 2015. Therefore, the State is ***not in compliance*** with this commitment to reduce recidivism to ACPFs.

It should be noted the 30-day readmission rates for the second quarter of year three range from 8.5% to 15.6% for the ten ACPFs for which OHA provides data. Similarly, the 180-day readmission rates range from 18.1% to 26.6%. So, some ACPFs are clearly under and some are over the statewide percentages for these two metrics. The State may want to consider an analysis of what appears to be a loose correlation between length of stay and readmission rates actually indicates some ways to impact these performance metrics statewide. The State may also want to consider identifying positive practices in ACPFs with lower readmission rates in order to help other ACPFs replicate them.

In addition to monitoring and reporting these data with the goal to reduce recidivism, OHA also committed in Subsection 31.b. to "provide a management plan for contacting and offering services to individuals with two or more readmissions to an acute care psychiatric hospital in a six-month period designed to assist the individuals to avoid unnecessary readmission in acute care hospitalization." OHA has specifically included a requirement in its CCO 2.0 Sample Contract stating CCOs "shall reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals."²³ The Sample Contract also obligates CCOs to "establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two or more readmissions to an [ACPF] in a six-month period."²⁴ OHA indicates the final CCO contract for 2020 – 2024 will include a definition of a

²² OHA did, however, provide data showing a reduction in readmission rates from 2013 to 2015 that is more than the increase seen during this OPP timeline. Hence, over time, both 30-day and 180-day readmission rates have come down significantly, but have increased some since the 2015 baseline used for the OPP.

²³ Ibid, Exhibit M, Section 3.f.(8).

²⁴ Ibid, Exhibit M, Section 3.f.(4).

“management plan” for this purpose with more robust requirements for CCOs to assure such plans are developed for such Members. OHA has also hired an Acute Care Coordinator who is working on the developing and monitoring of management plans by CCOs.

In Subsection D.32, OHA further commits to “identify individuals with SPMI who are homeless and who have had two or more readmissions . . . in a six-month period . . . [and] OHA or another system participant will connect these individuals to a housing agency or mental health agency with access to housing, in order to work to ensure those individuals are linked to housing in an integrated setting, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice.” OHA has included these requirements in its CCO 2.0 Sample Contract by requiring CCOs to “coordinate with system Community partners to ensure Members who are Homeless and who have had two or more readmissions to an [ACPF] in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing . . . ”²⁵

As just referenced, required reporting of data related to these OPP Subsections is included in the CCO 2.0 Sample Contract.²⁶ However, it is not yet clear how OHA will oversee the development of CCOs management plans or these required data or utilize them to assure CCOs and the system as a whole are meeting desired goals. Hence, OHA has made good faith efforts in these areas and is **working toward compliance** on these commitments but is not yet there.

OHA reports the number of individuals with SPMI who have two or more readmissions to an ACPF in a six-month period as part of the identification of such individuals as committed in Subsection D.32. There is no baseline data for this metric and the first quarter these data were reported was the second quarter of OPP year one. At that time there were 346 individuals with such readmissions. While the number has bounced around from quarter to quarter, every quarter since the first one reported has seen less individuals with such readmissions and as of the second quarter of year three (October 1 through December 31, 2018), only 302 individuals had such readmissions (compared to 1,084 individuals with SPMI discharged from ACPFs during this time). Because this commitment is simply to report, OHA is **in compliance** with this commitment and it would appear OHA is **in compliance** with helping to reduce recidivism for these specific individuals experiencing multiple readmissions. However, as indicated above, the commitment to reduce recidivism to ACPFs overall is not being met consistently. OHA may want to consider further analysis of those with a significant number of readmissions to determine what is causing this smaller number of individuals to experience many readmissions to ACPFs and working with system partners to craft plans and approaches to address these individuals’ unique service needs.

Average Length of Stay: OHA commits in Subsection D.35. to measure the average length of stay (ALOS) of individuals with SPMI in ACPFs, by hospital and to report this along with the number in each facility whose length of stay exceeds 20 days. At Baseline in CY 2015, the ALOS statewide was 8.9 days. Every quarter of the three-year OPP timeframe through December 2018 has seen a higher ALOS with that number generally increasing until the third quarter of year two, at which point the ALOS began to decline again and is currently reported at 10.8 days for the second quarter of year three. However, it is still at a higher number of days than baseline. ALOS, like other ACPF-related metrics, range by facility, from 7.65 to 13.96 days. OHA may want to consider an analysis of the different populations or the different practices associated with lower ALOS rates in order to help other ACPFs reduce their ALOS.

The baseline in 2015 for the number of individuals with a LOS exceeding 20 days was 385. Like many other metrics in this area, the numbers since then show a gradual increase and/or bouncing numbers over the first eight quarters of the OPP timeframe with a gradual decline each quarter since then, but still

²⁵ Ibid, Exhibit M, Section 3.f.(9 – 10). It should be noted that OPP Subsection D.33 indicates OHA may make use of interim housing described in Subsection D.26. for individuals who are homeless and are being discharged from ACPFs. However, OHA has indicated it is not using interim housing as specifically described in the OPP for adults with SPMI, although it does acknowledge that discharge plans do show some adults with SPMI are being discharged to homeless shelters pending further assistance with more permanent and stable housing. See discussion of this issue later in this Report.

²⁶ Ibid, Exhibit M, Section 5.

higher than baseline and even higher than the first quarter of the OPP timeframe. As of the quarter ending December 2018, the number stands at 464, with a range of 10 to 150 by various facilities. Obviously, this number can vary based on size of facility.

Since the OPP commitment is simply to measure and report these ALOS data and the data re number of individuals with stays exceeding 20 days, the State is ***in compliance*** with this commitment. A higher ALOS (and a higher number with a LOS over 20 days) can be a symptom of inadequate community alternatives, more difficulty moving individuals on to higher levels of care such as OSH, or a higher acuity of patients admitted into ACPFs. My interviews with stakeholders indicate many believe all of these issues are at play. OHA may want to consider further analysis of the ALOS over time and by facility to determine whether these data are identifying issues to be addressed.

Qualitative Goals for Acute Psychiatric Care

The OPP includes three qualitative commitments for individuals with SPMI in ACPFs.²⁷ These are discussed below.

Documentation of Linkages to Behavioral and Primary Health Care: This commitment is found in Subsection D.27. "All individuals with [SPMI] who are discharged from [ACPFs] (not including OSH) will have documentation of linkages to timely, appropriate behavioral and primary health care in the community prior to discharge." It's not clear if this commitment is one of documentation or of a judgment of timeliness and appropriateness of care. Since this commitment is about acute psychiatric care and discharge planning more than about care actually provided once the individual is in the community, I am interpreting this as a commitment to assure the discharge planning is done and is documented.

I wanted to determine if a significantly high percentage of individuals discharged did in fact have such discharge planning done and documented in their charts. Health Insights indicated in an interview with me they believe a high proportion of the discharge records they have reviewed from ACPFs do have adequate and appropriate behavioral health and primary care linkages documented. To test this proposition, I personally reviewed a small sample of 41 patient discharge records from eight ACPFs for the October to December 2018 quarter.²⁸ This review leads me to the conclusion this documentation of linkages prior to discharge is occurring the vast majority of the time for appropriate behavioral health care in the community post-discharge. In many cases, an actual appointment date and time, along with the behavioral health practitioner to be seen, was noted in the chart for the individual being discharged. The only times such documentation is missing is when the patient appears unwilling to participate in such post-discharge planning or the issue presented is more cognitive than behavioral health, and this occurred infrequently in the charts I reviewed. Hence, OHA is ***in compliance*** with this part of this commitment.

²⁷ In Subsection D.28. (and D.39.), OHA commits to "continue with its process to enroll all or substantially all indigent individuals with SPMI not yet enrolled in Medicaid prior to discharge from [ACPFs or EDs], consistent with state law." I considered this commitment in IC Report #1 and looked at data at that point regarding such efforts. It is my belief from that consideration, as well as from discussions with stakeholders, that ACPFs have every incentive to enroll Medicaid-eligible individuals as quickly as possible in order to be paid for the care they provide. This is especially true for ACPFs providing inpatient care (as opposed to EDs which may not have time to enroll an individual in Medicaid before he or she leaves the ED). Given some individuals who are admitted to ACPFs or EDs are not Medicaid eligible (e.g., individuals who are undocumented and not citizens) and given ACPFs have every incentive to enroll those who are eligible and given stakeholders have continued to assure me they are doing so whenever they can, I have not engaged in an independent review of this commitment. Likewise, the warm handoff analysis suggests that CCOs are identified for almost all of those discharged, indicating Medicaid will be a payer. That said, OHA may want to consider doing a review of other fund sources that could be utilized – for example, Medicare or commercial insurance – to assure the best maximization of resources for this expensive type of care.

²⁸ This exercise was a spot check rather than a true representative sample review. Hence, I cannot put an actual number or percentage to this effort, but I do feel comfortable with Health Insights report that this documentation of linkages is being done the vast majority of the time.

Documentation of linkages prior to discharge to appropriate primary care is another matter. This documentation was evident significantly less often – less than one-half – in the charts I reviewed. This documentation varied by whether the inpatient clinicians felt there was a primary care medical condition needing follow-up, whether the individual already had an established primary care practitioner (PCP) and connection, and by hospital. It is also possible, but I could not ascertain from the records, the behavioral health agency to which the individual was connected and referred also had primary care connections. For example, when an individual was referred to a community, veteran, or student health clinic for behavioral health care, primary care may also be available there. Likewise, when an individual is referred or transitioned to a residential treatment facility after discharge, that facility was likely to receive information about medication prescriptions needed for behavioral health and other health care needs. In some cases, the PCP was noted, but the documentation did not indicate a referral even though such may have occurred. Recognizing I reviewed the records of only a small portion of all individuals discharged during this particular quarter, I have to assess OHA as only ***in partial compliance*** with this OPP commitment because such primary care referrals are documented infrequently in the charts I reviewed. To the extent this is an important part of OHA's desired outcomes for ACPFs in the future, OHA should consider additional guidance to ACPFs either in regulation or in guidance documents about this expectation. Health Insights could also be requested to look for this specific documentation in future chart reviews they undertake for OHA.

Discharge Plans Include a Housing Assessment and Assessments Are Shared: This commitment is found in Subsection D.34. and includes multiple aspects. OHA commits generally to work with ACPFs, CCOs, and CMHPs to seek to ensure individuals with SPMI who are discharged from ACPFs are discharged to housing that meets the individual's immediate needs for housing. OHA commits to establish requirements for ACPFs to assess the housing needs of individuals with SPMI and the assessment will be documented in a plan for integrated housing as part of the individual's discharge plan. OHA also commits it will require for all individuals with SPMI who are CCO members, ACPFs shall consult with the individual's CCO in developing the assessment and will notify the individual's community provider regarding the plan for housing in order for the provider to facilitate the implementation of the plan.

Health Insights reports 84.6% of 937 individuals discharged from October to December 2018 had a housing plan as part of their discharge plans. This ranges from 74.7% to 90.2% across nine ACPFs. Significantly, these percentages were 86.5% to 100% in the previous quarter (July to September 2018). However, this decline is likely the result of an agreement to stop counting a shelter placement/referral as a housing plan unless it was for a short transitional period while the permanent housing placement was being finalized or readied. These numbers and my interviews with stakeholders suggest housing is a high priority for discharge planning and is in fact occurring most of the time with most individuals being discharged. While these percentages suggest housing is included in discharge plans in the vast majority of cases, it is clear additional efforts by OHA and/or ACPFs may be able to improve the results in this performance metric.

However, it is not clear from the Health Insights reviews or from my interviews whether housing assessments are being shared consistently with CCOs or community providers at this point. OHA has included in its CCO 2.0 Sample Contract the specific OPP language and all aspects of their commitments regarding housing assessments and collaboration with providers to assure housing is facilitated pursuant to the individual's housing assessment and plan.²⁹ Many of these commitments are also included in regulations governing ACPFs.³⁰ The CCO Sample Contract language leaves it to the CCOs, beginning in 2020, to assure they are included in the housing assessment process and in some cases, this requirement is general rather than specific. OHA is also working on a guidance document for CCOs to explain how and encourage CCOs to utilize health related services funding to support individuals in finding and/or maintaining housing. This guidance is expected to be released in August. However, the CFAA agreement with CMHPs is not specific about this expectation to do and share housing assessments. As the CFAA agreement is revised (see Footnote 36), this issue may need to be addressed

²⁹ CCO Sample Contract Exhibit M, 3.f.(10).

³⁰ O.A.R. 309-032-0870 includes all aspects of the State's commitments in Subsection D.34. except the specific requirement that ACPFs consult with the individual's CCO in developing the housing assessment.

more explicitly. OHA has clearly done significant work in this area and therefore is ***in compliance*** in some areas and is ***working toward compliance*** in others.

Connection to Housing Providers for Homeless Individuals with SPMI and Multiple ACPF Admissions: In Subsection D.32, OHA commits it or another system participant will specifically connect individuals with SPMI who are homeless and who have two or more readmissions in a six-month period to a housing or mental health agency to “work to ensure” those individuals are linked to housing in an integrated setting, consistent with treatment goals, clinical needs, and informed choice (D.32). OHA indicates it is attempting to assure all individuals admitted to ACPFs have their housing needs identified and addressed. As indicated above, Health Insights’ data suggest this is largely working. However, since these data reflect planning for all those being discharged, it is unclear whether those with SPMI who came into the ACPF homeless and have two or more readmissions in a six-month period represent a disproportionate number of those few who do not have adequate housing planned for at discharge. OHA will need to work with Health Insights to drill down to determine the actual numbers for this performance area in the OPP. As a consequence, ***I cannot determine at this point whether OHA is in compliance with this specific OPP commitment at this time.*** However, OHA’s efforts – described earlier – to require CCOs to address the housing needs of this specific population is a positive indication OHA is making efforts to ensure such specific individuals will be linked to housing in an integrated setting, consistent with clinical needs, treatment goals, and informed choice, as described in the OPP.

EMERGENCY DEPARTMENTS

In this area, OHA makes commitments to analyze and address boarding in emergency departments (EDs), to reduce recidivism to EDs for psychiatric purposes, and to reduce the rate of visits to EDs by individuals with SPMI for mental health reasons. These commitments are addressed below.

Efforts to Address Boarding

In Subsection D.37., OHA commits to work with hospitals to collect data regarding individuals with SPMI who present to emergency departments for mental health reasons and to analyze issues related to individuals staying in emergency departments (EDs) for over 23 hours, identify reasons for these long stays (often referred to as “boarding”), and provide proposals for solutions to address this issue. OHA also commits to presenting this analysis to the Legislature in the 2017 legislative session as well as provide it to USDOJ. OHA further commits to initiate additional community-based strategies to address this issue, beginning in the fall of 2016.

OHA did engage the Oregon State University College of Public Health and Human Services to do a study of ED boarding, the report of which is dated October 28, 2016.³¹ Data used for this study were from three sources and covered the 12-month period from October 2014 to September 2015. This study included comparisons of national data on boarding in EDs by those with and without mental health and substance use issues. The report on this study includes a discussion of interviews with stakeholders and summarizes quantitative and qualitative findings regarding why boarding is an issue in Oregon (and elsewhere in the U.S. as well) and recommends action steps to address these findings.

While this study is a good first step, it is limited in assisting OHA to address its commitments in the OPP as the OPP specifies data regarding individuals with SPMI in EDs longer than 23 hours. The study includes individuals with “serious mental illness” which is not defined precisely the same in the study as SPMI is defined by OHA for purposes of the OPP. The study also includes data regarding children and adolescents as well as adults. The study also uses over 6 hours and over 24 hours as two different time periods to calculate boarding incidents, but not over 23 hours as called for in the OPP. Therefore, it is not possible to obtain the specific data from this study meeting the exact OPP criteria. As indicated below,

³¹ See <http://www.mentalhealthportland.org/wp-content/uploads/2018/11/OHA-Psychiatric-ED-Boarding-Full-Report-Final.pdf>

going forward, OHA will need to agree with its data partners what exact data will be useful to determine “boarding” as opposed to simply the time it takes to be appropriately treated in an emergency room.

That said, the study is very useful – including recommendations for strategies to address the boarding issue – and was presented to the Legislature in February 2017 as committed in the OPP. Along with the study, OHA provided a Report Briefing highlighting the study findings and recommendations as well as “Next Steps” OHA indicates it will do to address the issue. The Report Briefing³² indicates Oregon is no worse in the area of boarding than other states, has lower boarding rates statistically than other states nationally, and references at least one state (Arizona) that has been specifically studied. However, it acknowledges the national and Arizona studies show those in EDs due to addiction or substance use were included in the boarding data, which was not the case in the Oregon study, so the national and Arizona data could be expected to be higher than Oregon’s. The Report Briefing also highlights a higher percentage of Oregon individuals (both children/adolescents and adults) with more severe psychiatric disorders experienced boarding (over 6 hours and over 24 hours) than those with non-severe psychiatric disorders, similar to other states and other studies’ findings.

It should be noted the study and the Report Briefing were conducted and released during the prior OHA Director’s administration. The current OHA Director and the new Behavioral Health Director, who started in April 2019, have both put new energy into some of the efforts described in the study and Report Briefing document, which covers boarding issues beyond what is addressed in the OPP. Consequently, some of the next steps and OHA actions described in the Report Briefing have been addressed and some have not. Others are in process. These efforts are summarized below.

³² <http://www.mentalhealthportland.org/wp-content/uploads/2018/11/0-OHA-Psychiatric-ED-Boarding-Report-Brief-Final.pdf>

TABLE 1 – OHA Action Steps to Address Emergency Department Boarding

NEXT STEPS (from p.6 of Report Briefing)	OHA ACTIONS (described on p.11 of Report Briefing)	STATUS
1. Use PreManage ³³ data to monitor ED boarding	1. Use new data sets to monitor ED boarding	No new reports have been released to date. The OAHHS discharge data set described in this Report will soon be provided to OHA for regular reporting pursuant to SB 23. See Footnote 33 re available data systems
2. Expand assertive community treatment (ACT) programs	2. Expand ACT programs	ACT programs have expanded to 35 programs, although the number of individuals with SPMI being served by ACT programs has seen little increase since the beginning of year two of the OPP (FY 2018); however, \$3M in new funding to increase ACT teams and services has been identified and will be released in this fiscal year (FY 2020); OHA is currently reviewing 14 applications to develop this additional ACT capacity.
3. Create a management plan for ED readmissions of individuals with SPMI	3. Management plan for ED readmissions of individuals with SPMI	The CCO 2.0 Sample Contract beginning in 2020 calls for CCOs to develop a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member with multiple readmissions, ³⁴ but OHA has not produced such a plan itself; the CCO Sample Contract also calls for CCOs to develop remediation plans with EDs with significant numbers of ED stays over 23 hours.
4. Continue to use the OHA acute care coordinator to address complicated individual issues and acute care systemic issues	4. OHA acute care coordinator	This position was empty for some time but has recently been re-hired; this staff person has been meeting with ACPFs to clarify expectations and make connections.
5. Expand mobile crisis services	5. Expand mobile crisis services	Mobile crisis services have been expanded statewide and the number receiving such services has expanded significantly (see IC Report #4 and OHA's latest narrative and data report).
6. Decrease reliance on Oregon State Hospital (OSH) for aid and assist restoration	6. Decrease reliance on the state hospital for aid and assist restorations	This reliance has not decreased to date (see recent rulings in <i>Oregon v Gilbreth</i> , et al. and <i>Oregon Advocacy Center v Mink</i>); however, OHA has released a plan to decrease wait times for admission to OSH and has been appropriated additional funding to increase community restoration options; OHA indicates it is in compliance with the seven-day requirement for OSH admission as of mid-July 2019. ³⁵
7. Support the development of community crisis services	7. OHA supports the development of community crisis services	New crisis centers have opened in Multnomah and Jackson counties, and all counties now have mobile crisis services; at least one other community has developed a crisis facility without OHA funding; Multnomah county is in the process of developing a drop-in resource center for individuals who are homeless and have mental health service needs; however, this facility will not be ready and open for a couple of years; at least one other
8. Invested \$1 million in psychiatric emergency services	8. Investment in psychiatric emergency services	Unity Center for Behavioral Health in Multnomah County is the only new psychiatric emergency services program opened in the last few years; it has experienced some difficulties with care, staff concerns, and local law enforcement misgivings; however, it is back up to full service now.
9. Expand child and adolescent ED diversion pilots	9. Expand child/adolescent ED diversion pilots	OHA indicates 8 such pilots have been funded; because this is not part of the OPP, I have not verified this.
10. Ask the Oregon Association of Hospitals and Health Systems (OAHHS) to consider the development of a bed registry	10. OHA will approach OAHHS to consider the development of a bed registry	Whether or not OHA has discussed this possibility with OAHHS, no such bed registry is in use or planned at this time.

³³ This and the Emergency Department Information Exchange (EDIE) system allow Oregon hospitals and other providers who are enrolled in health information exchanges to access and track information about ED users. OHA is providing ACT providers with a subscription to PreManage that will notify ACT teams when an ACT team client enters an ED and also allow the teams and other behavioral health users to enter care guidelines and upload crisis plans to be available to EDs through EDIE. The ED utility is convening a behavioral health learning collaborative to help these system users to effectively utilize these tools and to coordinate and communicate with EDs.

³⁴ CCO Sample Contract, Exhibit M, 3.c.(1) and (2).

³⁵ It should be noted the population determined to be “aid and assist” are not part of the OPP commitments. However, some individuals with SPMI do, of course, become part of the “aid and assist” population.

While some actions have been taken to address the issues underlying boarding of individuals with SPMI who present to EDs for mental health reasons, no regular data reports about boarding are available or have been produced beyond this initial 2016 study. In 2017, OHA introduced and supported a bill to require hospitals to provide data to determine numbers of those “boarded” in EDs. However, in part due to opposition by hospitals through their association (OAHHS), the bill did not pass. Hospitals agreed at that time to collect and provide the data voluntarily. While the hospitals did begin collecting and reporting the data to OAHHS, it was not available for utilization for this purpose until recently. As indicated later in this Report, a bill to require such data reporting by hospitals (SB 23) did pass in the 2019 legislative session, with OAHHS support.

Some of the action steps recommended in the original boarding study have not been addressed. Namely, expansion of community mental health services beyond mobile crisis services has not occurred.³⁶ The 2019 legislative session did result in an increase in funding for community competency restoration services, but that funding will not have an impact for several months while funding is distributed and programs are developed or expanded. In the meantime, additional beds are being funded and opened at OSH in Salem and Junction City to address the wait time for admission for individuals who are on aid and assist status needing competency restoration in a secure psychiatric facility. A bill passed during the 2019 legislative session (SB 24) will assure probation or parole violators can no longer be admitted to OSH for competency restoration and misdemeanants can only be referred and admitted to OSH if a certified forensic evaluator or a CMHP finds the individual to need hospital level of care due to the defendant’s dangerousness or acuity of symptoms. The bill also requires a court that determines a defendant lacks fitness to proceed to consider a CMHP recommendation whether the services and supervision necessary to safely allow the defendant to gain fitness (i.e., be restored to competency to go to trial) are available in the community rather than in an inpatient setting. This bill allows more options for this population than just admission to OSH. Along with OHA’s commitment to create more community restoration options for such defendants, this bill was intended to help decrease pressure on OSH admissions.

The original boarding study also recommended improvements in psychiatric services for individuals in EDs, provision of additional alternatives to inpatient care, more supportive services such as supported employment, promotion of insurance and health services reimbursement changes to incentivize community services, and increased transparency of waitlists for inpatient and OSH beds. While many of these issues are being addressed in various ways (including a recent workgroup and regulatory changes regarding admission to OSH), it is clear it will take significantly longer than the OPP’s three years to see changes that will impact boarding. And without regular data and reports specifically about boarding over 23 hours for adults with SPMI, it will be impossible to know whether any such changes have impacted boarding for the OPP population.

In Subsection D.38., OHA commits to use the data in the analysis in D.37 to assess the needs of individuals with SPMI who leave the ED and strategies for linking them to services as well as strategies to increase the number of individuals with SPMI who are connected to services at the time they leave EDs and collect data to measure the effectiveness of these strategies. At this point, OHA does not have the data specifically as described in the OPP and therefore is not using it as committed in the OPP.

In Subsection D.43., OHA indicated it was working with hospitals to determine a strategy for collecting data regarding individuals who are in EDs for longer than 23 hours, and would begin reporting this information in July 2017, and would provide data by quarter thereafter, by region. OHA indicates it will pursue efforts to encourage reporting on a hospital-by-hospital basis, specifically through legislative change and work with OAHHS regarding data collection statewide. In an interview with OAHHS’ data collection team, they indicated they receive data regarding boarding from most hospitals now, but the

³⁶ The CFAA budget for CMHPs was reduced by a total of \$9 million and set aside because of the caseload methodology currently utilized to provide this funding. A new funding formula methodology is expected to be developed in conjunction with CMHPs prior to OHA requesting the release of these set aside funds. In addition, \$7.6 million in funding was added to provide additional community competency restoration options for individuals found unable to assist in their own defense. However, approximately \$5 million of these funds was already available, but were made permanent by this appropriation.

data would not be completely consistent with the 2016 study given the differences in data systems used. However, OAHHS supported SB 23, which passed in the 2019 legislative session, to require reporting of such data, including entrance and exit times, for those entering EDs for behavioral health reasons. OAHHS indicates it has begun receiving such data from all Oregon EDs for the first quarter of CY 2019, and will be working with OHA to share and analyze these data beginning in the summer or fall of 2019. This will be a good source for data reporting going forward, with an analysis by diagnosis and age and common understandings regarding when boarding begins, to help OHA meet its OPP commitments in this area. However, the data are being captured for reporting currently and show times in EDs over 7 hours and over 24 hours. OHA and OAHHS will need to agree on timeframes for reporting, and specific diagnostic sets in order to set appropriate goals and strategies going forward. OHA is working on an agreement with OAHHS now and should eventually be able to gain access to historic data sets.

Given the status of these various efforts, OHA is ***in compliance*** to analyze data initially and present this analysis to the legislature. However, it is ***not yet in compliance*** with regular data reporting and monitoring, and therefore is ***not yet in compliance*** with commitments to use these data to initiate strategies to address the boarding issue for the OPP population. However, OHA is ***working on compliance*** by implementing some strategies and working on others to address the emergency and crisis needs of adults with SPMI (see also, IC Report #4). In addition, OHA has included specific requirements regarding CCOs working with EDs on the boarding issue for the 2020-2024 contract period. However, it is not yet clear how OHA will oversee or hold CCOs to these requirements.

Some stakeholders report having experienced a major growth in boarding incidents in EDs while others indicate boarding has been reduced through their own local efforts. None could describe specific OHA actions or activities directed to addressing this issue. OHA will have to do more to focus on this issue, assure the problem is understood, addressed, and gets better statewide.

Efforts to Reduce Recidivism to EDs for Psychiatric Purposes

In Subsection D.40., OHA commits to reducing recidivism and to track emergency department admissions of individuals with SPMI by hospital, monitor the number of individuals with SPMI with two or more readmissions to an ED for psychiatric reasons in a six-month period, continue to work with CCOs and CMHPs to better address the needs of these individuals in less institutional settings, and implement plans to address the needs of such individuals. Specifically, OHA commits to seek contract amendments to CCO contracts in 2018 that will require ACPFs to develop and implement plans to address the needs of such individuals in less institutional settings. As described above, these contract changes are included for CCOs in 2020 – 2024. Since CMHPs do not generally pay for inpatient or emergency department care, the CFAA for CMHPs does not adequately describe community providers' role in reducing ED use for psychiatric purposes or in addressing boarding issues. However, CFAA language regarding CMHPs' role in providing crisis services and the increases in such services should help to alleviate emergency room use.³⁷

OHA provides data regarding these commitments in its regular quarterly reports. At baseline, during 2015, 1,067 adults with SPMI were reported to have met this set of criteria. Fortunately, this number has continued to decline steadily (with an aberration or two) over the last 10 quarters. As of the end of December 2018 the reported number is 717. Especially given the lack of change in the rate of admissions (see below), this represents significant progress.³⁸ OHA has also included specific requirements for CCOs in 2020-2024 regarding ED utilization with a goal of reducing admissions to EDs, reducing the length of time Members spend in EDs, and providing data on ED utilization for behavioral health

³⁷ It should be noted the current CFAA language covers only the first 18 months of the usual two-year time period – through December 2019 – to allow OHA and CMHPs an opportunity to revise the language based on outcomes of the 2019 legislative session and to deal with formula issues affecting CMHP funding. (See also, Footnote 36.)

³⁸ OHA does report the number of such readmissions by hospital. However, they are not anchored in the number of admissions overall or the rate of admissions by facility. In order to see what facility is doing better or worse, one would need to compare each of OHA's quarterly reports. Similarly, OHA has indicated this number could be somewhat misleading in that it uses the latest admission to describe where the individual was readmitted. However, a particular individual could have been admitted and then readmitted into a different ED during the six-month period.

reasons.³⁹ OHA has also included use of EDs for psychiatric reasons by individuals with SPMI as an incentive metric for CCOs. Similarly, requirements for CMHPs and Choice contractors include in-reach and other work to address ED readmission issues by providing mobile crisis services and assuring individuals in ACPFs (including EDs) remain connected to community-based services. Hence, OHA is ***in compliance*** with this set of OPP commitments.

Efforts to Reduce the Rate of Visits to EDs by Individuals with SPMI for Mental Health Reasons

OHA commits in Subsection D.41. to reduce the rate of visits to general EDs⁴⁰ by individuals with SPMI for mental health reasons, as follows:

- a. By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline.
- b. By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.
- c. By the end of year three (June 30, 2019), OHA will have a quality improvement process to track whether emergency room visits are decreasing.

Data reported by OHA indicates the baseline rate in CY 2015 was 1.5 admissions per Member month.⁴¹ Therefore, the goal for the end of year one would have been 1.4 and 1.2 for the end of year two. Rather than declining, the rate actually increased to 2.0 by the end of year one, but did decline somewhat to 1.79 by the end of year two. However, the decline continues with a rate of 1.37 at the end of December 2018. If this decline continues, OHA may be able to meet the year two goal by the end of the year three. OHA is in the process of developing its BHQPIP to include the commitment in this Subsection and in Section E. of the OPP. This BHQPIP should be finalized by the end of CY 2019 or early 2020, and will include a process to track whether ED visits are decreasing, as committed in this Subsection. Hence, while the timeframes were not precisely met, the State is ***in compliance*** with the year two goal to reduce the rate of ED visits by the OPP population for mental health reasons and is working on compliance with having a quality improvement process to track the rate of these visits going forward.

Meetings with Independent Consultant re Emergency Room Use

Finally, in this area, in Subsection D.42., OHA commits to meeting with me, the Independent Consultant for the OPP, to discuss the use of EDs by individuals with SPMI who present to EDs for mental health reasons, which they have done and continue to be willing to do. However, the OPP specifically prohibits the addition of other performance outcomes about this issue other than what is already in the OPP, at least for the three-year period ending June 30, 2019. Hence, OHA is ***in compliance*** with this OPP provision.

SECURE RESIDENTIAL TREATMENT FACILITIES

Subsections D.49. and 50. of the OPP include commitments regarding civilly committed adults with SPMI who are receiving services in secure residential treatment facilities, specifically regarding their discharges from such facilities. One of these commitments is qualitative and the other is quantitative. Subsection D.49. indicates “civilly committed individuals in [SRTFs] whose clinical needs no longer necessitate placement in a secure facility shall be moved *expeditiously* [emphasis added] to a community placement

³⁹ CCO Sample Contract, Exhibit M, Subsection 3.c.(1) – (3).

⁴⁰ Not including specialty psychiatric emergency services such as Unity Center in Portland. OPP Footnote 3, page 14.

⁴¹ Note, OHA calculates the rate as the number of visits to general EDs by Member months. USDOJ would prefer this be reported by the number of individuals with SPMI who are Members of CCOs as there is currently not a way to obtain diagnoses on all CCO Members, since a person's diagnosis may not be available unless or until the individual is seen for a psychiatric emergency or other mental health service. Also, the comparison of facilities is somewhat misleading because OHA uses the latest admission to describe where the individual was readmitted. However, a particular individual could have been admitted and then readmitted at a different ED during the six-month period.

in the most integrated setting appropriate for that individual. Subsection a. goes on to indicate these moves shall be consistent with the housing provisions in Subsection D.50., which reads as follows:

"Civilly committed individuals who are discharged from [SRTFs] shall be moved to a community placement in the most integrated setting appropriate for that individual. Discharge shall be to housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. The individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated in light of cost, availability, and other factors stated above. Cost shall not be used as a justification for denying housing."

Subsection D.49.b. enumerates quantitative goals about lengths of stay of such individuals in SRTFs, specifically, by the end of year one (June 30, 2017), the goal is a 10% reduction from the baseline; and by the end of year two (June 30, 2018), the goal is a 20% reduction from the baseline. Subsection D.49.c. goes on to commit OHA to reporting regularly on the number of civilly committed individuals in SRTFs, their lengths of stay, and the number of individuals who are discharged; and starting July 1, 2017 (the beginning of year two of the OPP), the type of, and the placement to which such individuals are discharged.

The focus of these Subsections of the OPP is very narrow and only about the type, appropriateness, and speed of discharges from SRTFs and the lengths of stay in SRTFs of civilly committed adults with SPMI. Therefore, this set of commitments is not about the appropriateness of the admission of such individuals into SRTFs or whether Oregon has enough SRTF beds for such individuals. Nor is it about other populations in SRTFs, namely individuals admitted by guardians or individuals in such facilities who are under the oversight of the Psychiatric Security Review Board (PSRB) or who are there for competency restoration. While some of these populations and issues have been of concern in Oregon of late, this is not the focus of these Subsections of the OPP. Therefore, this report will focus solely on the appropriateness of discharges, the lengths of stay, and the collecting and reporting of disposition data for adults with SPMI who are leaving SRTFs.

Quantitative Commitments re Individuals with SPMI Leaving SRTFs

Lengths of Stay: OHA was but is ***not currently in compliance*** with the quantitative commitments it made to reduce the length of stay (LOS) of individuals with SPMI in SRTFs, given the reporting methodology utilized by OHA. The data provided by OHA is calculated based only on those individuals who are discharged in a given time period. OHA makes the case that this is the best way to calculate these numbers as otherwise the number could change literally daily if the LOS of all individuals with SPMI who are in SRTFs is included and could therefore be meaningless. That is, if some individuals leave on a given day and several individuals are admitted, the average LOS (ALOS) would go down precipitously without real meaning. On the other hand, by calculating ALOS on only those discharged, the ALOS in any given time period will fluctuate depending on how long those particular individuals have been in the SRTF before discharge. This approach to calculating and reporting the ALOS has perhaps worked against OHA as they have been focused recently on ensuring individuals who no longer need to be in an SRTF are released to more appropriate settings. This has led to an increase in the number of individuals released who had long lengths of stay (in some cases, literally years or even a decade or longer) and who are stable and could live in more integrated community settings.

The numbers tell this story. Baseline in 2015 for ALOS calculated in this way was 638 days (almost 1¾ years). Hence the goal for the end of year one was 574.2 days. OHA met this goal at 553 days, which however was up from 409.1 in the first quarter of year one. The goal for the end of year two was 510.2 days. This year started well below that goal at 449.7 days, but rose in quarter two of year two to 501.8 days, and to 663.2 days in quarter three and 676.0 days in quarter four. This was the time period in which OHA began focusing heavily on releases of individuals who had been in SRTFs for long periods of time, so the ALOS as they calculate it has actually seen a consistent increase during year two, possibly because OHA is doing the right thing focusing on discharges for the longest stay individuals.

There is no quantitative goal re LOS in SRTFs for year three of the OPP. However, in quarter one of year three, the ALOS went back down to 664.8 days but was back up in quarter two to 673.6 days. As longer stay individuals are being released, it is possible the numbers in the last two quarters of year three (January through March and April through June 2019) will begin to come down again. However, due to the six-month data lag in reporting, we will not know whether the numbers have come back down to or below the goal for the end of year two (510.2 days) until the final report from OHA is released in early 2020. So, while OHA is working specifically to reduce the overall length of stay in SRTFs for adults with SPMI who are civilly committed, the calculation of the ALOS for those being discharged has actually been going up since January 2018.

Another way to look at this issue of LOS was provided in the two previous January OHA narrative reports, at the request of USDOJ. In January 2018 and January 2019, for a point in time toward the end of year one (June 15, 2017) and toward the end of year two (June 15, 2018), OHA provided the following data:

TABLE 2 – Lengths of Stay of Individuals in Residence in SRTFs on 6/15/2017 and on 6/15/2018

# in Residence	# Persons in Residence < 120 Days	# Persons in Residence 120 – 365 Days	# Persons in Residence 366 – 2 Yrs (730 Days)	# Persons in Residence > 2 Yrs (731 + Days)
June 15, 2017 – 33	6 (18%)	11 (33%)	8 (24%)	8 (24%)*
June 15, 2018 – 53	19 (36%)	10 (19%)	11 (21%)	13 (25%)

*The percentages do not add up precisely to 100% due to omitted repeating decimals.

These data suggest the number and proportion of individuals in SRTFs for shorter time periods is growing while the proportion in residence for the longest period of time (greater than two years) has remained the same. In January 2019, OHA provided another view based on the 15 individuals discharged during the 12-month rolling timeframe (ending June 30, 2018) that resulted in the ALOS reported as 676 days, making the case that individuals with significantly long LOS were among those 15 discharged, namely:

TABLE 3 – Lengths of Stay of Individuals Discharged July 1, 2017 – June 30, 2018

# Discharged with LOS < 1 Yr	# Discharged with LOS 1+ to 2 Yrs	# Discharged with LOS 2+ to 3 Yrs	# Discharged with LOS 3+ to 4 Yrs	# Discharged with LOS 4+ to 5 Yrs	# Discharged with LOS 5+ to 6 Yrs	# Discharged with LOS 6+ to 7 Yrs	# Discharged with LOS 7+ to 8 Yrs
2	3	4	1	1	1	1	2

These data indicate 5 or 33% of those discharged in this time period were there less than two years, compared to 74% of those in residence at the end of this time period and 75% of those in residence in the previous 12 months. Ten or two-thirds of those discharged in this time period were there more than two years compared to just one-quarter of those in residence at the end of the previous two 12-month periods. This suggests that OHA is working toward compliance with the commitment to reduce the LOS of civilly committed individuals in SRTFs even though the numbers reported currently indicate OHA is **not in compliance** with this provision at this time. Future OHA reports will need to provide comparable data for LOS of those in residence at a point in time and LOS of those discharged in order to make a better comparison upon which to judge this commitment for the full three years of the OPP.

These data indicate OHA is **in compliance** with the commitment to report the number of individuals who are discharged (albeit not from the beginning of the OPP as implied in Subsection D.49.c.), and **in compliance** with the commitment to report the number of civilly committed individuals in SRTFs and their lengths of stay.

Dispositions for Individuals with SPMI Discharged from SRTFs: OHA also committed to begin collecting data about dispositions of adults with SPMI civilly committed to and discharged from SRTFs, beginning

July 1, 2017. Given the six-month data lag, the first data provided to address this commitment was provided in April 2019, covering three quarters of CY 2018 (January through September 2018). These data, along with data for the fourth quarter CY 2018 (through December 2018) are provided in TABLE 4 elsewhere in this Report. Therefore, OHA is ***in compliance*** with this reporting commitment.

Qualitative Commitments re SRTF Discharge Plans and Timing

As indicated earlier in this section of the Report, OHA committed in the OPP that civilly committed individuals in SRTFs whose clinical needs no longer necessitate placement in an SRTF shall be moved *expeditiously* to a community placement in the most integrated setting appropriate for that individual (Subsection D.49.), that is to *housing* consistent with the individual's treatment goals, clinical needs, and the individual's informed choice including geographic and housing preferences (Subsection D.50.). To test whether these qualitative commitments are being met, I (with help from OHA staff) reviewed the discharge plans and decision-making process in the charts of half (18 of 36) of adults with SPMI civilly committed to SRTFs and discharged in the nine-month period from January 1 through September 30, 2018.⁴² These chart reviews were conducted mostly at the office of the IQA⁴³ for OHA whose task it was to make determinations regarding whether individuals met the criteria for receiving services in an SRTF and whether they no longer met such criteria and were, therefore, ready to be discharged.

During this time the IQA's role, process, and criteria by which such determinations were made were under review and in flux, with OHA changing that role, process, and criteria because of public concerns about whether individuals were being released from SRTFs too soon and without adequate community services after release. These concerns were about all SRTF service recipients, not just those with SPMI who were civilly committed to such a facility. In response to these concerns, OHA stopped IQA-initiated discharges from SRTFs for a period of time and OHA staff began reviewing the IQA's work to determine whether the individual met criteria for SRTF placement and services and whether the individual's clinical needs no longer necessitated placement in a secure facility. The IQA continued in the role of reviewing charts and paperwork to determine these matters and made recommendations to OHA about discharge readiness. As recently as May 2019, the criteria being used for these determinations was continuing to undergo changes.

However, this Report is not about whether the IQA adequately performed its role(s), whether OHA adequately oversaw the IQA's work, or even whether the criteria and processes being utilized were as they should have been. Rather, the IC's role in this matter was to determine whether a sample of the charts the IQA reviewed showed the discharge occurred expeditiously after the individual's clinical needs indicated no further necessity for placement in an SRTF, and whether the placements to which individuals transitioned were consistent with their documented treatment needs, clinical goals, and informed choice.⁴⁴

During this nine-month period in 2018, 13 different SRTFs within the State had beds available for civilly committed individuals with SPMI. These facilities operated in nine different cities/towns within the State.⁴⁵ In order to assure the chart review findings were not specific to one or a few SRTFs or to specific

⁴² Note: For background and comparison, I reviewed the charts of four other individuals discharged from a PAITS SRTF to determine how these were different. These facilities are technically licensed as SRTFs, but are generally short term stays for diversion from hospitalization, especially OSH, or other restrictive environments. Earlier, I also reviewed a couple of charts at SRTFs I visited.

⁴³ For the time period covered by the OPP, KEPRO was this entity.

⁴⁴ Note: As in IC Report #4, an independent face-to-face clinical evaluation of individuals discharged from SRTFs was not conducted as the status of individuals' clinical needs and choices after the fact or after discharge could very well be different than at the time of decision-making, just before discharge. Hence, the chart review of a sample of individuals discharged during this nine-month period was conducted to identify whether the individual's needs and choices were clearly documented and whether individuals' transitions were to post-discharge settings consistent with what was documented for them and in a timely manner.

⁴⁵ Often, these facilities also have beds available for persons who are admitted *voluntarily* by their guardians, or who are under the jurisdiction of the Psychiatric Security Review Board (PSRB) and are required by this process to be in such a facility. These populations are not the subject of the OPP or my compliance assessments so none of the charts of such individuals were reviewed.

locations, the charts reviewed represented 18 individuals from 11 different SRTFs in seven different cities/towns within the State. The results of these discharge dispositions and the dispositions of those whose charts were reviewed, along with the discharge dispositions for the fourth quarter of CY 2018 are reported in TABLE 4 below.

TABLE 4: Dispositions of All Individuals Discharged January through September 2018 and October through December 2018 and Individuals Whose Charts Were Reviewed

Discharge/Transition Location or Disposition ⁴⁶	Total Count 1 st 3 Qs of CY2018 (through Sept)	Count of 1 st 3 Qs of CY 2018 Charts Reviewed	Total Count 4 th Q of CY2018 (Oct – Dec)
Adult Foster Home (AFH)	4	2	2
Discharged Against Medical Advice (AMA) – Location UNK	1	0	1
Independent Living	9	5	3
Psychiatric Hospital (OSH or ACPF)	1 (OSH)	1 (OSH)	0
Residential Treatment Facility**	12	6	6
Residential Treatment Home (RTH)	7	2	2
Supportive Housing*	2	2	0
TOTAL	36	18	14

* This is not the subset of housing considered *supported* housing as described in the OPP and in IC Report #4 but is, in fact, housing with system-provided services such as sober living or other supportive environments. No person discharged during this quarter went to either type of housing.

**One of the 12 discharges to an RTF was initially indicated as homeless, but upon a review of the chart, it was determined to be an individual discharged to an RTF respite bed, pending locating appropriate local housing.

SRTFs are, of course, a highly structured and locked environment so discharge to any other facility will require the individual to be able to live safely in a less structured environment. When I asked stakeholders what type of facility they felt anyone leaving an SRTF should go to, most indicated appropriately that it depends on the individual and his/her needs and desires. In some cases, stakeholders thought it would be optimal if an individual leaving an SRTF went first to an RTF or RTH so that structure and support without a locked environment could be experienced before independent living. On the other hand, many indicated some individuals being discharged are stable enough to live independently if an appropriate housing situation can be located. The numbers indicate that one-fourth (nine) of those discharged during the first nine months of 2018 and one-fifth (3) in the last quarter of 2018 did in fact go to independent living – their own apartment or with family or friends. In the first nine months, two more went to supportive housing units where they had their own unit, albeit with more units in the building occupied by others with behavioral health needs and with supportive services on site. Over 60% (22) in the first nine months and 71% (10) in the last quarter went to other residential settings while one went to OSH and one left against the advice of the facility without indication of where they were going. It's good to see the range of types of "placements" and some going to community housing with supportive services. The record reviews described below indicate generally the "placements" to which individuals were discharged during this time period were consistent with their documented clinical needs and treatment goals.

Summary of Review of Records for Individuals Discharged from SRTFs January through September 2018: As indicated in TABLE 5 below, a review of the materials available to the IQA and OHA in making decisions about transition and placement of individuals being discharged from SRTFs indicated some inconsistency in what was available for review. The information in most of the documents available for review were developed by clinical staff of the SRTF and included treatment plans, discharge summaries, discharge transition plans, Oregon's Medicaid Prior Authorization Request Form, Resident Assessment Checklist, and/or progress notes. In some cases, a checklist provided by the IQA was utilized although the IQA discontinued use of this form by SRTFs during this time period. In some cases, standardized assessment tools such as the LOCUS or a form based on the Oregon Administrative Rule (OAR)

⁴⁶ The various types of residential facilities in Oregon referenced in TABLE 4 are described on the OHA website at <https://www.oregon.gov/oha/HSD/AMH-LC/Pages/RT.aspx>.

requirements for SRTFs was available to the IQA reviewer. Also, during this time period, the IQA was not required to, but did meet with or assess some individuals in person for this purpose. Generally, the IQA relied on documentation provided by SRTFs.

The IQA does have responsibility to meet with and develop a person-centered plan (PCP)⁴⁷ directly with each individual. However, the documentation provided for this chart review included only a few person-centered plans available for review. The IQA indicates individuals are sometimes unwilling to engage in the PCP process or are unavailable for this process, although the IQA continues to reach out to engage individuals to complete a PCP. Even in the absence of a PCP, however, evidence of individuals' desires and preferences was often available in other materials utilized for the IQA's and OHA's review.

TABLE 5: Characteristics of Documentation in 18 Records Reviewed

DOCUMENTED EVIDENCE OF . . .	YES	NO	UNKNOWN OR UNCLEAR
Person Centered Plan Completed/Available	5	11	2
Individual's Choices/Preferences	15	3	-
CCO or Choice Provider Involvement	3	7	8
Effort to Assist Individual w/ Discharge Process	9	-	9
Consistency of Discharge "Placement" w/ Treatment Goals and Clinical Needs	15	-	3
Consistency of Discharge "Placement" with Individual's Informed Choice/Preferences	8	4	6
Prior History Considered in Discharge "Placement" Decision	17	-	1

While CCOs or Choice providers might have been involved in discharge planning for the individuals whose charts were reviewed, there was little evidence of this involvement and in almost half of those individuals reviewed, these entities were clearly not involved. There was, however, evidence of the SRTF providing assistance to the individual in the discharge process through referrals, assistance in visiting the potential after-discharge placement, assistance with housing applications, etc. Again, more assistance may have been provided, but was not noted in the particular charts/records reviewed for this process.

The most important two elements of the OPP revealed by the chart reviews were that the "placement" upon discharge was consistent with the documented treatment goals and clinical needs of the individuals being discharged. In the three cases in which this was unknown, the charts/records simply did not make this consistency clear rather than that the "placement" was inconsistent with the individuals' goals and needs. It was also clear in almost all of the cases that the individual's prior history was considered in the discharge "placement" decision. This is important as sometimes individuals are doing well because of the structure provided by an SRTF but historically have not done well when less structure or support is available. Hence, consideration of history, especially relatively recent history, is critical to assuring success upon release from the locked SRTF environment to any other environment that is not secure.

Of some concern is the number of cases in which there was lack of consistency or inadequacy of documentation of consistency of the "placement" decision with the individual's choices or preferences. In those four cases in which the "placement" was specifically inconsistent with choices/preferences, the records did indicate why. For example, an individual wanted to be off medications and on their own, whereas the clinical needs indicated even more intensive care in a hospital setting was necessary. Others wanted to live with family or friends that were no longer willing to have the individual live with them or were no longer around. In other cases, individuals wanted to study or do something that was not possible with the resources or background the individual currently had. Since a review of post-discharge records was not conducted, it is unclear whether the post-discharge setting and services began to assist those individuals work toward their choices and desires.

⁴⁷ The form utilized for this PCP was undergoing revision by the IQA and OHA during the time these charts were reviewed, which of course was after the time these individuals were discharged.

Perhaps the bigger concern in this area is the proportion of cases (one-third) in which the documentation was just not adequate to determine if the “placement” was consistent with the preferences and choices of the individual. While preferences and choices of various kinds were included in the materials of the vast majority (84%) of the individuals reviewed, it was not clear whether the actual discharge placement was what the individual agreed to and wanted, given their circumstances and clinical needs. In at least three cases, this was because choices and preferences were not documented. In others it was because the connection to choices and preferences of placement after discharge was not documented. Additional efforts to help those documenting discharge processes understand the importance of capturing this information about choice and preferences would be useful for SRTFs and for the IQA or other utilization reviewers in the future.

Another item looked for in the documentation reviewed but which is not reported in the TABLE 5 above is referral to or involvement of an assertive community treatment (ACT) team. Given the type of individuals living in SRTFs and specifically those with SPMI, a referral to ACT either shortly before or upon discharge would be expected, especially if they were not receiving ACT services prior to admission. In only one case was an ACT referral or involvement noted. While this is not a specific OPP commitment, OHA has been working to assure ACT teams are engaged before individuals eligible for ACT services leave OSH or SRTF environments. Hence, this is another area for further work by OHA to assure ACT referrals and engagement occur and these efforts are documented.

Given this overall review, OHA appears to be ***in compliance*** with the commitment regarding appropriateness of placement upon discharge and ***in partial compliance*** with the commitment that placements upon discharge will be consistent with individuals’ informed choices and preferences.

Timeliness of Discharges: Subsection D.49. of the OPP also commits to moving from SRTFs “expeditiously” those civilly committed individuals with SPMI whose clinical needs no longer necessitate placement in a secure facility. The OPP does not define “expeditiously”⁴⁸ or otherwise specify timeframes even though it does define goals for the timeliness of discharges from OSH after being found ready to transition (see Subsection D.20. and IC Report #4). While these latter timelines suggest that 30, 25, or even 20 days after being ready to transition is appropriate for discharge from an intensive inpatient unit, such a timeline is not appropriate for a treatment setting in which the individual has been living as their “home” for a significant period of time ranging from months to years.

In order to determine whether discharges are occurring expeditiously, I asked a number of stakeholders, including SRTF operators and community providers, what they thought the timeline should be and what length of time it generally took to find an appropriate discharge “placement” for individuals once they were determined to no longer need SRTF level of care. I also asked what factors impact that timeline. Some of these reported factors include:

1. Type of needed “placement” upon discharge, including stability or fragility of the individual, their special needs, and needed supervision and supports;
2. Lack of availability of alternatives, whether other types of residential facilities or supported or supportive housing (and lack of ACT capacity or confusion regarding ACT eligibility);
3. Openings or wait lists (after application, it is up to the facility to which the application is made to determine the process and timeline for decision-making as well as determine whether to accept the individual or not; many stakeholders indicated individuals being discharged from OSH have

⁴⁸ The word “expeditiously” is defined in general as “with speed and efficiency” as in “the directors will move expeditiously to reach a conclusion;” and “characterized by promptness” as in an expeditious answer to an inquiry.” However, these definitions do not provide a precise timeframe any more than the OPP does, but do confirm the meaning of this term is in a context. That is, the time needed to reach a conclusion or provide a prompt answer to an inquiry is heavily dependent on the context and the type of decision or inquiry. Hence, the term is considered in this Report in the context described in this section.

priority so can “bump” individuals ready to leave an SRTF from the wait list for RTF, RTH, or even AFH opportunities);

When asked what they believe “expeditiously” would mean in this context, many stakeholders were unsure, but indicated a reasonable range is from 30 – 90 days with some shorter and some longer depending on the individual circumstances. Some stakeholders indicated six months is a more reasonable transition timeline. Generally, the IQA approves an SRTF stay for 90 days at a time, with exceptions for short-term extensions, while Oregon regulations allow prior authorizations for up to 12 months. Therefore, arguably a discharge within 90 days of being found to no longer need this intense setting would be considered a reasonable period of time for a discharge to occur. O.A.R. 410-172-0720 also specifies a 90-day timeframe as the look-back period for the clinical documentation review to determine if an individual is appropriate for SRTF admission. SRTF operators interviewed or visited indicated they think of this 90-day period as a reasonable timeframe for discharge, but that they often request additional time beyond the allowed 90 days for the transition process after the IQA or OHA have found the individual to no longer need placement in a secure environment. They indicated getting an individual ready to leave a place they have been living for a considerable period of time takes considerable clinical interventions with some individuals who may be worried, concerned, or regressing before the transition can occur. In other cases, the individual is ready for transition, but an appropriate “placement” is not available. Many SRTFs assist individuals in making application for other settings (whether residential facilities or housing) and help the individual make a good choice by visiting facilities or apartments in which they may be interested. In some cases, SRTFs have already determined the individual is ready to leave so they begin the transition planning process before the next utilization review so that the IQA or OHA does not actually make a determination the individual is ready to be discharged (or that payment should be denied for a continued SRTF stay).

Given this scenario, and the reported necessity for requests for additional time for transition, the timeline from determination of no longer needing to be in a secure residential setting to discharge is hard to identify specifically from the records reviewed. However, the best information able to be derived from these records indicates three were discharged within just over a month or less; 11 were discharged within about 90 days; two were discharged within three to four months; and for two others, the dates are unknown (one of which left AMA therefore was not determined to be ready to be discharged).

Clearly, the timeline from readiness to discharge or denial of continued stay to actual discharge is a fluid timeline based on the individual’s situation as well as the vagaries of a system that is currently unable to accommodate all the needs. That said, I found no evidence of “foot dragging” or SRTFs attempting to hang on to individuals for their own reasons, with most discharges occurring within 90 days. OHA staff does sometimes intervene if they see communication breakdowns resulting in individuals ready to be discharged languishing in an SRTF setting.

Given the data from this review as well as stakeholder, OHA, and IQA input, a specific timeline for measuring “expeditious” discharge is not possible, and continued stay approvals are sometimes provided because transition planning is not yet completed. On the other hand, it is clear that system issues – such as lack of available alternatives and facilities being able to make their own decisions about who gets in and who does not – are prohibiting what could be quicker discharges in some circumstances. My review leads me to the conclusion that OHA is ***in compliance*** with this commitment, but needs to do more to assure community-based residential and housing alternatives are available, residential alternatives are within the CCOs’ risk-based responsibilities so that incentives are in play for movement to occur more rapidly, and residential settings are required to accept individuals referred to them unless they can make a case why that particular individual should not be admitted to their location. Each of these suggestions has been made in prior IC reports, and OHA has shown movement toward bringing residential services into CCOs’ responsibility in its CCO 2.0 Sample Contract and by standardizing rates for these services as of July 1, 2019.⁴⁹

⁴⁹ See CCO 2.0 Sample Contract, Exhibit M 3.g., <https://www.oregon.gov/oha/HSD/OHP/Pages/MH-Rates.aspx>, and <https://www.oregon.gov/oha/HSD/OHP/Announcements/Final%20standardized%20adult%20mental%20health%20residential%20rates%20effective%20July%202019.pdf> for information regarding rate standardization process.

STATUS OF OHA DATA AND NARRATIVE REPORTS

The OPP timeline is technically completed, as of June 30, 2019. However, due to a six-month data lag, OHA's performance on its commitments through the end of year three will not be available until early 2020. The most recently available data and narrative report from OHA at the time this IC Report was drafted and released in early August 2019 and covered the time period ending December 31, 2018 or half way through year three of the OPP timeline. This Report utilizes the data from this OHA report to assess compliance and describe efforts regarding the three performance areas covered by this IC Report.

A review of this most recent OHA data and narrative report for other OPP performance areas shows OHA's performance on the OPP quantitative measures continues to be mixed during this period. The number of individuals receiving crisis services, ACT services, supported housing, and peer-delivered services continues to rise, but ACT and supported housing numbers are still not at the OPP goals. The number of individuals receiving supported employment have gone down some in the most recent quarter but the number in competitive integrated employment has increased from last quarter, although still below the last quarter of FY 2017 (OPP year two). OSH's discharge numbers also continue to improve although are not yet at the goals set in the OPP. The number of individuals receiving criminal justice diversion services and the numbers of reported criminal justice diversions (pre- and post-booking) have gone down again for the second quarter in a row.⁵⁰

OHA continues to provide data about individuals receiving ACT services (Subsection D.4.) separately from its quarterly data and narrative reports since these data points "are to be collected internally as a part of the quality improvement monitoring of ACT programs to determine the effectiveness of individual programs and the statewide effectiveness of ACT." As committed to in the OPP, these data are collected quarterly and utilized by the Oregon Center of Excellence for ACT (OCEACT) for quality improvement purposes, to help with training and technical assistance for Oregon's ACT programs. For the period ending December 31, 2018, compared to the prior quarter (July through September 2018), the data show a few more individuals receiving ACT services (1,297 compared to 1,288) with a slightly smaller proportion homeless (15% compared to 17%), using the ED (13% compared to 14%), or in jail (7% compared to 8%). They also show a lower number and proportion receiving supported employment services (23% compared to 25%); a higher proportion stably housed (71% compared to 69%); and the same proportion competitively employed (8%) or hospitalized at OSH (2%) or at ACPFs (6%). These numbers will continue to be monitored and reported over the last two quarters of the OPP three-year timeframe.

It should be noted that with the selection of CCOs for the 2020 – 2024 period and the new CCO 2.0 contract language referenced in this Report, OHA is working to increase its staff and capacity to oversee CCOs' performance going forward and is working with CCO Behavioral Health Directors now to clarify performance expectations for the OPP and other behavioral health populations. In addition, OHA is undertaking a complete review and revision of its 309 and 410 regulations covering behavioral health and Medicaid services to be in line with OPP commitments and CCO 2.0 requirements and new statutory obligations. This effort is expected to be completed by January 1, 2020, with public comment now and requested on draft regulations between November 1 – 18, 2019. The CFAA language for CMHPs is also under review to make these documents nimbler on a yearly basis so CMHPs understand their roles and expectations as well. All these efforts are laudable and will help to align Oregon's system to be better able to meet the high intensity needs of the most vulnerable Oregonians.

OHA is also hard at work on a Behavioral Health Quality and Performance Improvement Plan (BHQPIP) that will guide its efforts beyond the timeline of the OPP especially in critical areas of the OPP for which the State is not yet where it committed to be by June 30, 2019. This BHQPIP is important for OHA and Oregon stakeholders to hold themselves accountable for continued systemic improvements in the future.

⁵⁰ See IC Report #4 for a discussion of concerns about these services and numbers.

CONCLUSION

OHA's efforts to date continue to show its commitment to addressing the OPP provisions and indicate a willingness to tackle big issues in consultation with stakeholders and with USDOJ's and the IC's input. Since the last IC Report, USDOJ and OHA met in February 2019 for their second of three annual meetings committed to by OHA. After that meeting, a number of additional materials and information were provided to USDOJ through the IC to assist USDOJ to understand OHA efforts and challenges as well as the status of a number of actions. A meeting was also held in April between USDOJ and OHA to introduce USDOJ attorneys to OHA's new Behavioral Health Director. At this meeting, a brief discussion occurred regarding issues associated with the aid and assist population as they impact OSH and community-based programs and service needs. Legislative efforts in process at that time were also discussed. The outcomes of the 2019 legislative process resulted in increased funding for community restoration efforts as well as a directive to address formula issues for community programs that could have had an adverse impact on community-based services for persons with serious and persistent mental illness. Work to implement this directive will be underway over the next few months.

The OPP represents an ambitious systems and services change undertaking. It contains many commitments, and many have been achieved. However, it remains clear that additional work will be needed over time, beyond the timeframe of the OPP, to meet the overall intent in many OPP areas, and OHA has laid considerable groundwork for these additional efforts. It also remains clear that OHA and USDOJ are both acting in good faith and are equally committed to improvements in Oregon's behavioral health care delivery system.

Appendix B of this IC Report #5 summarizes the status of activity in the three performance outcome areas covered by this Report. The next and last IC Report #6 will assess compliance with all performance outcome areas and the quality and performance improvement section (Section E.) of the OPP.

APPENDIX A

ACRONYMS USED IN OREGON INDEPENDENT CONSULTANT REPORTS

- ACPF – Acute Care Psychiatric Facilities
- ACT – Assertive Community Treatment
- ADA – Americans with Disabilities Act
- ADP – Average Daily Population
- AFH – Adult Foster Home
- A&IPS – Acute and Intermediate Psychiatric Services
- ALOS – Average Length of Stay (or mean)
- AMHI – Adult Mental Health Initiative
- APAC – All Payer All Claims
- AOCMHP – Association or Oregon Community Mental Health Programs
- BH – Behavioral Health
- BHQPIP – Behavioral Health Quality and Performance Improvement Plan
- CCO – Coordinated Care Organizations
- CFAA – County Financial Assistance Award
- CFR – Code of Federal Regulations
- CIE – Competitive Integrated Employment
- CIT – Crisis Intervention Team (or Training)
- CITCOE – Crisis Intervention Team Center of Excellence
- CMHP – Community Mental Health Program
- CMI – Chronic Mental Illness
- CMS – Centers for Medicare and Medicaid Services
- CSG – Council of State Governments
- CY – Calendar Year (from January 1 through December 31)
- DACTS – Dartmouth Assertive Community Treatment Scale
- DPSST – Department of Public Safety Standards and Training
- DSM – Diagnostic and Statistical Manual
- ECIT – Enhanced Crisis Intervention Training
- ED – Emergency Department
- EDIE – Emergency Department Information Exchange
- EHR – Electronic Health Record
- e.g. – For Example
- ENCC – Exceptional Needs Care Coordinator
- EOHSC – Eastern Oregon Human Services Consortium
- FEP – First Episode Psychosis
- FFP – Federal Financial Participation
- FFS – Fee for Service
- FMR – Fair Market Rent
- FPL – Federal Poverty Level
- FY – Fiscal Year (July 1 through June 30)
- GAF – Global Assessment of Functioning
- GOBHI – Greater Oregon Behavioral Health, Inc.
- HIPAA – Health Insurance Portability and Accountability Act
- HPB – Health Policy Board
- HUD – Housing and Urban Development
- IC – Independent Consultant
- ICD – International Classification of Diseases
- ICM – Intensive Case Management
- i.e. – that is
- IMD – Institution for Mental Diseases
- IPS – Individual Placement and Support
- JC – Junction City
- LEDS – Law Enforcement Data System
- LMHA – Local Mental Health Authority
- LPSCC – Local Public Safety Coordinating Council
- LTPC – Long Term Psychiatric Care
- LOS – Length of Stay
- M – Million
- MHAO – Mental Health Association of Oregon MHBG – Mental Health Block Grant
- MHHF – Mental Health Housing Fund (OHCS)
- MHS – Mental Health Services
- MOTS – Measures and Outcomes Tracking System
- MOU – Memorandum of Understanding
- NCQA – National Committee for Quality Assurance
- NOFA – Notice of Funds Availability
- OACP – Oregon Association of Chiefs of Police
- OAHHS – Oregon Association of Hospital and Health Systems
- OAR – Oregon Administrative Rule
- OCA – Office of Consumer Activities
- OCAC – Oregon Consumer Advisory Council
- OCBHJI – Oregon Center on Behavioral Health and Justice Integration
- OCEACT – Oregon Center of Excellence for Assertive Community Treatment
- OCJC – Oregon Criminal Justice Commission
- OEI – Office of Equity and Inclusion
- OHA – Oregon Health Authority
- OHCS – Oregon Human and Community Services
- OHP – Oregon Health Plan
- OPP – Oregon Performance Plan for Adults with Serious and Persistent Mental Illness
- OPRCS – Oregon Patient/Resident Care System
- ORS – Oregon Revised Statutes
- OSECE – Oregon Supported Employment Center for Excellence
- OSH – Oregon State Hospital
- OSJCC – Oregon Sheriff's Jail Command Council
- OSSA – Oregon State Sheriffs Association
- OSU – Oregon State University

- PAITS – Post-Acute Intermediate Treatment Service
- PATH – Projects for Assistance in Transition from Homelessness
- PCP – Person Centered Plan
- PDS – Peer Delivered Services
- PSRB – Psychiatric Security Review Board
- QHOC – Quality Health Outcomes Committee
- QPIP – Quality and Performance Improvement Plan
- QMHA – Qualified Mental Health Associate
- QMHP – Qualified Mental Health Professional
- RAC – Rules Advisory Committee
- RCF – Residential Care Facility
- RFA – Request for Applications
- RFP – Request for Proposals
- ROI – Release of Information
- RTF – Residential Treatment Facility
- RTH – Residential Treatment Home
- RTT – Ready to Transition (also Ready to Place)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- SE – Supported Employment
- § – Section
- SH – Supported Housing
- SIM – Sequential Intercept Model
- SMI – Serious Mental Illness
- SOS – Secretary of State
- SPOC – Single Point of Contact
- SPMI – Serious and Persistent Mental Illness
- SRTF – Secure Residential Treatment Facility
- SSI – Supplemental Security Income
- TA – Technical Assistance
- TAC – Technical Assistance Collaborative, Inc.
- TMACT – Tool for Measurement of Assertive Community Treatment
- UNK – Unknown
- USC – United States Code
- USDOJ – United States Department of Justice
- w/ – with
- w/in – within

APPENDIX B
SUMMARY OF STATE OF OREGON'S COMPLIANCE WITH OPP PROVISIONS ADDRESSED IN IC REPORT #5

Blue Shading Indicates Compliance as of Report Date

Yellow Shading Indicates Efforts at Compliance Underway But Not Yet Fully Completed, Timeline Not Yet Reached, or Unknown

Pink Shading Indicates Non-Compliance as of Report Date

OPP PROVISION NUMBER & TOPIC	GOALS & ACTIONS COMMITTED TO IN OPP	BASELINE CY 2015	COMPLIANCE STATUS 6/30/18 (OHA data through 12/31/18)
ACUTE PSYCHIATRIC CARE			
27. Discharges from acute care psychiatric facilities (ACPF) have documented linkages to BH care	All except transfers to OSH have documented linkages to timely, appropriate behavioral health care in community prior to discharge	N/A	IN COMPLIANCE
27. Discharges from acute care psychiatric facilities (ACPF) have documented linkages to primary health care	All except transfers to OSH have documented linkages to timely, appropriate primary health care in community prior to discharge	N/A	IN PARTIAL COMPLIANCE
28. Enroll all/substantially all individuals w/ SPMI in Medicaid prior to discharge	Aggressive enrollment strategies (See #39)	N/A	IN COMPLIANCE Hospitals have incentive to help enroll in order to bill; low proportion of uninsured suggests success
29a – c. % receiving a “warm handoff” from ACPFs	Receiving Warm Handoff By 6/30/17 – 60% By 6/30/18 – 75% By 6/30/19 – 85%	N/A	NOT IN COMPLIANCE 30% Updated guidance document released and distributed in August
29. Track and report percentage of individuals refusing a “warm handoff” from an ACPF	Aggregate data by ACPF, quarterly beginning with 2 nd Q FY 2017 (Oct 1 to Dec 31, 2016)	N/A	IN COMPLIANCE to report 4.1%
30. Require and report # discharged from ACPFs receiving a follow-up visit w/ CMH provider w/in 7 days	Report w/o Goals	79.4%	IN COMPLIANCE to report but % going down – 74.1% (95 th percentile nationally)
31a. 30 & 180-day rates of readmission, by ACPF	Report w/o Goals, but with a goal to reduce recidivism	30 days – 9.2% 180 days – 21.3%	NOT IN COMPLIANCE WITH REDUCING RECIDIVISM , although in compliance with reporting; 30 days – 11.6% 180 days – 23.5% WORKING TOWARD COMPLIANCE In CCO 2.0 contract language

OPP PROVISION NUMBER & TOPIC	GOALS & ACTIONS COMMITTED TO IN OPP	BASELINE CY 2015	COMPLIANCE STATUS 6/30/18 (OHA data through 12/31/18)
31.b. Report # w/ 2+ admissions in six-month period	Report w/o Goals	N/A	IN COMPLIANCE 302 (down from 346)
31b. Contacting/offering services to individuals w/ 2+ readmissions to ACPF in a six-month period, to avoid unnecessary readmissions	Management Plan	N/A	WORKING TOWARD COMPLIANCE In OAR and CCO 2.0 contract language
32. Assess housing needs of individuals with SPMI who have 2+ readmissions in six-month period & refer to housing agency/services	Housing assessments for individuals with SPMI w/ 2+ readmissions in 6 months	N/A	UNABLE TO DETERMINE FROM DATA AVAILABLE
33. May use interim housing for individuals in #32	(See #26)	(See #26)	N/A
34. Assess housing needs of SPMI individuals in ACPFs	Require ACPFs to consult w/ CCOs in developing assessment & notify individual's community provider re plan for housing	N/A	WORKING TOWARD COMPLIANCE CCOs, Choice, & CMHPs facilitate these efforts; in CCO 2.0 Contract
35. Avg length of stay of SPMI individuals in ACPFs; # w/ LOS >20 days	Report w/o Goals	ALOS – 8.9 days # >20 days – 385	IN COMPLIANCE with reporting ALOS – 10.8 days # >20 days – 464 (# admissions also up)
EMERGENCY DEPARTMENTS			
37. Boarding data analysis conducted and presented to legislature.	Boarding Study showing # using EDs; Reasons for staying >23 hrs w/ solutions presented to Legislature & USDOJ	N/A	IN COMPLIANCE
37. Boarding data collection & use of data to initiate community strategies re SPMI using EDs for MH reasons	Fall 2016, begin community-based strategies	N/A	WORKING TOWARD COMPLIANCE OAHHS now collecting data; working on sharing with OHA
38. SPMI individuals connected to services at time of leaving EDs	Initiate strategies to increase # connected; Track data to measure effectiveness	N/A	NOT IN COMPLIANCE
39. Continue enrolling indigent in Medicaid prior to discharge from EDs	Aggressive enrollment efforts (See #28)	N/A	IN COMPLIANCE (see #28)
40a. # SPMI individuals w/ ≥2 readmissions to emergency departments (EDs) in a 6-mo period	Report w/o Goals	1,067	IN COMPLIANCE # declining to 717

OPP PROVISION NUMBER & TOPIC	GOALS & ACTIONS COMMITTED TO IN OPP	BASELINE CY 2015	COMPLIANCE STATUS 6/30/18 (OHA data through 12/31/18)
40b. Address needs of SPMI individuals w/ ≥2 readmissions to EDs in 6-mo period	Collaborative efforts w/ CMHPs/CCOs to implement plans & contract amendments w/ CCOs to require ACPFs to develop and implement plans	CMHP contract revisions for 2019 - 2021; CCO 2.0 contract revised for 2020 – 2024	IN COMPLIANCE
41 a – b. Rate of visits by SPMI individuals to general EDs for MH reasons	FY2017 – ↓ 10% (1.4 / 1,000) FY2018 – ↓ 20% (1.2 / 1,000)	1.5 / 1,000 members	IN COMPLIANCE w/ Year Two Goal – (1.37 / 1,000)
42. Use of EDs by individuals w/ SPMI	Meet w/ Independent Consultant (IC) to discuss	N/A	IN COMPLIANCE
43. Data collection re individuals w/ SPMI in EDs >23 hrs	Work w/ hospitals on data collection strategy; By July 2017 – begin reporting by Q, by region (or by hospital if possible)	N/A	WORKING TOWARD COMPLIANCE OAHS now collecting data; working on sharing with OHA; strategies not yet developed, pending data discussions

SECURE RESIDENTIAL TREATMENT FACILITIES

49a. & 50. Expediently move civilly committed individuals in SRTFs to more appropriate community settings when they no longer need to be in SRTFs	Expediently move individuals no longer needing a secure setting to a community placement in most integrated appropriate setting	N/A	IN COMPLIANCE
49a. Move civilly committed individuals in SRTFs to community settings consistent with informed choice and preferences	Consistency with informed choices	N/A	IN PARTIAL COMPLIANCE
49b. (i – ii) and c. Seek to reduce LOS of civilly committed individuals in secure residential treatment facilities (SRTFs); report ALOS	FY2017 – ↓ 10% – 572 days FY2018 – ↓ 20% – 510.2 days	638.0 days	NOT IN COMPLIANCE 673.6 days
49c. Report # in SRTFs, LOS, & # discharged, and dispositions	Report 3 data points w/o Goals; Beginning 7/1/17 – collect data identifying type of placement at discharge	N/A for dispositions; see 49b. for LOS	IN COMPLIANCE w/ reporting

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