CCO Behavioral Health Report
July-December 2020
Measures of Behavioral Health Service Delivery

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Contents

Acknowledgments

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Executive Summary

Since its inception in 2012, Oregon's unique coordinated care model has made progress on the Triple Aim goals of better health, better care, and lower costs. The Oregon Health Plan (OHP), which is Oregon's version of Medicaid, is the source of health coverage for approximately one million Oregonians. The OHP and its Coordinated Care Organizations (CCOs) have improved access to primary care and reduced costly Emergency Department (ED) visits. However, there is still work to do to ensure all Oregonians have access to comprehensive behavioral health services.

As of the date of the publication of this report, there are 12 CCOs with 16 different service areas, each represented by a separate contract.

This document is the second semi-annual Behavioral Health Report (BHR) describing the Contract Year (CY) 2020 activities of Oregon's CCOs on behavioral health measures as required by the CCO contract. This report covers the period from 7/1/2020 through 12/31/2020. The first semi-annual report covering 1/1/2020 through 6/30/2020 is available online: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/CCO-BH-Service-Delivery-0321.pdf

This report aims to assess quality and access to care and hold CCOs accountable for progress on key metricsThe first semi-annual report served as a baseline for the following areas: 1) network adequacy and provider capacity information; 2) access to care as measured by timely prior authorizations for specific services; 3) a variety of behavioral health measures designed to assess the quality of and access to behavioral health services provided to members; and 4) assessment and comparison of CCO performance. This second semi-annual report and subsequent reports will examine progress in these key areas.

Emergency measures instituted due to the ongoing COVID-19 pandemic have impacted the entire healthcare system, especially the mental health system nationwide, and Oregon is no exception. Staff shortages, overcrowded hospitals, EDs, and increased demand for services due to secondary COVID impacts have stressed the delivery system almost to the breaking point.

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

OHA would like to thank the state's CCOs, Community Mental Health Programs (CMHPs), and community providers for their perseverance and dedication in serving some of Oregon's most vulnerable citizens during these trying times.

OHA also acknowledges the hard work and sacrifice of its employees: Oregon State Hospital staff and OHA office and field staff, many of whom were given additional COVID-related duties in addition to their regular workloads. Thank you for all you do.

Measures Reported by CCOs

Summary

This report is the second semi-annual report describing the progress of Oregon's CCOs in CY 2020 regarding certain behavioral health services. The purpose of this BHR is threefold. First, it allows OHA to exercise oversight of CCO activities and hold them accountable for fulfilling the provisions of the CCO contract. Second, it is a tool to help inform where system strengths and gaps exist and to aid in the formulation of quality improvement activities. Lastly, it is another opportunity for collaboration between CCOs and OHA to develop processes to serve Oregon's most vulnerable citizens better.

Coordinated Care Organizations

A CCO is a Managed Care Entity utilizing a network of physical, behavioral, and oral health providers that have agreed to work together in their local communities to serve people enrolled with the CCO for OHP services. There are currently 16 contracts through which CCOs serve over one million individuals on the OHP.

map.pdf

OHA signed CCO 2.0 contracts with CCOs to operate in communities across Oregon beginning on January 1, 2020. CCOs have the flexibility to create processes and systems that serve each community's unique needs. CCOs are provided with global budgets, allowing them to offer non-OHP covered services alongside OHP-covered benefits with the goal of meeting the Triple Aim of better health, better care, and lower costs. Additional priorities for the CCO 2.0 contract are focusing on Social Determinants of Health and equity, increasing value and pay for performance, and maintaining sustainable cost growth. This report serves to assess how completely the CCOs are achieving this goal for behavioral healthcare.

Medicaid Waiver

State Medicaid programs provide health care coverage for people earning less than 138% of the federal poverty level, and people who are aged, blind or experiencing disabilities. They are administered by individual states but must follow certain federal requirements. States may obtain an 1115 Medicaid Demonstration waiver from the federal government through the Centers for Medicare & Medicaid Services (CMS), which grants extra flexibility in how Medicaid funds are administered. Oregon has had an 1115 OHP Demonstration waiver since 1994. The 1115 OHP Demonstration waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include using best practices to manage and coordinate care; transparency in price and quality; paying for better quality care and better health outcomes; shared responsibility for health; sustainable rate of growth; and measuring performance.

In addition to the existing 1115 OHP Demonstration waiver, CMS approved Oregon's Substance Use Disorder (SUD) 1115 Demonstration waiver, effective April 8, 2021, through March 31, 2026. This SUD waiver complements and expands Medicaid services and supports covered by the 1115 OHP Demonstration waiver. A central part of the SUD waiver is enhancing residential treatment services as a crucial component in the continuum of substance use addiction benefits. It accomplishes this by permitting Oregon to receive federal funding for Medicaid services for individuals with a substance use disorder in residential treatment facilities with more than 16 beds.

This new federal funding, along with the resources provided in the Governor's Budget for 2021-23, allows for more significant investment in Oregon's vision to prevent, identify, and treat people with substance use disorder and help them sustain long-term recovery.

The other major component of the waiver increases the service array for OHP members with substance use disorders, including Community Integration Services composed of housing and employment reintegration skills training to assist individuals transition back into the community from inpatient residential levels of care.

Coordinated Care

A CCO is a network of health care providers (physical, behavioral, and oral health care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the OHP Medicaid. CCOs can better coordinate services and focus on prevention, chronic illness management, and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP-covered benefits with the goal of meeting the Triple Aim of better health, better care and, lower costs for CCO members. Before Oregon's CCOs were formed, physical, behavioral, and oral health care were not integrated, making it more difficult for patients and providers to coordinate care and more expensive for the state.

The Current State of Medicaid Expansion

As of December 2021, more than 1.1 million Oregon residents have OHP coverage through CCOs. The impact of COVID presented significant challenges to providing accessible coordinated services across the state. Workforce shortages, overtaxed medical services, quarantines, and "lockdowns" all played a part in hampering the provision of behavioral health services.

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

Behavioral Health Contract Updates

The CCO 2.0 contract holds CCOs accountable for developing a person-centered behavioral health system that members can count on, no matter who they are or where they live. The contract requires CCOs to:

- Administer behavioral health services, programs, and activities in the most integrated setting appropriate to the needs of members
- Assess the capacity of comprehensive services
- Address timely prior authorization and network adequacy issues that limit member choice and access to treatment
- Expand programs that integrate primary care into behavioral health
- Support electronic health record adoption and access to electronic health information
- Develop a diverse and culturally responsive workforce; and
- Ensure children who have behavioral health needs have access to appropriate services.

The CCO 2.0 contract requires CCOs to improve care for OHP members and hold down cost increases in Oregon's Medicaid program. The contracts represent the largest procurement in state history, totaling more than $6 billion for CY 2020.

Measure Development

The measures in this report are designed to assess the quality of certain services and access to behavioral health care. The CCO contract and relevant Oregon Administrative Rules served as the foundational documents for this report. OHA initiated most of these measures and is committed to working with CCOs on continuous process improvement. Data for measures in this report were submitted by CCOs or provided by OHA's Health Policy and Analytics unit.

Continuing Effects of the COVID-19 Pandemic

OHA declared a Public Health Emergency (PHE) in March 2020 as a response to the effects of the COVID-19 pandemic. OHA provided $25 million to support community partners as they prepared for an increased demand for physical and behavioral health needs. OHA encouraged CCOs and other community partners to use telehealth options. CCOs were asked to inform their members and provider networks about these options. Some CCOs also used funds to purchase necessary equipment for members so they could participate in video or telephone-based services. These efforts were implemented to make sure members had access to care while containing the spread of the virus.

As a result of the PHE, OHA has suspended some reporting requirements for CMHPs and other community partners to support them in focusing all efforts on addressing the needs of the community. This data suspension resulted in the omission of some data elements in this report (Appendix A). Subsequent reports will include additional data as it becomes available. Appendix A has the complete list of data elements the report will eventually include.

Report Highlights

One purpose of the BHR, as described in Exhibit M, Section 20 of the CY 2020 CCO contract, is to examine the quality of care and access to behavioral health services throughout the state. This second semi-annual report for CY 2020 continues analysis and discussion of information included in the baseline report and examines the following areas:[1] Future reports will address the entire calendar year.

- Access to care as measured by timely prior authorizations
- Specific behavioral health measures designed to assess the quality of behavioral health services provided to members
- Analysis and comparison of CCO performance
- Opportunities for performance improvement

This report provides each CCO with a view on how its performance compares to its peers on certain elements. The initial report served as a baseline for these measures. OHA is working with CCOs to address performance improvement issues and refine processes.

Data for each reporting area is compared to the requirements in the CCO contract. This report includes measures for the following:

- Cost and utilization of behavioral health services.
- Timely processing of prior authorizations for the following services: youth substance use disorder residential services, adult substance use disorder residential services, adult detoxification residential services, and youth mental health residential services.
- Wraparound Services: The Wraparound process is an intensive, individualized care management process for youths with serious or complex needs. Wraparound was initially developed in the 1980s to maintain youth with severe emotional and behavioral problems in their home and community. This

[1] Network adequacy and provider capacity information is a metric still being developed.

metric tracks the number and percentage enrolled in Wraparound services with data broken down by race, ethnicity, and language.

- Measures for adults with Serious and Persistent Mental Illness (SPMI) include Assertive Community Treatment, Supported Employment Services, warm handoffs, peer-delivered services, acute psychiatric facilities, and ED utilization.

Future Reports

Results from the initial reporting period (1/1/2020-6/30/2020) were used for the baseline for all metrics. The CCO contract requires CCOs to be in 100% compliance with the measures described in this report. OHA is working with CCOs and other external partners to remove barriers to success and improve outcomes. Future reports will examine successful strategies CCOs may share to improve service provision.

Cost and Utilization of Behavioral Health Services

Cost and utilization data are analyzed to improve health equity and access to services. This data will aid in analyzing and controlling costs as well as help determine how resources are assigned.

Comments and Analysis

The following data was based on paid outpatient and professional claims for behavioral health services on the OHP Prioritized List in 2020. The data was extracted from DSSURS in May 2021, and it does not include inpatient or pharmacy claims.

This section provides the following calculations:

- Estimated prevalence counts based on the number of members with a primary, secondary, tertiary, or detailed diagnosis for a behavioral health disorder in claims.
- The percent served calculates the percent of persons in the prevalence estimate who received services for that disorder.
- The service per 1,000 member months counts encounters paid for services for behavioral health disorders per 1,000 member months.

There were 34 Behavioral Health conditions — each on a separate line — included in the 2020 Prioritized List. The table below provides information on the top 10 behavioral health conditions based on estimated prevalence counts.

Top Ten Behavioral Health Conditions

Top 10 Disorders by Estimated Prevalence	Prevalence Count	Percent Served	Services/ 1,000 MM
Line 414 OVERANXIOUS; GENERALIZED ANXIETY DISORDER	110,830	60.4%	24.1
Line 7 MAJOR DEPRESSION	86,548	65.8%	26.3
Line 5 TOBACCO DEPENDENCE	82,925	19.2%	1.6
Line 4 SUBSTANCE USE DISORDER	69,805	68.9%	133.8
Line 444 ADJUSTMENT DISORDERS	58,377	64.3%	20.6
Line 173 POSTTRAUMATIC STRESS DISORDER	43,162	84.9%	32.3
Line 121 ATTENTION DEFICIT/HYPERACTIVITY DISORDERS	33,904	80.6%	12.0
Line 26 BIPOLAR DISORDERS	23,509	73.7%	12.2
Line 203 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE	21,627	66.0%	6.2

Line 22 SCHIZOPHRENIC DISORDERS	**13,880**	**81.7%**	**16.7**

The following table provides information about all behavioral health conditions on the Prioritized List for persons of all ages. This includes the percentage of members with a behavioral health diagnosis in any of the first three diagnoses or on the detailed diagnosis (estimated prevalence); the percentage of the prevalence population who received treatment services based on billing codes on the Prioritized List; and the total services per 1,000 member months.

Behavioral Health Conditions on the Prioritized List (persons of all ages)

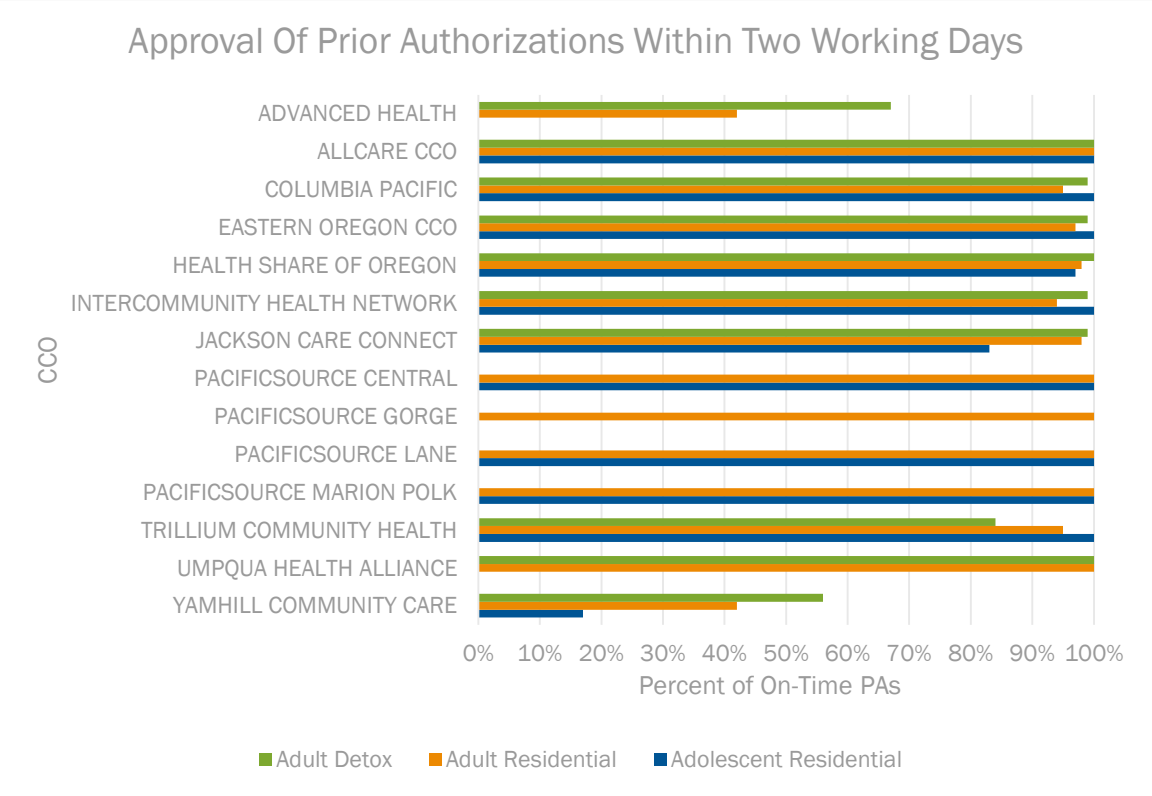
Plan Name	Estimated Prevalence	Percent Served	Services/ 1,000 MM
ADVANCED HEALTH	31.5%	64.1%	283.6
ALLCARE CCO	27.0%	63.5%	267.1
CASCADE HEALTH ALLIANCE	30.0%	68.3%	310.7
COLUMBIA PACIFIC	31.0%	69.0%	291.2
EASTERN OREGON CCO	26.6%	66.8%	205.6
HEALTH SHARE OF OREGON	28.9%	72.1%	407.6
INTERCOMMUNITY HEALTH NETWORK	30.8%	70.3%	302.1
JACKSON CARE CONNECT	30.5%	72.9%	358.8
OPEN-CARD / FEE-FOR-SERVICE	9.3%	53.4%	95.2
PACIFICSOURCE CENTRAL	32.8%	72.7%	382.8
PACIFICSOURCE GORGE	25.8%	72.2%	211.1
PACIFICSOURCE LANE	33.8%	75.5%	403.5
PACIFICSOURCE MARION POLK	26.8%	73.1%	375.4
TRILLIUM COMMUNITY HEALTH	32.1%	74.3%	488.9
UMPQUA HEALTH ALLIANCE	36.2%	66.9%	342.1
YAMHILL COMMUNITY CARE	26.3%	71.9%	283.0
Overall Figures	**27.3%**	**70.2%**	**313.6**

Prior Authorizations for Substance Use Disorder Services

CCOs reported information on prior authorizations (PAs) pertaining to the following SUD services: a) residential treatment for youth, b) residential treatment for adults, and c) residential withdrawal management for adults. Per the contract, CCOs have discretion whether to require PA for these SUD services. If a CCO requires PA for these services, OAR 410-141-3835 requires the CCO to decide 95% of them within two working days. Cascade Health Alliance (CHA) does not require PA for these services and is not included in the PA measures.

The table below summarizes PA data for these three services. The table shows reported percentages of PA that are approved within two working days.

- ***SUD residential treatment for youth:*** Of the 14 CCOs that require PA, nine CCOs performed at 97%-100%, with eight of those CCOs achieving 100%. One CCO achieved an 83% on-time rate, and the other CCO reported a 17% authorization rate within two working days. Three CCOs reported that their members did not require this service.
- ***SUD residential treatment for adults:*** Of the 14 CCOs that require prior authorizations, 12 CCOs achieved 94% through 100% timely approvals, with six achieving 100%. Finally, two CCOs achieved a 42% timely authorization rate. One CCO reported zero PAs.
- ***Residential detoxification and withdrawal management for adults:*** Only three CCOs achieved a 100% compliance rate for PAs for this service. Four CCOs achieved 99% PA rates. The remaining three CCOs achieved 87%, 67%, and 56%, respectively.



Reporting Period: 7/1/2020 through 12/31/2020. Data Source: CCO BHR Submission.

Comments and Analysis

Nearly all CCOs showed improvements in timely PAs for all categories during the second half of the calendar year. This is commendable, especially considering the ongoing impacts of COVID and the attendant crowding, delays, and staff shortages. Through improved performance, CCOs have demonstrated their understanding of how necessary speedy authorizations are for increased treatment engagement and acceptance. CCOs have several resources at their disposal to improve authorization rates. Communication platforms such as Collective help staff from different agencies work together to successfully engage individuals in the treatment process. CCOs have also worked with community providers to improve the quality of documentation submitted for treatment approval. The better the documentation submitted for approval, the faster the CCO can approve treatment.

Accomplishments and Challenges

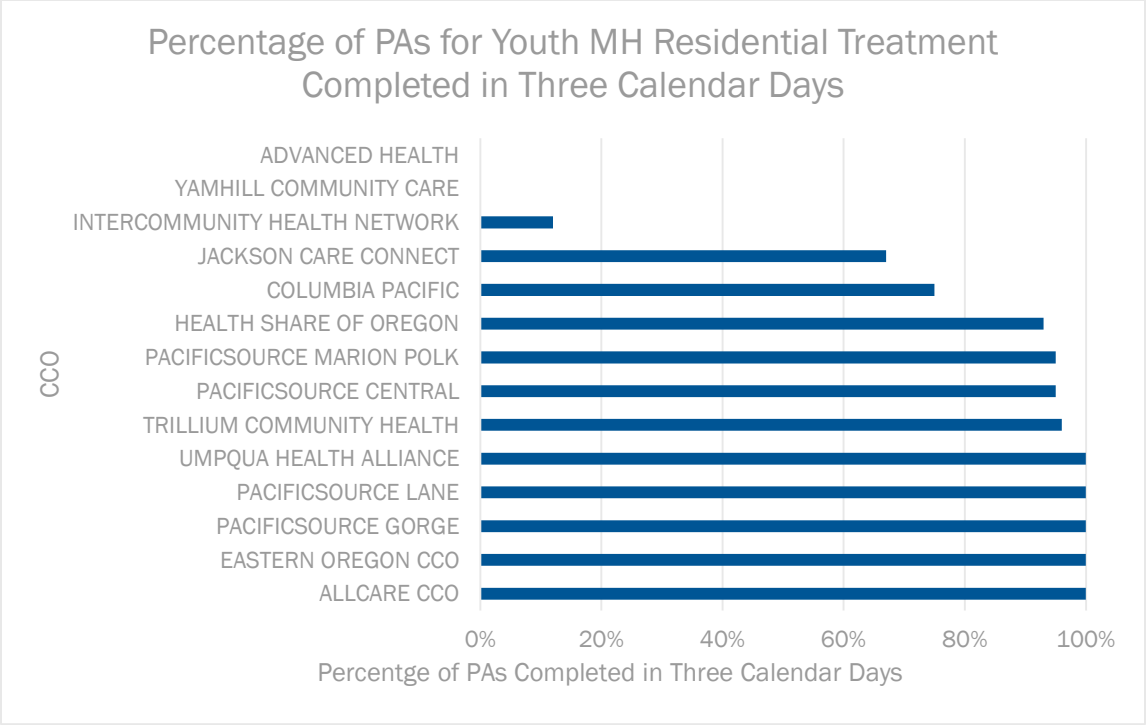
CCOs reported the following successful strategies to increase timely PAs: As previously noted, CHA does not require PA for these SUD services, which facilitates rapid initiation of treatment. Several other CCOs are planning to initiate a process for instant approval, with retrospective review to ensure treatment criteria were met. For CCOs that require PAs, having robust care coordination and transparent processes significantly expedite approvals.

CCOs identified two principal challenges to timely decision-making on PAs: difficulty reaching hospital/treatment center staff and hospitals/treatment facilities submitting insufficient documentation for review. CCOs regularly meet with providers to provide training and technical assistance with documentation.

Prior Authorizations for Youth Mental Health Residential

CCOs are required by contract to decide 100% of PAs for mental health residential services for youth within three calendar days. Of the 14 CCOs that require PA for these services, nine CCOs achieved 93%-100%, with five CCOs achieving 100%. Two CCOs reported 67%-75%, and one CCO reported 12%. One CCO reported that none of its members required this service. This is a substantial improvement in PA since the last reporting period, especially considering the disruptions to the system imposed by COVID. Timely PAs are essential to avoid delays in starting treatment. Most families seeking to admit a child to residential treatment do so as a result of being in crisis, and any delay in approving and initiating treatment could have severe consequences for the family.

The table below summarizes PA data for youth mental health residential treatment, showing percentages of those who received prior authorizations in three calendar days.



Reporting Period: 7/1/2020 through 12/31/2020. Data Source: CCO BHR Submission.

Comments and Analysis

Nearly all CCOs showed improvements in timely PAs for all categories. This is commendable, especially considering the ongoing impacts of COVID and the attendant crowding, delays, and staff shortages. Through improved performance, CCOs have demonstrated their understanding of how necessary speedy authorizations are for increased treatment engagement and acceptance. CCOs have a several resources at their disposal to improve authorization rates. Communication platforms such as Collective help staff from different agencies work together to successfully engage individuals in the treatment process. CCOs have also worked with community providers to improve the quality of documentation submitted for treatment approval. The better the documentation submitted for approval, the faster the MCO can approve treatment.

As stated above, COVID has presented significant challenges to daily operations. Despite this, CCOs improved performance in this area. All CCOs have made timely authorizations a priority. The longer it takes to initiate treatment, the greater the chance the individual will not engage in treatment.

Most CCOs were able to process PAs within specified timeframes. Successful strategies reported were educating providers regarding the required documentation and having consistent staff interaction with providers. All Pacific Source regions stopped requiring PAs in March 2020 as a COVID relief measure.

Challenges reported by CCOs were staff turnover and shortages due to COVID and providers not sending enough/correct documentation to allow for authorization of treatment. OHA plans to follow up with CCOs having low rates of timely PAs, providing technical assistance as needed, and collaborating on solutions.

Accomplishments and Challenges

CCOs reported the following successful strategies to increase timely PAs: CHA does not require PA, which facilitates rapid initiation of treatment. Several other CCOs are planning to initiate a process for instant

approval, with retrospective review to ensure treatment criteria were met. For CCOs that require PAs, having robust care coordination and transparent processes significantly expedite approvals.

CCOs identified two principal challenges to timely authorizations: difficulty reaching hospital/treatment center staff and hospitals/treatment facilities submitting insufficient documentation for review. CCOs regularly meet with providers to provide training and technical assistance with documentation.

Wraparound

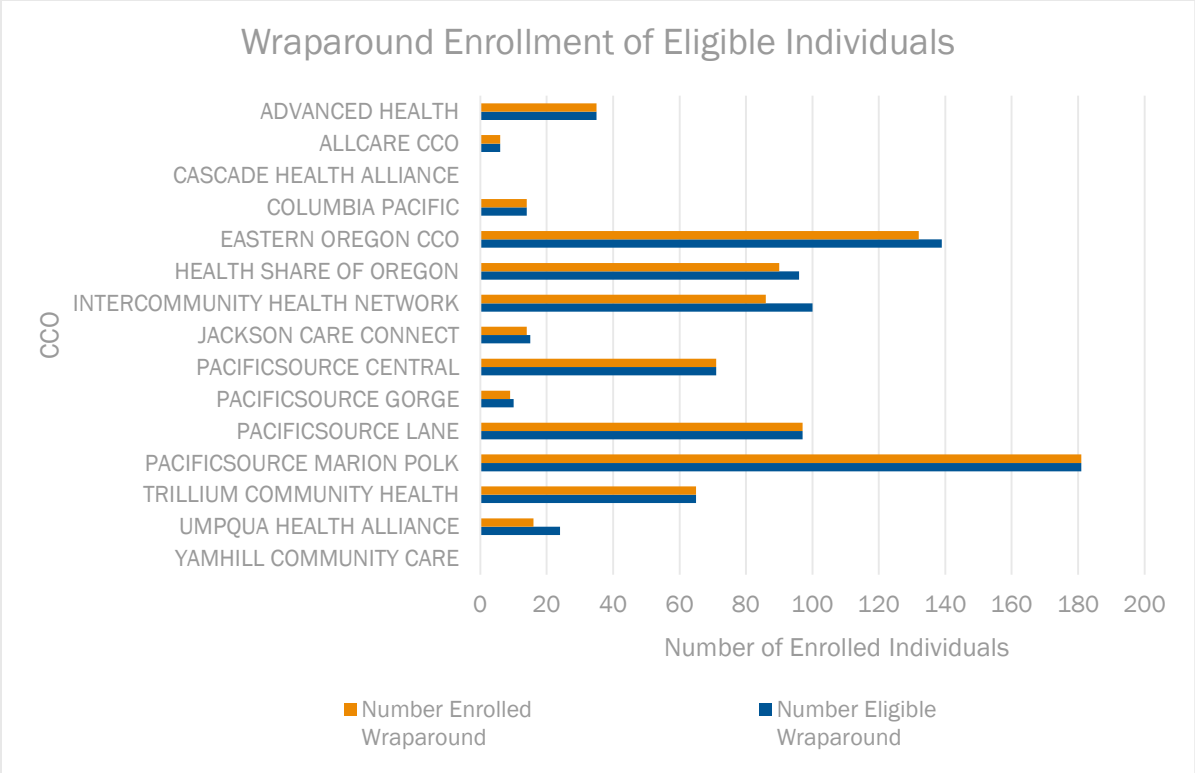
Fidelity Wraparound is a team-based planning process involving a member 0-17 years of age (or members who continue receiving Wraparound services from 18-25 years of age) and the member's Family, with the goal to keep or re-establish youth in homes with their families. Children and youth ages 0-17 who experience complex mental health issues and are involved in mental health and one other system (e.g., foster care, special education, juvenile justice, intellectual/developmental disability programs) are eligible for Wraparound services. Once eligible for Wraparound, children and youth may receive services through age 25.

Wraparound Enrollment for Eligible Youth

CCOs are required to provide Wraparound services for all children and young adults who meet the criteria. If a CCO lacks provider capacity to provide Wraparound, the CCO must notify OHA and develop a plan to increase capacity. Lack of capacity may not be a basis for eligible members to be placed on a waitlist for Wraparound.

CCOs report Wraparound enrollment numbers and percentages, defined as the number enrolled in wraparound services from among those determined to meet criteria, divided by the number who met criteria for Wraparound services. The reporting period is determinations made from July 1, 2020, through December 31, 2020. This data includes total enrollment, and enrollment by race, ethnicity, and language.

This measure shows CCO enrollment of individuals in Wraparound services by identifying the number of eligible youths enrolled in Wraparound services.

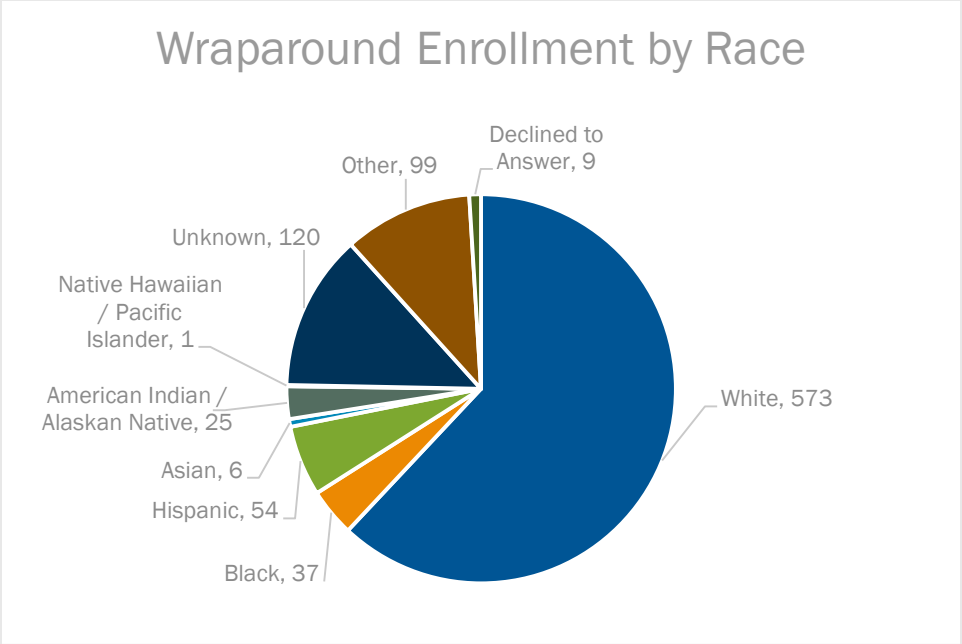


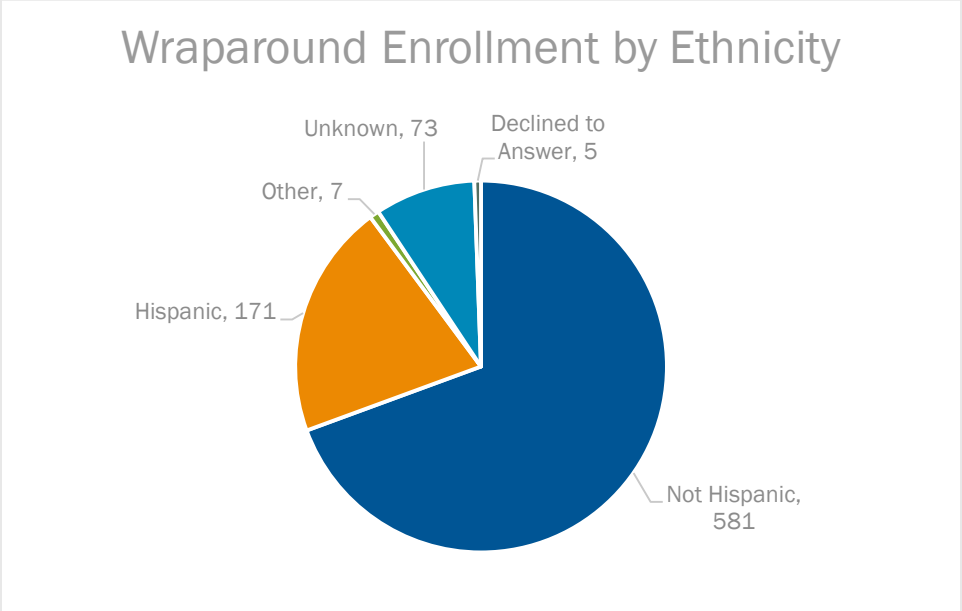
Reporting Period: 7/1/2020 through 12/31/2020. Data Source: CCO BHR Submission.

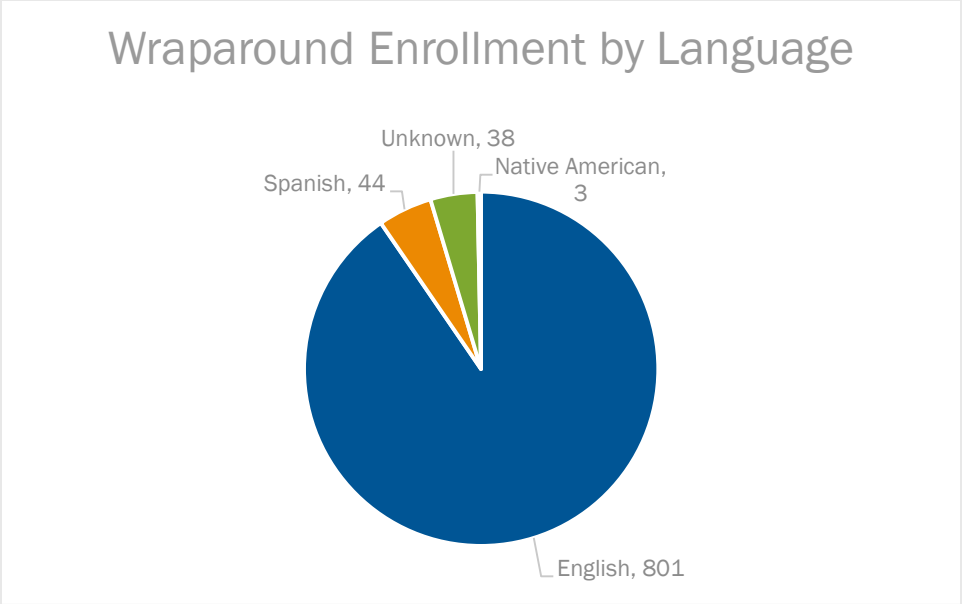
Wraparound Race, Ethnicity, and Language

Understanding the diversity of those served by the CCO can inform the CCO regarding diversity and health equity activities. Noting the primary language of those served can inform the CCO whether more diversity/bilingualism in personnel is needed. The demographic analysis will help identify underserved populations and help inform efforts to increase access to treatment.

Below are high-level graphs to visually illustrate these demographics. More detailed charts can be found in Appendix B.


Wraparound Enrollment by Race
Declined to Answer, 9
Other, 99
Unknown, 120
Native Hawaiian / Pacific Islander, 1
American Indian / Alaskan Native, 25
Asian, 6
Hispanic, 54
Black, 37
White, 573


Wraparound Enrollment by Ethnicity
Unknown, 73
Declined to Answer, 5
Other, 7
Hispanic, 171
Not Hispanic, 581



Reporting Period: 7/1/2020 through 12/31/2020. Data Source: CCO BHR Submission.

Comments and Analysis

For this reporting period (7/1/2020 through 12/31/2020), twelve CCOs enrolled 90% or more of eligible youth in services. The three CCOs that did not achieve at least 90% enrollment were IHN with 86%, Umpqua with 67%, and CHA with 47%. Reasons cited for the lower scores include individuals declining Wraparound, families moving before services can be initiated, access problems in more rural areas, and the demands placed on the system by the pandemic.

The CCO Comprehensive Behavioral Health Plan (CBHP) submitted in July 2021 detailed CCO service area demographics and behavioral health service rates. Along with this report, the CBHP provides a comprehensive look at service equity issues and access to services. OHA plans on publishing this document sometime in the coming months. CCOs have been diligent in outreach to diverse populations. Providing culturally appropriate services to members is a high priority for all CCOs. Each CCO engages in outreach to diverse racial, ethnic, and LGBTQ communities. OHA, the CCOs, and our community partners have committed to constantly improving culturally appropriate, accessible behavioral health services with a commitment to ensuring health equity for all Oregonians.

Accomplishments and Challenges

Several strategies identified by CCOs to increase enrollment for underrepresented populations include comprehensive promotion and information campaigns aimed at community groups, tribes, treatment partners, law enforcement, schools, Peer Run Organizations, etc. Other successful strategies are ensuring a diverse workforce, having a dedicated team of “specialists,” and creating as many “right doors” for initiating treatment as possible.

The effects of the pandemic, difficulty in finding culturally diverse staff, lack of sufficient technology for members to engage in telehealth have all been cited as challenges to increasing the number of individuals from underrepresented populations in Wraparound services.

CCO Reporting Measures for Adults with Serious and Persistent Mental Illness

Assertive Community Treatment

Assertive Community Treatment (ACT) is an evidence-based practice designed to provide comprehensive treatment and support services to adults diagnosed with SPMI. Services are to be provided in the most integrated community setting possible. A multidisciplinary team provides the complete range of ACT services. CCOs are required to assess members with SPMI to determine eligibility for ACT services. A provider or care coordinator then meets with the member to discuss ACT services and provide information to support the member in making an informed choice regarding participation. This information must include a description of ACT services, how to access ACT services, an explanation of the role of the ACT team, how supports can be individualized based on the member's self-identified need, and ways the ACT team can enhance a member's care and support independent community living.

Availability of ACT services can assist individuals in maintaining community tenure and can lead to reduced utilization of more restrictive levels of care, including involvement in the justice system. Not all individuals with SPMI want or need ACT services, but members who qualify for and desire ACT services shall be added to a waitlist if no program is available in the member's service area. If a CCO cannot provide ACT services, it is the responsibility of the CCO to notify OHA and develop a plan to increase capacity. Lack of capacity may not be a basis for eligible members to be denied ACT services. When a member is denied ACT services, it is the responsibility of the CCO to issue a Notice of Adverse Benefit Determination to the member, detailing steps for the member to file an appeal.

The table below identifies the number of members with SPMI per CCO as well as the number and percentage of individuals enrolled in ACT services.

	SPMI		ACT	
CCO	**Number**	**%**	**Number**	**%**
ADVANCED HEALTH	1,760	1.7%	21	1.2%
ALLCARE CCO	3,005	2.9%	54	1.8%
CASCADE HEALTH ALLIANCE	1,718	1.7%	68	4.0%
COLUMBIA PACIFIC	2,087	2.0%	46	2.2%
EASTERN OREGON CCO	3,598	3.5%	92	2.6%
HEALTH SHARE OF OREGON	27,938	27.0%	321	1.1%
INTERCOMMUNITY HEALTH NETWORK	4,858	4.7%	66	1.4%
JACKSON CARE CONNECT	3,786	3.7%	36	1.0%
PACIFICSOURCE CENTRAL	4,715	4.6%	35	0.7%
PACIFICSOURCE GORGE	811	0.8%	13	1.6%
PACIFICSOURCE LANE	6,523	6.3%	42	0.6%
PACIFICSOURCE MARION POLK	7,182	7.0%	85	1.2%
TRILLIUM COMMUNITY HEALTH	3,677	3.6%	27	0.7%
UMPQUA HEALTH ALLIANCE	2,548	2.5%	25	1.0%
YAMHILL COMMUNITY CARE	1,896	1.8%	30	1.6%
OPEN-CARD / FEE-FOR-SERVICE	27,214	26.3%	92	0.3%

TOTAL	**90,896**	**100%**	**1,002**	**1.1%**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source: MMIS.

Comments and Analysis

ACT is the most comprehensive community treatment available. Oregon has set a standard statewide rate for ACT enrollment of 47/100,000 individuals. OHA believes this is the minimum ratio for ACT enrollment amongst the general population. As of 12/31/2020, the Oregon Center of Excellence for Assertive Community Treatment estimated ACT programs have the capacity to serve 1,504 individuals statewide. As of 12/31/2020, the ACT enrollment statewide, including non-Medicaid funded individuals, was 1,395, slightly over 90% of capacity. Considering the pandemic's strain placed on the system, this slight increase since the last reporting period in enrollment is a direct reflection of CCOs and other community partners' commitment to providing community integrated services to people experiencing SPMI. Oregon's goal for FY 2021 (by June 30, 2021)[2] is 1,400 individuals in ACT.

Accomplishments and Challenges

Strategies identified by the CCOs as being successful in increasing/maintaining ACT enrollment include: utilizing value-based contracting to ensure timely access to and capacity for a full spectrum of services including ACT; thoughtful collaboration and communication between contractors to provide comprehensive case coordination and maintain treatment engagement; and providing technical assistance to providers to maintain fidelity and comprehensive services. Some challenges identified by the CCOs include: insufficient affordable/low barrier housing for individuals with SPMI, which makes treatment and recovery more difficult; members needing simultaneous SUD services; members declining ACT services; and workforce shortages that make maintaining capacity difficult.

ACT programs will continue to experience unusual challenges until the pandemic has subsided, but OHA is committed to supporting our partners and contractors on an ongoing basis.

Supported Employment Services

Supported Employment (SE) services provide support and interventions to help members obtain and maintain integrated, paid, competitive employment. These services are provided in a manner that allows individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices. Availability of SE can assist individuals in maintaining community tenure and can lead to reduced utilization of more restrictive levels of care. COVID has impacted SE programs principally through a decrease in available jobs and workforce shortages with regard to staffing these programs.

The table below indicates the number of members with SPMI per CCO and the number and percentage of members receiving SE.

	SPMI		SE	
CCO	**Number**	**%**	**Number**	**%**
ADVANCED HEALTH	1,760	1.7%	78	4.4%
ALLCARE CCO	3,005	2.9%	157	5.2%
CASCADE HEALTH ALLIANCE	1,718	1.7%	20	1.2%

[2] This data will not be available until 12/31/21, due to a six-month lag in data reporting.

COLUMBIA PACIFIC	2,087	2.0%	36	1.7%
EASTERN OREGON CCO	3,598	3.5%	155	4.3%
HEALTH SHARE OF OREGON	27,938	27.0%	397	1.4%
INTERCOMMUNITY HEALTH NETWORK	4,858	4.7%	13	0.3%
JACKSON CARE CONNECT	3,786	3.7%	146	3.9%
PACIFICSOURCE CENTRAL	4,715	4.6%	36	0.8%
PACIFICSOURCE GORGE	811	0.8%	22	2.7%
PACIFICSOURCE LANE	6,523	6.3%	36	0.6%
PACIFICSOURCE MARION POLK	7,182	7.0%	116	1.6%
TRILLIUM COMMUNITY HEALTH	3,677	3.6%	37	1.0%
UMPQUA HEALTH ALLIANCE	2,548	2.5%	36	1.4%
YAMHILL COMMUNITY CARE	1,896	1.8%	93	4.9%
OPEN-CARD / FEE-FOR-SERVICE	27,214	26.3%	96	0.4%
TOTAL	**90,896**	**100%**	**1,441**	**1.6%**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source: MMIS.

Comments and Analysis

Oregon's SE program has gained national recognition for offering high-fidelity employment services to individuals with an SPMI. The Oregon SE program collaborates with state Vocational Rehabilitation services to maximize the effectiveness of employment services provided to those who experience SPMI. Although data from 2020 was impacted by a COVID-19-related data collection pause and the impact of the pandemic on the availability of jobs, the existing data indicate that the employment rate for individuals accessing SE was approximately 40%.

Accomplishments and Challenges

Successful strategies identified by the CCOs include: close collaboration between the CCOs, CMHPs, Acute Care Psychiatric Hospitals, and other community providers, which improved member engagement and follow-through with treatment; regular planning meetings with Choice[3] contractors to coordinate community integrated care and make sure appropriate SE services are offered to members who could benefit from them; and promoting and educating members regarding SE opportunities.

Among the challenges identified were workforce shortages and loss of SE opportunities due to COVID. Other challenges identified were lack of stable housing for members, workforce shortages, long waiting lists resulting from workforce shortages, and inadequate public transportation in more rural areas.

Peer Delivered Services

Peer Delivered Services (PDS) assist individuals in remaining in their communities and help reduce the use of more restrictive levels of care such as Secure Residential Treatment Facilities. CCOs are required to inform members and encourage members to use PDS. There are many types of PDS, such as Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, Youth Support Specialist, and others. CCOs

[3] The Choice program utilizes a collection of community partners to collaboratively case manage an individual and provide person centered, self-directed treatment in the most integrated setting appropriate to their needs. Choice has been in effect since 2010.

are required to provide members with information, including a description of PDS and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider, and the ways that PDS can enhance members' care. A full description of PDS can be found at https://www.oregon.gov/oha/HSD/AMH-PD/Pages/index.aspx

The table below identifies the number of members with SPMI per CCO and the number and percentage of members receiving PDS.

	SPMI		PDS	
CCO	**Number**	**%**	**Number**	**%**
ADVANCED HEALTH	1,760	1.7%	57	3.2%
ALLCARE CCO	3,005	2.9%	111	3.7%
CASCADE HEALTH ALLIANCE	1,718	1.7%	118	6.9%
COLUMBIA PACIFIC	2,087	2.0%	64	3.1%
EASTERN OREGON CCO	3,598	3.5%	264	7.3%
HEALTH SHARE OF OREGON	27,938	27.0%	1,467	5.3%
INTERCOMMUNITY HEALTH NETWORK	4,858	4.7%	122	2.5%
JACKSON CARE CONNECT	3,786	3.7%	135	3.6%
PACIFICSOURCE CENTRAL	4,715	4.6%	457	9.7%
PACIFICSOURCE GORGE	811	0.8%	32	3.9%
PACIFICSOURCE LANE	6,523	6.3%	280	4.3%
PACIFICSOURCE MARION POLK	7,182	7.0%	334	4.7%
TRILLIUM COMMUNITY HEALTH	3,677	3.6%	200	5.4%
UMPQUA HEALTH ALLIANCE	2,548	2.5%	59	2.3%
YAMHILL COMMUNITY CARE	1,896	1.8%	125	6.6%
OPEN-CARD / FEE-FOR-SERVICE	27,214	26.3%	519	1.9%
TOTAL	**90,896**	**100%**	**4,130**	**4.5%**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source: MMIS.

Comments and Analysis

The table above is based on Medicaid billing codes for PDS, without differentiating what specific service has been provided. OHA had begun comparing Oregon's PDS numbers to numbers available nationwide, but COVID mitigation and emergency procedures have postponed that work. The analysis will resume as soon as the pandemic permits.

The table above reflects only PDS for services billed to Medicaid. CCOs can pay for PDS in various ways, some of which do not involve submitting traditional healthcare claims by providers. As a result, the above data is incomplete. OHA has encouraged CCOs to use peers in as many settings as possible, including outreach into the community. OHA is working with CCOs, counties, and Oregon's PDS network to integrate and incentivize the coordination of peer-delivered services. The OHA Health Systems Division (HSD) recognizes the value of PDS in transforming a behavioral health system of care based on recovery.

The disruption caused by COVID 19 has affected all healthcare system components, and PDS has been impacted as well. Workforce shortages, insufficient telehealth technology, overtaxed providers, and

diminished services have challenged continuing PDS. OHA's community partners are to be commended for their diligence and commitment to providing the best possible service and access during this trying

Accomplishments and Challenges

As previously described, COVID has presented a challenge in expanding and maintaining a robust level of PDS. However, CCOs and their community partners have implemented some successful strategies to sustain these services.

Among the activities identified by the CCOs are increasing the workforce by a dedicated promotional campaign and fully paid training that includes PDS certification and having peers involved in initiation and engagement activities during ED visits and mobile crisis calls.

CCOs identified the following issues as barriers to providing PDS: Peer worker salaries are generally lower than professional or other paraprofessional positions. Once a peer worker has built some experience, it is not unusual for them to seek better opportunities. Some Peer providers say the length of time for the certification and background check process is as excessively long. It hampers the ability to provide services and bill during this wait time. It also makes it difficult to recruit staff in rural areas. Peers also do not generally possess sufficient computer skills for documentation, necessitating further internal training.

Acute Care Psychiatric Facilities

Community-based Acute Care Psychiatric Facilities (ACPFs) provide services to individuals who need short-term psychiatric stabilization, rather than long-term hospitalization at the Oregon State Hospital or other types of institutional settings. CCOs are required to provide acute inpatient hospital psychiatric care for members who do not meet the criteria for long-term psychiatric care and for whom it is medically appropriate. This metric can measure ACPH utilization among different CCOs and help improve outpatient care quality and availability. CCOs report the number of members admitted to ACPHs for a mental health diagnosis and provide the percentage among adult CCO members with an SPMI.

The table below identifies the number of members with SPMI per CCO, and the number and percentage of members admitted to ACPHs for a mental health diagnosis.

		ADMISSIONS	
CCO	**SPMI**	**Individuals**	**Percent**
ADVANCED HEALTH	1,760	36	2.0%
ALLCARE CCO	3,005	45	1.5%
CASCADE HEALTH ALLIANCE	1,718	16	0.9%
COLUMBIA PACIFIC	2,087	53	2.5%
EASTERN OREGON CCO	3,598	37	1.0%
HEALTH SHARE OF OREGON	27,938	1,106	4.0%
INTERCOMMUNITY HEALTH NETWORK	4,858	93	1.9%
JACKSON CARE CONNECT	3,786	64	1.7%
PACIFICSOURCE CENTRAL	4,715	102	2.2%
PACIFICSOURCE GORGE	811	9	1.1%
PACIFICSOURCE LANE	6,523	174	2.7%
PACIFICSOURCE MARION POLK	7,182	154	2.1%
TRILLIUM COMMUNITY HEALTH	3,677	105	2.9%

UMPQUA HEALTH ALLIANCE	2,548	37	1.5%
YAMHILL COMMUNITY CARE	1,896	35	1.8%
OPEN-CARD / FEE-FOR-SERVICE	27,214	407	1.5%
TOTAL	**90,896**	**2,432**	**2.7%**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source MMIS.

Comments and Analysis

CHA has the lowest utilization of ACPHs at 0.9%, and Health Share of Oregon the highest, at 4.0%. It is unclear from the data submitted whether more rural CCOs, such as CHA, have less demand per capita than larger CCOs, or if lack of inpatient resources requires utilization of alternative strategies. OHA is currently analyzing the impacts of COVID on ACPHs.

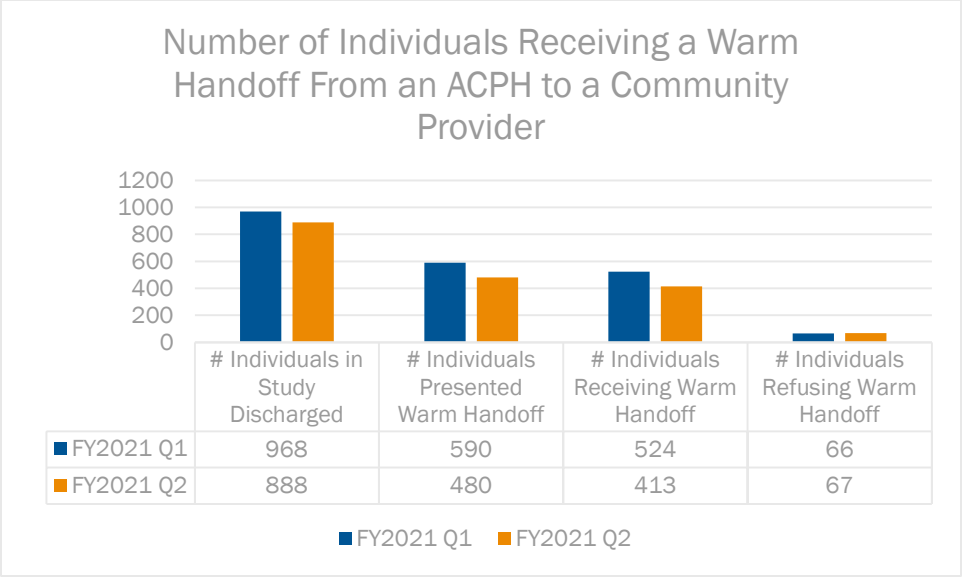
Accomplishments and Challenges

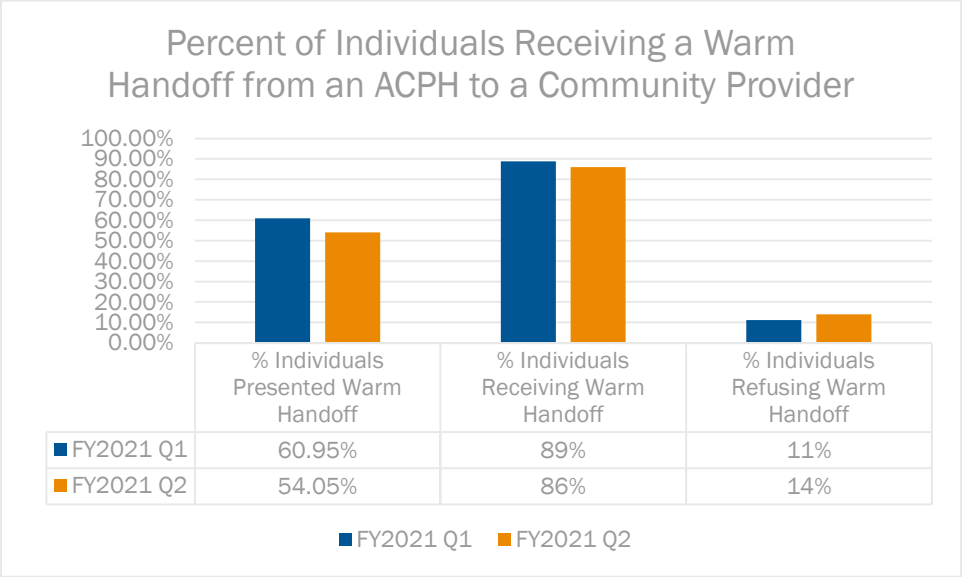
CCOs several strategies to lower hospital admission rates for psychiatric reasons, including providing robust crisis intervention services, comprehensive outreach and follow-up at many encounter points, and use of technology such as the Collective Platform. Maximizing community-based services such as ACT also helps reduce inpatient psychiatric admissions.

Additional challenges identified in achieving this metric include higher acuity patients presenting to ACPHs due to restricted admissions at OSH and other facilities due to the pandemic, members with co-occurring SUD issues that require hospitalization to safely detox, individuals with housing instability, and individuals refusing to participate in community-based services.

Warm Handoffs from Acute Care Psychiatric Hospital

CCOs are required to provide every patient discharged from an ACPH with a Warm Handoff to a community case manager, peer, or other community providers prior to discharge. CCOs were told to report the number of CCO members discharged from ACPHs with documentation of Warm Handoffs and the percentage of those persons among adult CCO members with an SPMI. This measure can inform system partners about how well CCOs and community partners coordinate continuing care after discharge from an ACPH.





Reporting Period: 7/1/2020 through 12/31/2020. Data Source: HealthInsight/Assure.

Comments and Analysis

This data is sorted by fiscal quarter and by CCO for the data collection period. This is the first report this data has been available sorted by CCO. The previous report depended on aggregate numbers for each quarter. By way of comparison:

Reporting Period	Warm Handoff Offered	Warm Handoff Received
1/1/20 - 3/31/20	49%	43.1%
4/1/20 - 6/30/20	37.8%	31.4%
7/1/20 - 9/30/20	60%	89%
10/1/20 - 12/31/20	51%	84%

Data Source: HealthInsight/Assure

In general, the rates for Individuals being offered and accepting Warm Handoffs have improved, even considering the challenges and stressors placed on the system by COVID. Especially dramatic is the improvement in the Warm Handoff acceptance rate. This demonstrates an across-the-board commitment by CCOs and other community partners to improve engagement rates for those transitioning from ACPH.

For the quarter ending 9/30/2020:

- Three CCOs offered Warm Handoffs to discharging individuals at 85% or greater.
- Six CCOs offered Warm Handoffs from 53.3% to 78.7% of individuals discharging from an ACPH.
- Five CCOs offered Warm Handoffs to 40% to 45% of individuals discharging from an ACPH.
- One CCO offered Warm Handoffs to 30.4% of discharging individuals.

The percent of individuals accepting a Warm Handoff for this period is as follows:

- Six CCOs had a Warm Handoff acceptance rate of 100%.
- Seven CCOs had a Warm Handoff acceptance rate between 87% and 97%.
- Two CCOs had a Warm Handoff acceptance rate of 50%.

For the quarter ending 12/31/2020:

- Two CCOs offered Warm Handoffs to 75% through 76.5% of discharging individuals.
- Four CCOs offered Warm Handoffs to 61% through 67% of discharging individuals.
- Four CCOs offered Warm Handoffs to 50% through 58.3% of discharging individuals.
- Four CCOs offered Warm Handoffs to 9.1% through 46.5% of discharging individuals.
- One CCO did not offer Warm Handoffs.

The percent of individuals accepting a Warm Handoff for this period is as follows:

- Four CCOs had a Warm Handoff acceptance rate of 100%.
- Three CCOs had a Warm Handoff acceptance rate of 94%.
- Four CCOs had a Warm Handoff acceptance rate of 80% through 88%.
- Three CCOs had Warm Handoff acceptance rates of between 43% and 66%.
- One CCO did not document Warm Handoffs.

Accomplishments and Challenges

Among the successful strategies employed by CCOs to increase Warm handoffs has been the use of the online care collaboration platform called “the Collective Platform”. The Collective Platform makes it easier for the extended members of the patient’s treatment team to communicate and collaborate. This makes Warm Handoffs and continuing coordination of care easier post-discharge. Another successful strategy reported by CCOs is assigning personnel to respond to members visiting the ED or admitted to an ACPH. This also helps improve continuity of care through early engagement, and comprehensive follow-up.

CCOs also reported several challenges in trying to achieve this metric:

- Hospital crowding, delays, and staff shortages due to COVID.
- Lack of equipment to support increases in telehealth, in hospitals, community providers’ offices, and in members’ homes
- Lack of stable housing for members hinders engagement in treatment and follow-up contact.
- Members not wishing to participate in follow-up care.
- Complications exchanging/sharing member SUD information due to 42 CFR Part 2.

OHA will continue to provide technical assistance to CCOs and other community partners to boost Warm Handoff rates. OHA will also continually assess the impact of COVID mitigation measures and adjust procedures as indicated.

Follow-up Visits

CCOs are required to ensure that members receive a follow-up visit with a CMHP within seven days of discharge from an ACPH.

This measure is a long-standing Healthcare Effectiveness and Data Information Set (HEDIS) measure to assess how comprehensively post-discharge engagement occurs across CCOs. The table below identifies CCO members discharged from ACPHs who received a follow-up visit within seven days.

	ACPH MEMBERS		
CCO	**Number Discharged from ACPHs**	**Number Receiving Follow-Up Visit within 7 Days**	**Percent Receiving Follow-Up Visit within 7 Days**
ADVANCED HEALTH	35	24	68.6%
ALLCARE CCO	43	33	76.7%
CASCADE HEALTH ALLIANCE	17	14	82.4%
COLUMBIA PACIFIC	52	36	69.2%
EASTERN OREGON	40	25	62.5%
HEALTH SHARE OF OREGON	986	698	70.8%
INTERCOMMUNITY HEALTH NETWORK	83	57	68.7%
JACKSON CARE CONNECT	80	66	82.5%
PACIFICSOURCE CENTRAL	96	81	84.4%
PACIFICSOURCE LANE	149	125	83.9%
PACIFICSOURCE MARION POLK	134	125	93.3%
PACIFIC SOURCE GORGE	8	6	75.0%
TRILLIUM COMMUNITY HEALTH	106	77	72.6%
UMPQUA HEALTH ALLIANCE	33	25	75.8%
YAMHILL COMMUNITY CARE	46	35	76.1%
TOTAL (CCO ONLY)	**1,908**	**1,427**	**74.8%**
OPEN-CARD / FEE-FOR-SERVICE	132	69	52.3%
TOTAL (CCO + OPEN-CARD / FFS)	**2,040**	**1,496**	**73.3%**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source: MMIS

Comments and Analysis

The statewide cumulative average for this measure is 73.3%, up from 71.9% in the last report. Pacific Source Marion Polk had the highest percentage of seven-day follow-up at 93.3%. OHA, CCOs, CMHPs, and LMHAs continue to work towards establishing how follow-up services within seven days after discharge can be improved.

Accomplishments and Challenges

CCOs have identified several activities that assist in providing hospitalized members with a seven-day follow-up after discharge. Among the more successful activities were assigning specific staff to help the individual member transition from an inpatient setting; using the Collective Platform to help CCOs and their subcontractors more easily follow individuals who have been hospitalized; and comprehensive communication between community treatment partners.

Some of the challenges to meeting this metric are difficulty following up with undomiciled members, lack of notification to CCO of inpatient hospitalization, workforce issues, and COVID-19 impacts.

Housing Services

CCOs are required to coordinate with community partners to ensure members who are homeless and who have had two or more readmissions to an ACPH or an ED in a six-month period are connected to a housing agency or behavioral health agency to develop a housing plan in an integrated setting, consistent with the member's treatment goals, clinical needs, and informed choice. The CCO is required to work with OHA and the CMHPs to ensure that members who are discharged from an ACPH are discharged to housing that meets the individuals' immediate need for housing. CCOs are required to work with ACPHs to develop each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the member's treatment goals, clinical needs, and informed choice. The CCO is required to notify, or require the ACPH to notify, the community provider to facilitate the implementation of the housing plan.

This measure gauges how effectively the CCOs and other system partners address social determinants of health, specifically housing. This measure identifies the number of members discharged from ACPHs who are homeless, that are connected to a housing provider with an appropriate documented housing assessment, as well as the percentage of such persons among CCO members discharged from ACPHs. For the period 1/1/2020 through 12/31/2020, 11,062 individuals, or 88.4% of those discharged from an ACPH had a housing plan.

In November 2021, the Measure 110 Council approved $270 million for housing, treatment, and other supports for individuals experiencing SUD disorders. These funds allowed Oregon to expand its selection of community-based housing and services for this population.

Comments and Analysis

Housing status is not routinely and uniformly collected across CCOs, making it difficult to report on the percent of homeless members across the state. However, when homelessness or housing insecurity is noted in treatment, housing plans are developed prior to discharge. There are several ways CCOs track risk for homelessness to develop uniform data collection around this information.

The housing shortage, and the effects of the pandemic on the economy and health and well-being of Oregon's citizens, have created several housing challenges. OHA continues to collaborate with Oregon Housing and Community Services and CCOs to develop ongoing guidance information. CCOs should analyze gaps in services and implement mitigation strategies.

Accomplishments and Challenges

COVID-19 has placed increased burdens throughout the continuum of care. Particular areas include bottlenecked transitions between levels of care, staff shortages, increased houselessness, and disruption of services due to capacity limitations and facilities closing. While Oregon continues to invest in Supported Housing, OHA also funds other environments, such as licensed residential treatment facilities and structured (Supportive) housing. Supported Housing, while providing the most integrated living opportunities, takes more time to create and can only accommodate a small number of individuals per project and is not currently meeting the number of unhoused individuals who are in need of varied levels of social and behavioral health services. OHA recognizes that providing a safe, stable living environment is the first step in supporting them on their journey into recovery. For this reason, OHA has housing resources as a priority behavioral health issue.

Acute Care Psychiatric Hospital Readmissions

Readmissions to ACPH: CCOs were told to report the number of members discharged from ACPHs who are readmitted in 30 days and 180 days, as well as the percentage of those members among CCO members discharged from ACPHs.

Duplicated totals mean individuals had more than one event. 180-day numbers are not available due to data lag and are not included.

SPMI INDIVIDUALS ADMITTED TO, DISCHARGED FROM AND READMITTED TO ACUTE COMMUNITY PSYCHIATRIC HOSPITALS BY CCOS

(July 1 - December 31, 2020)

CCO	SPMI	ADMISSIONS		DISCHARGES		READMISSIONS WITHIN 30 DAYS	
		Number	Percent	Number	Percent	Number	Percent
ADVANCED HEALTH	1,760	36	2.0%	38	2.2%	3	7.9%
ALLCARE CCO	3,005	45	1.5%	44	1.5%	6	13.6%
CASCADE HEALTH ALLIANCE	1,718	16	0.9%	15	0.9%	3	20.0%
COLUMBIA PACIFIC	2,087	53	2.5%	49	2.3%	3	6.1%
EASTERN OREGON CCO	3,598	37	1.0%	38	1.1%	6	15.8%
HEALTH SHARE OF OREGON	27,938	1,106	4.0%	1,124	4.0%	171	15.2%
INTERCOMMUNITY HEALTH NETWORK	4,858	93	1.9%	90	1.9%	15	16.7%
JACKSON CARE CONNECT	3,786	64	1.7%	64	1.7%	8	12.5%
PACIFICSOURCE CENTRAL	4,715	102	2.2%	103	2.2%	28	27.2%
PACIFICSOURCE GORGE	811	9	1.1%	9	1.1%	0	0.0%
PACIFICSOURCE LANE	6,523	174	2.7%	180	2.8%	26	14.4%
PACIFICSOURCE MARION POLK	7,182	154	2.1%	160	2.2%	28	17.5%
TRILLIUM COMMUNITY HEALTH	3,677	105	2.9%	105	2.9%	7	6.7%
UMPQUA HEALTH ALLIANCE	2,548	37	1.5%	37	1.5%	3	8.1%
YAMHILL COMMUNITY CARE	1,896	35	1.8%	42	2.2%	2	4.8%
OPEN-CARD / FEE-FOR-SERVICE	27,214	407	1.5%	414	1.5%	39	9.4%
UNDUPLICATED TOTAL	**90,896**	**2,432**	**2.7%**	**2,471**	**2.7%**	**342**	**13.8%**

Note: The readmits within 180 days columns are covered because there was no sufficient follow up period.

Data Source: MMIS

Comments and Analysis

The statewide rate for readmission to an ACPH at 30 days is 13.8%. 180-day readmission data remains unavailable due to data lag. For the 30-day measure, re-admission rates to ACPHs for CCO members ranged from 0 (PacificSource Columbia Gorge) to 27.2% (PacificSource Central Oregon).

Readmissions to ACPHs for adults with SPMI can indicate inadequate services in community settings. Readmissions can result from barriers to access, lack of services, insufficient case management, or inadequate engagement on the part of community providers. Improving community services is a good way to lower readmission rates to ACPHs. Readmission to acute care indicate gaps in care coordination, gaps in warm handoffs where needed, or a lack of connection of individuals to social services workers/community resources/community providers such as primary care providers. This data shows room for growth in collaborative relationships between the CCO, hospitals, CMHPs, including the crisis system and peer-delivered Services. CCOs should identify if delays or gaps in follow-up are due to a lack of adequate health information technology. OHA will work with CCOs to understand the challenges and issues affecting readmission rates.

Accomplishments and Challenges

CCOs have successfully employed several strategies to lower hospital readmission rates for psychiatric care. These have included providing robust crisis intervention services, comprehensive outreach and follow-up at

many encounter points, and the use of technology such as the Collective Platform that helps community partners coordinate care and follow up with discharged members. Challenges identified in meeting this metric include difficulty following up with undocumented members, workforce shortages, COVID-19 impacts, and members declining to participate in follow-up services.

Emergency Departments

Several important provisions of the CCO contract stipulate addressing the following key areas:

- Reduce visits to EDs
- Reduce repeat visits to EDs
- Reduce the length of time members spend in the ED
- Ensure members are contacted and offered services to prevent utilization of the ED
- Ensure members with SPMI who have been discharged from the ED receive a follow-up visit from an intensive care coordinator within three days.

CCOs are required to work with hospitals on strategies to reduce ED utilization and to work with CMHPs and OHA to develop and implement plans for members who have two or more visits to the ED for behavioral health reasons within a six-month period. When an adult with SPMI visits the ED, this is sometimes an indication that the individual was not receiving or not benefiting from community services and supports. A decreased rate of ED visits can indicate individuals are having their mental health treatments and needs met in the community.

The table below shows the number of CCO members admitted to the ED for a mental health diagnosis, as well as the percentage of those members among adult CCO members with an SPMI.

Rate of ED Visits for Psychiatric Reasons BY CCO: 1 Jul 2020 THROUGH 31 Dec 2020

CCO	Individuals with SPMI	Total Member Months (MM)	ED Visits	ED Visit Rate per 1,000 MM
ADVANCED HEALTH	96	90,950.102	137	1.51
ALLCARE	115	204,228.573	163	0.80
CASCADE HEALTH ALLIANCE	51	77,554.707	78	1.01
COLUMBIA PACIFIC	62	108,835.544	78	0.72
EASTERN OREGON	131	188,954.709	165	0.87
HEALTH SHARE OF OREGON	1,586	1,362,836.550	2,613	1.92
INTERCOMMUNITY HEALTH NETWORK	167	237,757.157	228	0.96
JACKSON CARE CONNECT	125	185,125.116	192	1.04
PACIFICSOURCE CENTRAL	159	207,242.001	213	1.03
PACIFICSOURCE GORGE	24	45,170.730	33	0.73
PACIFICSOURCE LANE	267	243,916.936	390	1.60
PACIFICSOURCE MARION POLK	292	356,863.883	457	1.28
TRILLIUM COMMUNITY HEALTH	194	164,979.917	293	1.78
UMPQUA HEALTH ALLIANCE	118	117,421.144	169	1.44
YAMHILL COMMUNITY CARE	95	100,088.177	128	1.28
OPEN-CARD / FEE-FOR-SERVICE	782	609,109.187	1,064	1.75
TOTAL	**4,264**	**4,301,034.433**	**6,401**	**1.49**

Data Source MMIS

Comments and Analysis

Currently the overall average rate is 1.49 ED visits per 1,000 member months. The CCO with the lowest ED utilization rate for the period was Columbia Pacific with 0.72 visits per 1,000 member months. Trillium Tri-County had the highest utilization for its members at 2.28 visits per 1,000 member months. The Fee for Service (FFS) group had a lower utilization rate than the last reporting period at 2.75 visits per 1,000 member months but was still higher than many CCOs. This reinforces the idea that being a CCO member reduces the utilization of higher levels of care by providing more community-based supports. CCOs should use methods such as environmental scans and community needs assessments to identify community-based resources and social determinants of health that lead to lower utilization of ED. This is an area where CCOs should also leverage the expertise of Peers for outreach and to be part of first line of contact for members with SPMI.

Accomplishments and Challenges

As with all ACPH metrics, operating a robust system of community-based integrated supports can help reduce hospital/ED utilization by providing sufficient supports prior to a crisis. Also, using technology like Collective to better case manage treatment for members with an SPMI. Among the challenges identified were members declining services, leading to a crisis, some members' preference for utilizing ACPHs and EDs, and lack of stable housing.

Summary

The emergency measures undertaken to address COVID-19, as well as the impact of massive wildfires statewide in the Summer of 2020 produced a severe strain on Oregon's social services and physical and behavioral health services. Behavioral health services were especially affected. Staff and financial resources were diverted to provide needed care for COVID-19 patients.

To help support CMHPSs, providers, and contractors in meeting their community's needs, OHA waived certain data collection and reporting requirements so their personnel could provide needed emergency services. As such, certain data points are missing from this report. OHA is working on solutions to these issues and hopes to have processes in place by next year's report. OHA will issue revised guidance utilizing information obtained in this report to improve the usefulness of information obtained in subsequent reports.

Despite these challenges, CCOs and their community partners managed to improve on several key metrics: ACPH utilization, Warm Handoffs, 7-day follow-up post-hospitalization, and ED utilization. Other metrics have only been slightly affected due to extraordinary efforts by CCOs and their partners to continue to serve the most vulnerable Oregonians.

OHA will meet with CCO Behavioral Health Directors to review the baseline data in this report and develop goals to improve behavioral health. OHA will continue to work with CCO Behavioral Health Directors to determine if these measures adequately assess access and quality of services.

Appendices

Appendix A

Community Mental Health Programs and behavioral health providers were essential service providers during the pandemic. OHA temporarily suspended the collection of certain data by CMHPs, some of which would have been utilized in this report. Additionally, due to the pandemic and limited staff resources, several measures that would involve CCO data collection remain under development at OHA. As a result, this report is missing the following data elements:

- CCO network adequacy and provider capacity information
- CMHP data for the following behavioral health measures:
    - Number and percentage of CCO members who, once determined Ready to Transition (RTT) by Oregon State Hospital (OSH), receive care coordination from CCO (for Assertive Community Treatment (ACT)
    - Number and percentage of CCO members referred to ACT and meeting criteria for ACT
    - Number and percentage of CCO members meeting criteria and accepted into ACT
    - Number and percentage of CCO members accepted and admitted into ACT
    - Number and percentage of denials to ACT
    - Number and percentage of program denials reviewed for appropriateness by CCO
    - Number and percentage of Notice of Action for Adverse Benefit Determination (NOABD) issued
    - Number and percentage of members discharged from ACPFs with documentation of linkages to appropriate behavioral and primary health care prior to discharge
- Data not currently captured by CCO for the following metrics:
    - Number and percentage discharged from Oregon State Hospital (OSH) to Secure Residential Treatment Facilities (SRTF) and Acute Care Psychiatric Hospitals (ACPH)
    - Number and percentage of members admitted to Acute Care Psychiatric Hospital (ACPH) within thirty (30) days and one hundred and eighty (180) days of discharge from OSH.
    - Number and percentage of members receiving Secure Residential Treatment Services
    - Number and percentage of members receiving Residential Treatment Services (non-Secure)

Appendix B

WRAPAROUND RACE

CCO	WHITE	BLACK	HISPANIC	ASIAN	AMERICAN INDIAN / ALASKAN NATIVE	NATIVE HAWAIIAN / PACIFIC ISLANDER	UNKNOWN	OTHER	DECLINED TO ANSWER
ADVANCED HEALTH	19	1	1		1		10		
ALLCARE CCO	6								
CASCADE HEALTH ALLIANCE	11	3	1						
COLUMBIA PACIFIC	10				3	1		2	
EASTERN OREGON CCO	109	2			4				4
HEALTH SHARE OF OREGON	45	12	11	3	5		5	15	
INTERCOMMUNITY HEALTH NETWORK	78	3						9	
JACKSON COUNTY	6		4		1		1		5
PACIFICSOURCE CENTRAL	56		7	2	1			2	
PACIFICSOURCE GORGE	4							5	
PACIFICSOURCE LANE	45	6	13				26	7	
PACIFICSOURCE MARION POLK	136	8	6		7		1	23	
TRILLIUM COMMUNITY HEALTH PLAN	19		9		1			36	
UMPQUA HEALTH ALLIANCE	14	1			1				
YAMHILL COMMUNITY CARE	15	1	2	1	1		77		
TOTAL	**573**	**37**	**54**	**6**	**25**	**1**	**120**	**99**	**9**

WRAPAROUND ETHNICITY

CCO	NOT HISPANIC	HISPANIC	OTHER	UNKNOWN	DECLINED TO ANSWER
ADVANCED HEALTH		31	1	3	
ALLCARE CCO	5			1	
CASCADE HEALTH ALLIANCE				19	
COLUMBIA PACIFIC	10	1		3	
EASTERN OREGON CCO	100	29	1	2	
HEALTH SHARE OF OREGON	60	14	5	11	
INTERCOMMUNITY HEALTH NETWORK	86				5
JACKSON COUNTY	4	4		6	
PACIFICSOURCE CENTRAL	64	7			

PACIFICSOURCE GORGE	6				
PACIFICSOURCE LANE	83	14			
PACIFICSOURCE MARION POLK	136	45			
TRILLIUM COMMUNITY HEALTH PLAN	27	10		28	
UMPQUA HEALTH ALLIANCE		16			
YAMHILL COMMUNITY CARE					
TOTAL	**581**	**171**	**7**	**73**	**5**

WRAPAROUND LANGUAGE

CCO	ENGLISH	SPANISH	UNKNOWN	NATIVE AMERICAN
ADVANCED HEALTH	24	2	6	3
ALLCARE CCO	6			
CASCADE HEALTH ALLIANCE	18		1	
COLUMBIA PACIFIC	14			
EASTERN OREGON CCO	129	3		
HEALTH SHARE OF OREGON	86	4		
INTERCOMMUNITY HEALTH NETWORK	86		14	
JACKSON COUNTY	13	1		
PACIFICSOURCE CENTRAL	72	2		
PACIFICSOURCE GORGE	6			
PACIFICSOURCE LANE	87	10		
PACIFICSOURCE MARION POLK	160	21		
TRILLIUM COMMUNITY HEALTH PLAN	48		17	
UMPQUA HEALTH ALLIANCE	16			
YAMHILL COMMUNITY CARE	36	1		
TOTAL	**801**	**44**	**38**	**3**

Reporting Period: 7/1/2020 through 12/31/2020. Data Source CCO BHR Submission.

Oregon Health Authority

HEALTH SYSTEMS DIVISION
Office of Behavioral Health