INDEPENDENT CONSULTANT REPORT #3

OREGON HEALTH AUTHORITY

ACTIVITIES TO IMPLEMENT

THE OREGON PERFORMANCE PLAN

Peer-Delivered Services
Supported Employment
Oregon State Hospital
Assertive Community Treatment

Submitted by Pamela S. Hyde, J.D.
Hyde & Associates –
Policy and Practice Consulting, LLC

April 2018

ACKNOWLEDGEMENTS

Many Oregon Health Authority (OHA)[1] staff and Oregon behavioral health system stakeholders continue to help me and the Oregon behavioral health system to 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). As with the first two Independent Consultant (IC) reports, OHA staff met with me, provided me with materials and information, and briefed me on the State's plans for and work toward meeting OPP commitments. I continue to appreciate the openness with which OHA staff work with me and their collective efforts to implement OPP commitments.

Key OHA staff continue to assist me to understand and obtain the information and access I need about services, funding, policies, regulations, and contracts being changed to assure OPP commitments are implemented. These staff include Cissie Bollinger, Michael Morris, Michael Oyster, and Richard Wilcox, as well as Ted Falk and Brian Olson. For this report in particular, individuals at Oregon State Hospital, namely John Swanson, Arthur Tolan, Cheryl Meyers, Tyler St. Clair, Tyler Jones, Scott Hillier, Dean Carlisle, Kerry Kelly, and Russ Isher, along with other members of the OSH clinical and program staff, worked with me to understand changes underway at OSH and its plans for the future, as well as data collection and documentation processes. Staff of Options for Southern Oregon which operates the Oregon Center of Excellence for Assertive Community Treatment (OCEACT) and the Oregon Support Employment Center for Excellence (OSECE), namely Jeff Krolick, Heidi Herinckx, and Crystal McMahon, also deserve recognition not only for their good work, but for their time and effort to brief me and answer my questions.

Many other staff and stakeholders too numerous to name continue to meet with me, provide input, ask good questions, and point me toward information to explain how the State is working to move Oregon's behavioral health system along and to report on these activities and outcomes.

Finally, a 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 serious and persistent mental illness 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 – SCOPE OF REPORT #3

This is the third report of the Independent Consultant (IC) regarding the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP). The context of the development of the OPP and the commitments of 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. This IC Report #3 is limited to assessing the State of Oregon's compliance as of April 2018 utilizing year one data[3] as well as the State's efforts to comply with specific provisions of the OPP in the following four areas:

- peer-delivered services;
- supported employment;
- Oregon State Hospital; and
- assertive community treatment (ACT).

Appendix B to this report summarizes the status of compliance as of the end of year one and the date of this report with the State's commitments in these four areas.

IC Reports #4 and #5 will each address other subsets of the ten (10) services and Performance Outcomes in Section D of the OPP. The sixth and final IC report to be released in early 2020, after the State of Oregon's final narrative and data report is released, will address Quality and Performance Improvement commitments in Section E as well as compliance overall with all provisions of the OPP.

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. This report is the IC's work product and represents my judgments as IC. However, 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.

PEER-DELIVERED SERVICES – ***IN COMPLIANCE***

Subsections D.16 through 18 of the OPP describe the State of Oregon's commitment to increase the availability of peer-delivered services (PDS). PDS is defined[5] in Subsection B.6.k as follows:

[2] IC Reports #1 and #2 as well as other materials related to the OPP can be found on OHA's website at http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx
[3] Note: Another quarterly report was released by OHA in late April providing data through the first quarter of OPP year two. Those data will be addressed in a future IC report. This report will continue to address only data through OPP year one.
[4] All references in this report to Subsections are to the OPP unless otherwise noted in the text.
[5] See IC Report #2 for discussion of the definition of PDS and related terms such as peer support specialists in regulations and contracts.

> Peer-delivered services are community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience. These services are intended to support individuals and families to engage individuals in ongoing treatment and to live successfully in the community. OHA may utilize peer-delivered services in providing other mental health services such as ACT, crisis services, warm handoffs from hospitals, and services at the Oregon State Hospital.

OHA's commitment is to increase the availability of PDS, consistent with this definition. Discussions with peers within OHA central office, at OSH, and during program visits in 2017 indicate peers are helping to engage adults with SPMI in treatment and are helping to support such adults with community living needs, getting to appointments, negotiating public benefits and community interactions, and engage in person-centered planning. In the OPP, OHA committed to increase the number of individuals who are receiving PDS by 20 percent by the end of year one (by June 30, 2017) and by an additional 20 percent by the end of year two (by June 30, 2018).

OHA reported in its January 2018 narrative and data report that 2,156 individuals received PDS in calendar year 2015, the baseline year for comparison with year one of the OPP. A 20 percent increase would require at least 2,587 individuals to have received PDS in the fourth quarter of FY 2017 ending June 30, 2017. OHA reports 2,880 persons received PDS in that quarter, exceeding the goal by 293 individuals. Thus, OHA is ***IN COMPLIANCE*** with its year one commitment in this area. OHA's goal for increasing individuals receiving PDS by an additional 20 percent would mean at least 3,456 individuals receiving PDS services by the end of year two (FY 2018 ending June 30, 2018).[6]

The OPP definition of PDS acknowledges the potential utilization of peers in providing mental health services that may be billed as other than specific PDS. Subsection D.17 – 18 indicate OHA will measure the number of PDS by using Medicaid billing data, noting again that "many individuals receive peer-delivered services which are billed under another Medicaid billing code, and which are not captured by this methodology." OHA indicates a belief that this methodology "significantly undercounts" the number of persons actually receiving PDS in Oregon. Nevertheless, OHA commits to use Medicaid billing data to track increases in PDS for purposes of reporting and meeting the OPP commitments in this area.

Many peers and others working in Oregon's behavioral health delivery system who spoke with me about this issue agree that Medicaid billing for PDS probably undercounts the delivery of services by peers since peers are sometimes utilized in services that are billed in other ways, for example ACT billing for a team service which includes certified peers who do not bill separately, or crisis services delivered by trained peers but billed as a crisis service. Similarly, services delivered by peers who are also clinicians may bill for clinical services such as psychiatry, nursing, counseling, case management, or other therapeutic or rehabilitative services. Others argue that unless a peer is trained and certified, and unless the nature of their job is solely or at least primarily the delivery of peer-oriented and peer-delivered services, those services should not be considered or counted as a PDS. Given this potential difference of opinion, it is probably safe to say that persons defined as peers are delivering other PDS in Oregon and the methodology for OHA's data and narrative reports (and hence for this IC Report) probably does (safely) undercount PDS in Oregon.

OHA indicates no other State or federal funds are utilized to provide PDS other than Medicaid. OPP specifically notes in Subsection D.17 that it will continue to explore better and more accurate ways to count PDS, and if a more accurate way is identified, OHA may agree to modify the methodology to track the provision of PDS. While OHA has on-going efforts to identify peers providing services either in organizations ineligible, unable, or unwilling to bill for Medicaid, and to register or identify individuals who

[6] If the 20 percent additional were calculated on the first year's 20 percent additional number rather than on the higher number actually receiving PDS at the end of year one, the goal for year two would be only 3,105. However, in its data specification sheet for SE services, OHA committed to adding 20 percent more than the actual number at the end of year one, that is, the higher number of 3,456 individuals served as its goal for year two.

have received training as a peer but are not recognized as a Medicaid eligible practitioner, the likelihood of these efforts resulting in an accurate statewide methodology for capturing additional PDS any time soon is unlikely. Hence, the Medicaid billing system most likely will continue to be the best method for capturing and reporting comparable cross-year data on PDS during the time period covered by the OPP.

OHA's Office of Consumer Activities (OCA) works with programs around the State to enhance and expand peer provided services. A Memorandum of Understanding with the Mental Health Association of Oregon (MHAO) utilizes a SAMHSA grant to provide training for Coordinated Care Organizations (CCOs) on how to expand and bill for PDS. Some CCOs support peer-operated organizations and programs even if they are unable to bill Medicaid directly. OCA works with County Mental Health Programs (CMHPs) and non-profit organizations, especially peer-operated organizations, on training, billing, and qualifications for peers to deliver and bill for Medicaid funded PDS. MHAO is creating a non-academic non-profit entity to serve as a hub for peer services and to host a database to capture certified peer specialists, including peer wellness specialists and peer support specialists for addiction, adult mental health, child mental health, and family peer workers. This database may help recognize those who are doing peer work, but who may not be paid as such.

OCA also works with the Oregon Traditional Health Worker Commission within the Oregon Office of Equity and Inclusion (OEI) to help support peers as service providers. This Commission hosts a registry of traditional health workers beyond peers. While additional certified peer workers are employed by Oregon State Hospital to work with patients on person-directed treatment and discharge planning, their work is not billed to Medicaid and hence, is not captured in the OPP numbers reported by OHA.

Finally, OCA works with the Oregon Consumer Advisory Council, the Oregon Family Support Network and the Consumer/Survivor Coalition to promote peer driven and provided services. OCA is developing a peer leadership network to promote ways peer voices can be heard throughout the service delivery system. OCA advocates for peers to be supervisors of peer workers or at least to provide input to peer worker supervision. OCA provided input to the outpatient services regulation changes and is also advocating for peer services to be reported through MOTS even if not Medicaid billable and for PDS to be specifically named as a required service in CCO contracts. OHA supports OCA's advocacy work, even if the Office's advocacy positions are not always initially adopted.

SUPPORTED EMPLOYMENT – ***IN COMPLIANCE***

OPP Subsections 45 – 48 commit OHA to report the following:

- The number of individuals with SPMI who receive supported employment (SE) services who are employed in competitive integrated employment (CIE)[7];
- The number of individuals with SPMI who no longer receive SE services and are employed in CIE without currently receiving supportive services from a SE specialist (but who may rely upon natural and other supports); and
- Regularly monitor these data for the purpose of improving SE services.

These subsections do not specify a numeric goal; rather they only commit OHA to report these data and monitor (and presumably use) these data to improve SE services. Hence, OHA is meeting these commitments as described more fully below.

Subsection B.6.n defines SE services as:

> individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that allows individuals to

[7] OPP Subsection 48 states the understanding that receipt of SE services does not guarantee a job or work for a specific number of hours. Therefore, this number is those so employed for any number of hours.

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[8] practices.

Subsection B.6.d defines CIE as full-time or part time work:

(i) at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill;

(ii) with eligibility for the level of benefits provide to other employees;

(iii) at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and

(iv) as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions."

These subsections about SE indicate that only services billed to Medicaid or are paid for with State general funds used for treatment of the indigent are the source of data provided for this reporting. OHA requires SE programs to meet fidelity[9] standards in order to receive either of these fund sources. OHA indicates no State funds for SE services were available this biennium (including FY 2017). In its January narrative and data report, OHA notes that baseline data from FY 2015 is not available for SE services and that OHA uses quarterly reports from SE programs as the source of the OPP data reported, that is, data regarding those competitively employed upon graduation from the program. As of June 30, 2017 (end of year one), 757 individuals were reported by OHA as receiving SE services and employed in CIE. As of that quarter, OHA reported 110 individuals no longer receiving SE services and employed in CIE. Since OHA is reporting on these two elements, it is ***IN COMPLIANCE*** with these OPP provisions.

Currently, 37 programs assessed as meeting fidelity standards are providing SE services in 35 Oregon counties. Only Lake and Lincoln counties do not have fidelity SE programs at this time. Polk county is working on developing a SE program that can meet fidelity standards. Almost 1800 individuals were receiving SE services from programs meeting fidelity standards during the last quarter of FY 2017.

OHA has entered into an Intergovernmental Agreement with Josephine County (Options for Southern Oregon, Inc.)[10] to operate the Oregon Supported Employment Center for Excellence (OSECE). OSECE is the State's agent to assess fidelity of and provide training and technical assistance (TA) for SE programs throughout the State. Pursuant to its Agreement, OSECE utilizes the data about CIE of those receiving services to help improve the programs it monitors. It is required to design an intensive training for each SE provider; conduct annual (or every 18 months) fidelity assessments; collect SE aggregate data; offer an annual SE/IPS conference; and provide seminars on IPS and SE services. The approach to individual program training plans as well as the approach to general training takes into account where programs are struggling in achieving CIE for individuals served. OSECE also maintains an advisory board and involves consumers and family members in a County's planning, implementation, and assessment processes.

[8] The term "evidence-based" is defined in OPP Subsection B.6.f as "well-defined practices that are based directly on scientific evidence and that have been demonstrated to be effective through research studies."
[9] Fidelity is defined in OPP Subsection B.6.g as meaning that the ". . . supported employment provider is providing services that are faithful to the evidence-based practice model (. . . Individual Placement and Support [IPS]) and obtains a satisfactory score from . . . OSECE, as part of their regular reviews."
[10] See IC Report #2 for a further description of this agreement.

OSECE is also required to provide subject matter expert assistance for SE to OHA as required. OSECE remains as a part of the national SE/IPS learning collaborative (formerly through Dartmouth).[11]

OSECE utilizes and the Oregon outpatient behavioral health services regulations[12] require use of the Individual Placement and Support (IPS)[13] model of SE focused on helping adults with SPMI seek, obtain, and maintain competitive employment. As a result, CIE is the goal for clients receiving SE services. Therefore, all individuals reported as receiving SE services and employed are in CIE employment. OSECE indicates 38-43% of individuals receiving SE are employed at any given time, thereby indicating that a higher number of individuals are receiving SE but are not yet employed. Those in CIE and no longer receiving SE services are individuals who have graduated from the program with a competitive job and are deemed to no longer need SE services. However, neither OHA nor OSECE are able to follow individuals after they graduate from SE services. Therefore, how long employment continues after the end of SE services is unknown.

As OHA's agent for SE program fidelity assessments and improvements and because OSECE maintains its own knowledge of nationally recognized learning about IPS SE and because it uses its knowledge and the data reported above to help improve Oregon's SE services providers, OHA is currently ***IN COMPLIANCE*** with this commitment of the OPP.

OREGON STATE HOSPITAL – ***WORKING TOWARD COMPLIANCE***

The State of Oregon's commitments in the OPP regarding Oregon State Hospital (OSH) began years ago with a review by USDOJ of the conditions within OSH. Oregon agreed to make and has made significant changes in the facility and the treatment and services provided for persons admitted to OSH. As conditions within the facility improved, the State's obligations pursuant to the Americans with Disabilities Act (ADA) as interpreted by the U.S. Supreme Court's 1999 *Olmstead v L.C.* case became USDOJ's and Oregon's focus. This resulted in the 2016 OPP in which the State of Oregon through OHA committed to changes in OSH's admission and discharge processes and numbers, specifically for civilly committed adults with serious and persistent mental illness (SPMI),[14] and in changes to improve community-based services for adults with SPMI to help prevent admission to and upon discharge from OSH.

OSH is comprised of two campuses – one in Salem and one in Junction City. Together these campuses admit about 1500 patients each year, most of whom are forensic patients admitted from Oregon courts and a few individuals admitted by consent of their guardians. The Salem campus is the larger of the two campuses serving about 85 percent of all OSH patients. The Salem campus serves a little over 500 patients of all types and Junction City serves just over 70 patients at any one time. About one-quarter of the total OSH population on the two campuses at any given time are civilly committed adults with SPMI subject to provisions of the OPP.[15]

OPP Numeric Provisions Regarding OSH

[11] See http://psycnet.apa.org/record/2014-04299-001 for a 2014 article updating the experience of this longstanding learning collaborative.
[12] See OAR 309-019-0270 through -0310 for this requirement and the requirement that providers of SE services must meet IPS SE fidelity requirements.
[13] See https://ipsworks.org/index.php/what-is-ips/ for a description of IPS and the value of this approach. See also OSECE's website www.osece.org.
[14] OPP Subsection D.19 specifically notes that paragraphs D. 20 to D.26 apply only to civilly committed adults individuals at OSH, except to the extent specifically noted in D.26. Other individuals in OSH are either admitted "voluntarily" by guardian or are admitted through court action determining the individual to be not guilty by reason of insanity or in need of restoration to competency before standing trial for a criminal offense. The latter two groups are often referred to as forensic populations. Those adults with SPMI who are in "voluntary by guardian" or forensic status are not part of this section of the OPP but may be impacted by some of the other of the State's OPP commitments regarding community-based services.
[15] See https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/99004 for 2016 numbers presented to the legislature in February 2017. Note: civilly committed patients and those admitted "voluntarily by guardian" are combined in the numbers in the referenced presentation.

The OPP focuses on two main areas:

- speed of discharge of civilly committed adults with SPMI admitted to OSH once they are ready for transition (RTT) (Subsections D.20-22 and D.24); and

- appropriateness of services for this population upon discharge from OSH (Subsection D.23 and D.25 – 26[16]), especially the receipt of ACT services for those appropriate for this service (Subsection D.23).

Some of these OPP commitments involve numeric goals aimed at decreasing lengths of stay overall and especially after an individual is determined to be RTT. Others involve processes OHA – and specifically OSH – will utilize to help meet these numeric goals and documentation of appropriateness of services upon discharge. The numeric goals along with actual data reported by OHA as of the end of year one (FY 2017) are as follows:

OPP NUMERIC COMMITMENTS RE SPEED OF DISCHARGES (w/ Subsections)	ACTUALS
• By the end of year one (June 30, 2017), 75% who are Ready to Transition (RTT) will be discharged within 30 calendar days of placement on that list (Subsection D.20.a)	• 60.9% as of 4th quarter FY 2017 – ***NOT IN COMPLIANCE*** (however, this percentage has risen from 51.7% baseline (CY 2015) and has fluctuated each quarter throughout FY 2017 as would be expected, always above baseline)
• OSH will track and report on discharges extended to and occurring on the business day following a weekend day or holiday (Subsection D.20.d-e)	• 1 during FY 2017 – tracking and reporting, therefore ***IN COMPLIANCE***
• At the end of year one (June 2017), 90% will be discharged within 120 days of admission (Subsection D.24)	• 46.7% as of 4th quarter FY 2017 – ***NOT IN COMPLIANCE*** (however, this percentage has risen from 37.9% baseline (CY 2015) and has generally been moving, albeit slowly, in the desired direction

It should be noted that the OPP identifies the preferred discharge timeline to be within 72 hours of the determination that the individual is RTT. While no numeric goal is stated in the OPP, OSH reports that only 2.4 percent of discharges occurred with 3 days of being placed on the RTT list at baseline (CY 2015) and has increased to 8.1 percent at the end of FY 2017. While this percentage is headed in the right direction, the specific individuals who are at OSH at the time, and the competition for and availability of housing and other community settings for services at the time an individual is determined to be RTT will likely continue to result in this percentage fluctuating.

Process Provisions Regarding Clinical Reviews

The OPP includes a commitment that "if an individual is at OSH for more than 90 days, the OHA Director or designee shall perform a clinical review of the individual's status to determine whether a continued stay at OSH is necessary." (Subsection D.24.a) Similarly, "[i]f the OHA Director or designee determines that there is an appropriate clinical justification for the individual to remain at OSH, the Director or . . . designee shall approve the extension of the individual's stay for up to 45 additional days" . . . and every 45 days thereafter until the individual is discharged. (Subsection D.24.c-d) "If the OHA Director or

[16] Subsection D.26 commits the State with the option to use limited, interim, short-term, community-based housing for individuals ready for discharge from more restrictive settings and for whom permanent housing is not yet available. OHA asserts it does not use such interim, short-term housing settings and therefore this Subsection does not apply. At this point, I have no reason to doubt OHA's assertion.

designee determines that there is not an appropriate clinical justification for the individual to remain at OSH, the Director of OSH shall work to expeditiously identify and move the individual to an appropriate clinical placement." (Subsection D.24.e) Finally, this part of the OPP commits OHA to review best practices on this issue annually.

Initially, the OSH Medical Director was designated to perform these clinical reviews. OSH's process included the Medical Director doing this clinical review every 30 days (rather than every 45 days) after a civilly committed adult with SPMI had been at OSH for more than 90 days. By reviewing the justification provided by clinical staff for each such individual still at OSH, the Medical Director was able to direct individuals to be placed on the RTT list if there was no reason for the individual to remain at OSH. This process also allowed the Medical Director to talk with clinical staff, especially physicians, to assist with such determinations and with the documentation of the clinical determination. If the Medical Director determined continued stay was not clinically justified, the individual was simply moved to the RTT list, rather than a particular effort by the OSH Director to expeditiously identify and move the individual to a more appropriate clinical placement. This has helped with the culture change described later in this report to assist OSH admissions to be for shorter lengths of time and services within the hospital to be focused on providing short-term treatment rather than long-term institutionalization.

However, the volume of these clinical reviews and the difficulties of patient record processes at OSH has resulted in the Medical Director being unable to keep up with the necessary reviews within the desired timelines, given all his other duties. Therefore, consistent with Subsection D.24.f, OSH has reviewed its practices and considered whether an additional staff person should be hired just for this clinical review process or whether its external review organization – KEPRO[17] – would be better suited to conduct these independent reviews within the identified timeframes. The contract with KEPRO was amended effective January 2018, to require KEPRO to provide these clinical reviews for civilly committed adults with SPMI at OSH (as well as for those who are in OSH on a "voluntary by guardian" status). This KEPRO role was effective April 1, 2018. Since this contract and process change is new, it is unclear whether this change will positively affect the fulfillment of the OPP commitment regarding 90-day and 30-day reviews. However, it is clear that OSH is ***WORKING TOWARD COMPLIANCE*** with this OPP provision and the provision to review best practices on this issue annually. An analysis of data and the results of this change in process and the manner in which an individual is moved to a more appropriate clinical placement when there is not sufficient justification for the individual to remain at OSH will be considered more fully in a future IC report.

Efforts Working Toward Compliance with OSH Numeric Goals

The number of civilly committed adults with SPMI being treated in OSH at any one time has declined over the last couple of years, from 145 as of July 2015 (FY 2015) to 125 as of the end of FY 2017. The number of such individuals discharged has increased from 192 in FY 2015 to 272 in year one of the OPP (FY 2017 ending June 30, 2017). The average length of stay (LOS) of this population has also decreased from 233.4 in FY 2015[18] to 194.5 in FY 2017. Similarly, the median[19] LOS has also decreased from 163.5 to 125.5 in this time period. Similarly, as noted above, the percentage of those discharged within 120 days has increased from 37.9 percent in FY 2015 to 46.7 percent in FY 2017. The percentage released in

[17] KEPRO is the organization that does continuing stay reviews for individuals in Secure Residential Treatment Facilities as well as for individuals in OSH. These entities are described more fully in IC Report #2.

[18] Note, the OPP indicates in Footnote 2 on page 10 the average LOS was 7.3 months. This is approximately the same as the number of days reported above for those discharged from OSH. The average LOS for all civilly committed patients in OSH as of the end of FY 2015 was 428.8 days or approximately a little over 14 months. This number has also declined to 294.1 days as of the end of OPP year one (FY 2017).

[19] "Median" length of stay is what is often referred to as the "middle" point separating the higher half of this population from the lower half. This number is helpful because those with very short stays or those with very long stays can influence the calculation of the average. That is, as those who have been in OSH a long period of time are released, the average LOS can come down significantly. On the other hand, as those with more difficult treatment needs requiring a longer LOS to stabilize are admitted and as those who are more able to be treated in community settings are released, the average LOS is likely to go up, even if OSH is doing what it ought to be doing and what OHA committed to be doing in the OPP.

less than 3 days (72 hours) after being determined to be Ready to Transition (RTT) has increased from 2.4 percent in FY 2015 to 8.1 percent in the last quarter of FY 2017.

These numbers and percentages show OSH is moving in the right direction, even though they are not yet in compliance with the commitments in the OPP. OHA and OSH are making good-faith and meaningful efforts to meet the OPP commitments. However, as OSH releases those able to move to community settings sooner and assures that only those with the most extensive treatment needs are admitted, the likelihood may be that it will be harder for OSH to reduce the length of stay and discharge individuals more quickly. Time will tell as the next two years of the OPP data are known.

OSH leadership appears to be taking seriously the need not only to change the numbers but to change the culture at OSH and in the community mental health system so that the state facilities are understood by both community and OSH staff as a treatment episode in the care of the individual rather than as a setting in which to place or "park" an individual unable to be served by the community at a given point in time. This culture change is critical for the numbers to change. This change began with the previous permanent superintendent and has continued under the leadership of the interim superintendent[20] and with the medical and social work leadership assigned to direct the OPP process at OSH. Some of the changes moving Oregon's mental health services delivery system and especially OSH toward this changed culture about OSH's role are described below.

Role of Choice and KEPRO Contracts – The contracts with Choice providers and with KEPRO are described in IC Report #2. OHA is working to align the respective roles of these entities as well as the role of OSH staff in discharge processes of patients at OSH. OHA has included numeric performance goals in Choice and KEPRO contracts. OSH staff's role is to determine when the individual is RTT based on treatment response and treatment needs while the community's role is to provide an appropriate living situation and appropriate treatment services upon discharge. This has required considerable engagement with clinical decision-makers at OSH to be willing to document what they believe an individual may need in the community upon discharge but not to substitute their decision for the community's decision about the individual's living setting or treatment once discharged. OSH physicians are being asked not to refuse to discharge the individual when they do not agree with the community's plans for the individual, but rather to talk with the community's staff about why they believe a certain type of treatment or supervision will be needed for the individual to be successful in the community once discharged from OSH. These are hard role changes and are being expected and supported by OSH leadership.

OHA has clarified that all final decisions about continued stays (and about contested or denials of admission) are made by KEPRO, with Choice providers responsible for the coordination needed to transition an individual to a community treatment setting and/or housing. As an independent body, KEPRO is contracted to make decisions about admission based on clinical treatment needs, not based on long-term care needs. However, it is not clear at this point whether KEPRO is staffed up, ready, and able to assume all these responsibilities. It is also not yet clear whether Choice providers are all acting consistently in determining and arranging for living and treatment settings upon discharge. OHA staff is working on these issues with these entities.

Interdisciplinary Teams (IDTs) – OSH is working to schedule IDT meetings in a manner such that community participation is maximized. This will help OHA to hold Choice contractors (many of whom are CMHPs or CCOs) to an obligation to be present at IDT meetings. OSH is also holding team meetings that function somewhat like community-based teams to review all clients of a given unit to determine whether they can move quickly to the RTT list and if so how to support Choice contractors to secure an appropriate location for those who need housing or a residential treatment setting. I watched one of these teams in action and while additional support may be needed, the team was clearly focused on getting each individual out to the community as quickly as their treatment response would allow. Some confusion continues about hospital social work staff's role as opposed to Choice contractors' role. However, OHA staff are working with OSH to clarify roles and responsibilities. I will discuss these initiatives further with OSH later to learn the results of these efforts.

[20] In February, a new permanent superintendent was named and will begin sometime in the first half of 2018.

Ready to Transition (RTT) List Management – OSH has also hired individuals specifically designated as transition assistants or community resource coordinators. These individuals will assist the IDTs and community staff to stay coordinated and facilitate the discharge of those on the RTT list more quickly. They will free up social work staff to do those functions that require a social work license, making the process more efficient for them, other OSH staff, and staff in the community working on individuals' discharges. Two of OSH's security staff have also been re-oriented to do transportation and a warm hand off for individuals who are leaving OSH.

In addition to adding or designating staff to help with the discharge process, OSH is revising its RTT list management process to assure individuals are placed on this list as soon as the individual is ready to transition rather than waiting for an appropriate setting or housing to be available before discharge readiness is determined. This change may make it more difficult for OSH to meet its numeric goals but will help clarify that a stay at OSH is a treatment episode, not a place for someone to languish until an appropriate community treatment setting or supported (or supportive) housing is available.

Hospital Admission and Discharge Regulation – This regulation (OAR 309-091-000 et seq.) was identified in IC Report #2 as antiquated and in need of revision. As a consequence, OHA has prioritized this regulation for amendments with a temporary rule expected in summer 2018 followed by a permanent rule within six months following the temporary rule promulgation. Discussions have begun with the OPP Stakeholder Advisory Council, which includes peers and advocates as well as representatives of CMHPs, CCOs, and acute psychiatric inpatient facilities about changes needed in this regulation.

Forms and Policies – Forms and policies used by OSH to govern and provide information to and from community settings for persons referred for admission or admitted to OSH have been or are being revised. I have met with OSH and OHA staff on more than one occasion to be briefed and provide input on how these forms and policies are evolving to assure the community understands the person being referred is still the community's patient and is not being handed over to OSH with community ties broken; to require the community to provide a preliminary discharge plan (that is, plans for where the patient will go upon discharge) at the time of admission to OSH; and to assure the treatment and care plan for the individual while in OSH is directed toward stabilizing the individual's treatment needs for return to community living as soon as possible. These forms and polices include:

- OSH Discharge and Conditional Release Planning Policy 6.103
- OSH Protocol for Civil/Voluntary by Guardian Discharge Policy
- Treatment Care Plan Form
- Community Living Assessment and Referral Form
- Continuing Care/Discharge Plan Form
- Client Living Preferences Form
- Ready to Transition Form
- Request for Long Term Psychiatric Care Determination – Initial 90 Day Authorization

These efforts to change forms and processes are not just for show or for documentation. These efforts appear to be sending a clear message to hospital and community staff that OSH is not for "long term placement," but rather is for specific and specialized treatment for those who have not responded to treatment available in acute psychiatric care facilities. Terms such as "client," "resident," and "patient" are being discussed to determine the right message for the role of the hospital. Increasingly, the use of terms such as "individual" or "patient" are being considered to convey the expectation of a short term stay for treatment purposes, not a long term residential or institutional expectation. Even the term "long term psychiatric care" is being reconsidered as forms and regulations change to change the perception from OSH being a long-term placement to OSH being a treatment episode for those individuals who need the specialized care OSH provides but not necessarily for a long period of time.

Specialized Treatment Team for Those in OSH for Long Periods of Time or Who are Fearful of Leaving – To OSH's credit, it has created a specialized treatment team with newly hired staff focused specifically on those civilly committed adults with SPMI who have been at OSH a long period of time or who have indicated an unwillingness to leave or harbor fear about community living. This team addresses the individual's interests (music, cooking, sewing, sports, work, etc.) and utilizes their individual strengths to engage them in the process of exploring community settings and community treatment options. While the team is new, my interaction with them and hearing about some of their successes suggests this team is making headway with some of the individuals currently at OSH with the longest stays or exhibiting the most concern about leaving the facility.

CCO Contract and Law Changes – Subsection D.20.f and D.22 commit OHA to work with CCOs to help them meet their obligations regarding the discharge of their members from OSH, consistent with Oregon Administrative Rules (OARs). These subsections also commit OHA to enter into performance-based contracts with CMHPs, CCOs, or other entities to help it meet the timelines for discharge in the OPP. OHA has done so with Choice contracts and with KEPRO. And, while OHA has not yet tackled OAR changes regarding Medicaid managed care or contract changes with CMHPs noted as needed in IC Report #2, OHA has undertaken the important task of addressing CCO contracts. OHA has announced it will extend by one year the five-year contracts entered into with CCOs before the OPP was in effect. OHA has indicated it will include in this contract extension for CY 2019 – the last six months of year three of the OPP – an exhibit specifically addressing the CCOs' obligations with regard to the OPP and the population it addresses. OHA has also included the IC and USDOJ in the process of reviewing drafts of this special exhibit. After this extension is complete, OHA's process for developing the procurement or application process for the new five-year CCO contracts for CY 2020-2024 will begin and could have significant implications for the success of the OPP commitments.[21]

In addition to changing CCO contracts to address OPP issues, OHA supported SB 1549 which passed the Oregon Legislature and was signed by the Governor effective March 16, 2018. This change in law allows individuals to continue as members of CCOs even while in OSH[22] for up to one year. While a significant amount of detailed work will be needed to implement this law, OSH has already started a working group to help assure CCOs remain responsible for their member even while a patient at OSH. It will be critical to assure the financial implementation of this new law does in fact incentivize CCOs to stay involved and assure their members are either treated successfully in acute care psychiatric facilities or community-based settings and are discharged from OSH as soon as possible after admission.

The CCO contract extension, the CCO five-year contract procurement/application process, and the implementation of CCOs' on-going responsibility for their members are important steps in creating performance-based contracts with the CCOs. These changes bear watching over the next few months.

OPP Commitments Regarding Linkages to Appropriate Services Upon Discharge

Subsection D.23.b commits OHA to assuring those not meeting the level of care for ACT "shall be discharged with services appropriate to meet their needs." Subsection D.25 goes further and states "[e]very individual discharged from OSH shall be discharged to a community placement in the most integrated setting appropriate for the individual" consistent with "the individual's treatment goals, clinical needs, and the individual's informed choice." This subsection also notes geographic and housing preferences are to "be reasonably accommodated, in light of cost, availability, and the other factors [i.e., needs and preferences] stated above" although "cost shall not be used as a justification for denying housing." This subsection also states "[d]ischarges shall not be to a secure residential treatment facility [SRTF] unless clinically necessary. No one shall be discharged to a [SRTF] without the express approval of the Director of OHA or . . . designee."

[21] CMHP contracts will be revised for FY 2020 and FY 2021 beginning in 2019, while the CCO procurement or application process is underway. The interface of these two processes will also be important for OPP commitments.
[22] This issue was identified in IC Report #2. OHA has taken this seriously and is working to make the necessary changes to assure CCOs continue to have responsibility for individuals for which they are responsible even when they are admitted to OSH.

This subsection is loaded with concepts that must be interpreted, documented, and considered for each individual leaving OSH and in some cases for each geographic area within the State. Specifically, the prohibition on discharge to an SRTF without the approval of the Director of OHA or a designee is being implemented through the KEPRO contract which must determine eligibility for SRTFs and provide prior and continuing stay authorization for each individual referred to or in an SRTF. While the KEPRO contract is consistent with the commitment to discharge to an SRTF only with a designee's express approval, I have not yet reviewed the impact of that process but will do so for a future IC Report on those subsections addressing SRTFs. Similarly, while Choice providers have been engaged by OHA to assure the needs and preferences of individuals leaving OSH are accommodated to the extent possible given cost, availability, and choices, I have not yet met with Choice providers to hear from them how they do this process. Finally, a review team under my direction will be viewing charts at OSH and at community programs throughout the State later this year. That process will include a review of the documentation and some of the settings to which individuals from OSH are referred and are living and receiving services. Our goal as a team and my goal as IC in that process will be to determine how OHA is interpreting and implementing this subsection for the individuals it serves at OSH. Therefore, I will comment further on this subsection in the next IC Report (#4).

OPP Subsection D.23 commits that "everyone discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative." Footnote 1 on page 10 of the OPP acknowledges that receipt of ACT services "involves an issue of individual choice." This footnote goes on to state "OHA shall make diligent efforts to inform each individual leaving OSH who is eligible for ACT about ACT services, in order to understand and address the individual's concerns about ACT and to tailor ACT services to the individual." This footnote commits OHA to "provide data to USDOJ about individuals by quarter who are offered ACT services and refused." Presumably this means individuals in OSH. These data are not yet kept consistently and have not yet been provided to USDOJ.

At this point, OSH keeps track of individuals scheduled for discharge and referred to ACT services. However, reviews of the ACT tracking matrix by myself and an OSH social work staffer, along with a quick review of some patient charts revealed some inconsistencies between the tracker (which is completed by multiple parties) and patient charts which in some cases appear to be incomplete. OSH staff are working to improve chart documentation while Choice contractors and staff are being provided direction by OHA staff regarding how to assure and report appropriate ACT referrals.

Similarly, Subsection D.23.a requires those discharged from OSH and referred to ACT who refuse those services to be provided "alternative evidence-based intensive services," subject again to individual choice. The definition of an "evidence-based alternative" and "alternative evidence-based intensive services" is not well understood by OSH or community providers. OHA may want to consider creating guidance to OSH and to the field about these terms and possible options. These might include services such as critical time intervention;[23] time limited intensive case management without the full ACT team approach but with intensive navigation to other clinical and rehabilitative services such as psychosocial rehabilitation and peer supports/wellness management; general case management as a hub with an ala carte menu of best practices to support the individual while developing a relationship to engage the individual further in more intensive services.[24]

OHA also commits in this subsection to document efforts to provide ACT to individuals (presumably those being discharged from OSH) who initially refuse ACT services and to document efforts to accommodate their concerns. Because individuals' desires about ACT services, alternative services, and even about discharge plans change as their treatment and planning proceed, OSH is undertaking several activities to clarify for staff the process of identifying those who may be appropriate for ACT upon discharge and to engage individuals about the benefits and opportunity of ACT services upon discharge. Specifically, OSH is working to add intervention regarding ACT to the Treatment Care Plan document and for all IDTs in

[23] See Center for Advancement of CTI at https://www.criticaltime.org/cti-model/.
[24] See for example article by Dixon, L re engagement of individuals with serious mental illness at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/.

order to keep track of engagement of individuals entering OSH and those already in OSH about this service. The idea of assessing interest over time and engaging an individual regarding their interest in ACT is different from an actual decision by the individual to reject ACT services, which should only occur upon discharge. OHA (and OSH) are also working to determine specifically what criteria distinguishes referral to ACT from the need for an SRTF, reflecting the understanding that an individual should never be referred to both at the discharge process (even though both may be considered as an individual's treatment process unfolds while in OSH).[25] A specific process is underway by OSH leadership to clarify and assure engagement, assessment of interest, addressing of an individual's concerns, and documenting refusal at discharge if appropriate. Form revisions as well as documentation instructions to IDTs and hospital staff are being included in this process re-engineering.

While OHA is ***NOT YET IN COMPLIANCE*** with this part of the OPP about ACT referrals, documentation of refusals, and providing data about such to USDOJ, they are taking the process seriously and are working toward putting into place better engagement of individuals at OSH as well as better forms and processes to meet and document the commitments in these subsections of the OPP. I will ask OSH for data and information about these issues later, after their processes are more fully developed.

ASSERTIVE COMMUNITY TREATMENT (ACT) – ***IN PARTIAL COMPLIANCE***

ACT is defined in Subsection B.6.b and similarly in regulation at OAR 309-019-0226. As with OSH, OPP Subsections D.1-5 includes numeric and process commitments by OHA to increase availability and access to ACT teams meeting national standards for this evidence-based service.

Numeric Goals and Data Commitments Regarding Individuals Receiving ACT Services

Subsection D.1.a commits OHA to increase the number of individuals with SPMI served by ACT teams, specifically to assure 1,050 individuals will be served by the end of year one (FY 2017). In its January 2018 report, OHA reports 1,170 individuals receiving ACT services by the fourth quarter of FY 2017. This number compares to 815 receiving ACT services in the baseline year (CY 2015) and has been steadily increasing since the beginning of the OPP. Therefore, OHA is ***IN COMPLIANCE*** with this year one numeric goal. The goal by the end of year two (ending June 30, 2018) is for 2,000 individuals to be served (an additional 950 individuals over the year one goal and 830 more than were receiving ACT services at the end of year one). As indicated in Subsection D.5, these data are provided from quarterly reports provided by ACT programs and capture services funded by Medicaid as well as State funds. State funds have also been provided through the Interagency Agreement with Josephine County, Options for Southern Oregon, for the Oregon Center of Excellence for ACT (OCEACT) which conducts fidelity assessments, provides technical assistance and training, and collects data from ACT programs. Beginning January 1, 2018, the programs' quarterly reports will be submitted to OCEACT to validate and send in aggregate to OHA. OHA has invested in OCEACT's data base which will be used to accelerate OCEACT's efforts to provide technical assistance and monitor fidelity. This data base is not yet required, but most programs are already using it, and it will eventually replace the quarterly reporting template.

Subsection D.1.d notes that OHA may waive fidelity requirements regarding the number of individuals served by a team and the proportional reduction in staff for ACT teams in rural areas if the teams are unable to achieve fidelity and shall report on any such waiver to USDOJ. OHA has managed this commitment by defining in regulation three different sizes of teams – small (ten to 40 individuals), mid-size (41 to 79 individuals), and large (80 to 120 individuals)[26] – with varying staffing requirements

[25] See also later in this Report a discussion of ACT eligibility requirements in OAR regulations. The issue of ACT team denials of persons referred is also addressed in another section of this Report.

[26] While ten individuals served is generally lower than a functional ACT team would serve unless the team is just getting started, OHA has allowed this small team size to provide ACT team services in those small or rural areas where only a small number of individuals need this level of care. Similarly, while 120 persons served by a single ACT team is possible, it is not usual. Such a team size may be seen especially in larger areas while other ACT teams are in development. OCEACT reports as of December 2017, most of the State's ACT teams are small teams serving over 20 or mid-size teams with only two teams beginning to approach the upper number of 120 served. Both of these larger teams are operating in Multnomah County.

according to size. As a result, no waivers of fidelity requirements have been provided as of this time. (See further description of ACT related regulations later in this report.)

OHA has been working through OCEACT to increase the number of ACT teams meeting fidelity standards to assure sufficient capacity is available. As of December 12, 2017, 26 ACT teams have been certified by OCEACT as meeting fidelity requirements with 11 more programs in development or provisionally certified.[27] These teams range in current capacity from eight individuals to 110 with a total capacity for serving 1,201 individuals. The additional developing ACT programs will be able to serve another 200 – 300 individuals. This compares to no teams certified as meeting fidelity as of 2012, and approximately 10 teams certified as meeting fidelity by June 30, 2015 with several more in development.[28] Accordingly, the growth in ACT teams and ACT capacity is significant. However, four counties in Oregon – Jefferson, Lake, Lincoln, and Sherman – have no current plans for developing ACT programs, leaving a portion of the State's population (about two percent) without access to ACT services. Lake and Sherman are largely frontier and not likely to be able to support an ACT team even at the small team size. Jefferson county is largely rural and also may not be able to support even a small ACT team. Lincoln county, however, while including rural areas, would benefit from an ACT team and should be able to support at least a small team. OCEACT estimates the need in these four counties could be over 50 individuals. Statewide, the unmet need is estimated by OCEACT to be over 1,000 individuals. If the additional programs currently in development are certified as meeting fidelity, and if existing ACT teams expand as additional individuals are referred, OHA's year two goal for numbers served may be met either by the end of year two or at least by the end of the OPP timeline.

Subsection D.1 and D.2 also commit OHA to provide ACT services to everyone who is referred to and eligible for ACT similar to Subsection D.23.a which commits that everyone discharged from OSH who is appropriate for ACT shall receive ACT (or an evidence-based alternative; see discussion of this issue in the section about OSH earlier in this report). This commitment may be hard to meet if some counties in Oregon continue to have no ACT program development and no services available. OHA has provided funding for ACT team development and is currently targeting the largest three counties (Multnomah, Clackamas, and Washington), geographic areas with the highest demand for additional ACT services.

Subsection D.4 commits OHA to gather certain specified data regarding individuals with SPMI receiving ACT services. While these data 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," OHA is committed to establishing regular reporting of these metrics and making these reports available to USDOJ. To date, OHA is collecting this data through program submissions to OCEACT. These data (listed below) were provided to USDOJ and me for the first time in April 2018 and will be utilized by OCEACT to identify areas for technical assistance and training.

- Number of individuals served; and
- Percentage of clients who:
    - are homeless at any point during a quarter
    - have stable housing for 6 months
    - using emergency departments during each quarter for a mental health reason
    - hospitalized in OSH during each quarter
    - hospitalized in an acute care psychiatric facility during each quarter
    - are in jail at any point during each quarter
    - receiving Supported Employment services during each quarter
    - are employed in CIE.

[27] Twenty-four of these teams were reported by OCEACT as meeting the minimum score of 114 or more in the annual fidelity assessment occurring at various times during 2017. One other team was within 3 points of meeting the minimum score. Other teams were in development during 2017 and have since met the minimum fidelity score requirement.

[28] The OCEACT contract to conduct fidelity assessments began July 1, 2013.

Given OHA is meeting its year one numeric goals and has begun to provide the data about individuals served by ACT, OHA is currently ***IN COMPLIANCE*** with OPP commitments regarding ACT numbers. Time will tell whether and how these latter data are being used for quality improvement purposes.

OHA Commitments Regarding ACT Admission Criteria, Referrals, and Denials

In Subsection D.1.c, OHA commits to maintaining a waitlist(s) for those who are eligible and appropriate for ACT and assuring for those who are on such a waitlist for more than 30 days that OHA will take action to reduce the waitlist and serve such individuals by either increasing team capacity to a size still consistent with fidelity standards or by adding additional ACT team(s). While the timeline for this commitment has not yet occurred, the time is near. Arguably, since ACT is a Medicaid benefit that must be available for those who need and are eligible for this service, there should not be a waitlist, at least for Medicaid beneficiaries. However, for those who are not Medicaid eligible, or for those who are in a location where an ACT team meeting fidelity standards is either not yet up and running or is not able to expand quickly to meet the need, it is possible an individual needing such a service may have to wait for a period of time to be admitted to an ACT team. As OHA develops the CY 2019 contract extension for its CCOs (see description of this process earlier in this report), it has committed to working with CCOs regarding timely access to this service. At this time, OHA and OCEACT report they are unaware of anyone eligible and appropriate for ACT services waiting to be admitted, especially not for longer than 30 days. That said, it is unclear at this point whether individuals may be waiting without OHA or OCEACT being aware. OHA is working with OCEACT to determine how best to manage this waitlist process as the time for this requirement nears. This process bears watching over the next few months.

Subsection D.3 commits OHA to track denials of individuals to ACT teams to determine if denials are based on established admission criteria, and to take corrective action if providers are improperly rejecting individuals for ACT services. The first paragraph of Section D indicates that unless otherwise specified, the completion date for all provisions in the OPP is July 1, 2019. Accordingly, this commitment to track denials technically may not be required until July 1, 2019. In April 2018, OHA provided me with a list of individuals who have been denied ACT services along with reasons for their denial. This list indicates a significant number of individuals denied due to inability to engage or an assessment by the team that the individual did not meet the criteria for ACT even though the referral was from a Choice contractor or another program that had found the individual did meet criteria for ACT. In many instances, it is not clear from this list whether the individual denied was provided ACT services by another provider, provided alternative services, or simple left as an inappropriate referral. I will meet and discuss this tracking list and its use with OHA staff as they continue to refine this process.

OHA has assigned the individual working with the Choice providers to work on ACT related issues, and to assure Choice and ACT providers are working together to determine eligibility and appropriateness for ACT. This staff person has begun to include OCEACT in various Choice provider meetings, some of which are held at OSH. The OHA staff person is also working with OCEACT and ACT programs to address reporting of denial of referrals as well as the issue of taking corrective action if providers are improperly rejecting individuals for ACT services. OCEACT has identified 10 appropriate reasons for ACT denials in its ACT Data Dictionary, along with an opportunity to specify any other reason for denial. These include:

1. Doesn't meet diagnostic criteria for primary diagnosis of severe and persistent mental illness[29]
2. Doesn't meet functional impairment criteria according to national program standards for ACT programs
3. Dangerous behaviors which cannot be managed in community setting
4. Medical condition which cannot be managed in community setting

[29] Note IC Reports #1 and #2 discuss the issues with regard to inconsistent definitions of SPMI in regulations and contracts. While the data used for OPP reporting is generally pulled consistently, these differences in definitions can have an impact on judgments regarding whether a particular individual meets criteria for ACT or not. For example, OAR 309-019-0245(1)(c) indicates individuals with psychiatric illnesses other than those diagnoses included in the SPMI definition may be eligible for ACT.

5. ACT team does not have capacity
6. Client declines ACT services
7. Guardian declines ACT services
8. Client accepted into residential care
9. Client accepted into another ACT program
10. Referral pending

National standards and OAR 309-019-0248(5) do allow ACT providers to make the decision whether to admit an individual to a particular ACT team, and the reasons listed in the OCEACT Data Dictionary generally are appropriate. The issue is in the implementation. The criteria for admission are broad (see discussion below regarding OHA regulations governing ACT) with many different entities having the ability to judge and interpret whether a particular individual meets those criteria or not. As a consequence, determining exactly who is "eligible and appropriate" and assuring consistency of judgments about this issue will be critical in order for OHA to meet its commitment regarding all persons eligible for ACT receiving services and addressing improper rejections of individuals for ACT services. Given the complexity involved and the work underway, it appears OHA is currently ***WORKING TOWARD COMPLIANCE*** but is not yet there on these issues.

Regulatory Issues Regarding ACT

Subsections D.1.e commits OHA to develop criteria for admission to ACT consistent with the definition in the OPP and based on national standards and provide them to USDOJ. Subsection D.1.f commits OHA to incorporating those admission criteria into administrative rules. As indicated earlier, OHA has incorporated the elements of the OPP definition of ACT into its regulations at OAR 309-019-0226 and has developed admission criteria and incorporated those into regulation at OAR 309-019-0245. These regulations were revised and have been public and therefore available to USDOJ for over a year. In that regard, OHA is ***IN COMPLIANCE*** with these Subsections of the OPP.

However, the admission criteria are broader than one would generally expect or than may have been intended.[30] As written, the criteria imply that individuals other than those with SPMI may be eligible, and that any one of the functional limitations listed may result in an individual being eligible for ACT services. National standards would suggest some of these limitations may need to be paired with other limitations before an individual is eligible and appropriate for ACT. For example, difficulty maintaining consistent employment or difficulty with homemaker functions alone may not be sufficient to make one eligible or appropriate for ACT. Rather psychosocial rehabilitation and/or supported employment services might be more appropriate for such an individual, even if they do meet the diagnostic criteria for being SPMI. Similarly, high service utilization or difficulty maintaining a safe living situation alone may not be sufficient to result in an individual with SPMI needing ACT services. This might be solved by simply adding the word "and" or the word "or" between the listed functional criteria. Because of the confusions regarding referrals and denials noted earlier, OHA should consider additional clarification regarding who and how the diagnostic and functional impairment criteria are applied for purposes of determining ACT eligibility (that is, meeting minimal criteria) and appropriateness (that is, a clinical decision regarding need and likely benefit).

While not a diagnostic criterion, OHA may also want to review the regulatory requirement in OAR 309-019-0242(3)(b) which requires an ACT team to provide a minimum of 40 percent of all services in-community, as opposed to in-office. Generally, national standards would suggest at least 75 percent of ACT team services should be provided in-community. The State's billing requirements may affect this

[30] Comments in this and earlier sections regarding ACT national standards come from discussion with Lorna Mosher, PhD, the Director of the University of North Carolina's ACT Technical Assistance Center at the University's Department of Psychiatry. She is a clinical psychologist, author, teacher, and speaker who has consulted with ACT teams throughout the U.S. (including Oregon) and around the world. She is co-author of the TMACT, a tool for assessment of ACT team fidelity to the evidence regarding ACT effectiveness. The TMACT is generally considered more robust than the original DACTS still used by Oregon and some other states for assessment of ACT fidelity. See https://www.med.unc.edu/psych/directories/faculty/lorna-moser.

requirement regarding service location so a review by OHA is in order to assess how this requirement and billing requirements interact and to assure most services are provided out-of-office. While most Oregon ACT teams may exceed the 40 percent requirement, the fidelity assessment process evaluates and ranks performance on several criteria. Therefore, it is possible for a team to meet fidelity overall although ranking low on this one criterion. Since this is such a crucial part of a quality ACT team process, I would recommend this criterion be revised to reflect closer to the higher expectation for all ACT teams. Now is a good time to make any needed changes in ACT regulations (OAR 309-019-0225 through -0250) since the behavioral health outpatient regulations of which these are a part are currently undergoing revisions to address other needed OPP related changes.

While Oregon has adjusted the fidelity scale it uses – the Dartmouth Assertive Community Treatment Scale (DACTS) – to include a couple of items from the newer Tool for Measurement of Assertive Community Treatment (TMACT), OHA may want to consider at some point working with OCEACT and the State's ACT programs to move toward use of the newer TMACT scale. The TMACT utilizes more intense criteria about how a team does its work rather than the DACTS approach to measuring staffing and functionality. This is not likely a good move to make until ACT teams are fully up and running, the decision-making processes are ironed out and adequately documented, and operating ACT programs are able to meet most of the State's need for this service. However, consideration of this change at some point may help the State to continue to improve ACT services statewide.

Since OHA has developed and included criteria for admission in its regulations which are available to USDOJ, it is close to compliance with this commitment. However, since it needs to make some adjustments to its criteria in order to assure they are not overbroad according to national standards, OHA is currently ***IN PARTIAL COMPLIANCE*** with these OPP commitments.

STATUS OF OHA DATA AND NARRATIVE REPORTS

The most recently available narrative report from OHA at the time this report was drafted was released at the end of January 2018 and covered the time period ending June 30, 2017 or year one of the OPP timeline. The next OHA data report is due in late April – after this report is in the 30-day review period by OHA and USDOJ – and will provide data through the end of September 2017, representing only the first quarter of year two. Because this IC Report #3 covers only four of the ten performance outcomes in Section D of the OPP, and because the commitments and goals are often set by year, this report utilizes only the data provided for these four performance outcomes from the January 2018 report.

Using the January 2018 report, OHA is in compliance in some areas and appears to be on track in others. On the other hand, the data show some concerns regarding OSH discharge timelines and rates of visits to EDs. Similarly, in some areas OHA is tracking data but does not have a specific goal to meet, and in some cases these data show concerns about the direction or trend. These include readmissions to EDs and acute care facilities, length of stay in ACPFs, and whether jail diversions are working to prevent individuals with SPMI from being booked into jails rather than provided alternative community-based treatment. OHA is cognizant of these data trends and considering how to impact the areas of concern.

CONCLUSION

Given the enormity of this larger task of alignment, OHA's efforts to date 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. Significantly, Oregon is meeting its OPP commitments in PDS and SE and some aspects of OSH and ACT while actively working toward others. Appendix B summarizes the status of activity in the four performance outcomes covered by this IC Report #3. Future IC reports will assess whether these efforts have succeeded in these and other areas 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
- 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
- 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
- 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
- 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
- PATH – Projects for Assistance in Transition from Homelessness
- PDS – Peer Delivered Services
- QHOC – Quality Health Outcomes Committee
- QMHA – Qualified Mental Health Associate
- QMHP – Qualified Mental Health Professional
- QPI – Quality and Performance Improvement
- RAC – Rules Advisory Committee
- RFA – Request for Applications
- RFP – Request for Proposals
- 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
- 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
- USC – United States Code
- USDOJ – United States Department of Justice
- w/ – with
- w/in – within

APPENDIX B
SUMMARY OF OHA COMPLIANCE WITH OPP PROVISIONS ADDRESSED IN IC REPORT #3

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 SECTION D NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data FY 2017 IC Report thru early 2018)
Assertive Community Treatment			
1a – b. # SPMI individuals served by ACT Teams	By 6/30/17 – 1,050 By 6/30/18 – 2,000	815	***IN COMPLIANCE*** 1,170 as of Q ending 6/30/17
1c. Reduction of waitlist for ACT	After 6/30/18 – if 10 individuals on waitlist >30 days, increase team capacity or add teams	2015 – 10 ACT teams meeting fidelity; others in development # on waitlist not available for CY 2015	***PENDING*** Timeframe not yet reached; As of Dec 2017 – 26 ACT teams meeting fidelity; 11 in development
1d. Waiver of ACT fidelity requirements (rural teams)	Report w/o Targets	No waivers needed	***IN COMPLIANCE*** Team size and related required staffing now in regulation
1e – f. Criteria for admission to ACT incorporated into administrative rules	By 7/1/16 – Develop criteria consistent w/ OPP definition & national standards; incorporate in regs	Criteria developed and in regulation; regulation undergoing revisions	***IN PARTIAL COMPLIANCE*** Criteria may need some revisions; Regulation under revision
2. Individuals who need ACT will be admitted to ACT	Develop process to assure admission to ACT	N/A	***UNKNOWN*** Tracking process under development
3.Track denials to ACT teams; corrective action if improperly rejected	Tracking process; corrective action capacity	N/A re denials; corrective action process in development	***NOT YET IN COMPLIANCE*** Tracking process underway; corrective action process under development

OPP PROVISION SECTION D NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data FY 2017 IC Report thru early 2018)
4a – i. Report data re ACT clients (w/in a quarter)	a. # served b. % homeless c. % housed 6 mos d. % using EDs e. % hospitalized in OSH f. % hospitalized in acute care g. % in jail h. % receiving SE i. % in CIE	815 served Other data elements not available for 2015	***PENDING*** Data first provided April 2018; Regularity of reporting and use for quality improvement in process
Peer-Delivered Services			
16a – b. # receiving peer-delivered services (PDS)	FY2017 – ↑ 20% (2,587) FY2018 – ↑ 20% over 2,880 (3,456)	2,156	***IN COMPLIANCE*** 2,880 served as of Q ending 6/30/17
17. Explore better ways to track PDS	Process for improvement w/o goals or timelines	In process	***IN COMPLIANCE*** Under consideration, but not likely to happen during OPP timeline
Oregon State Hospital			
20 a – d. % OSH individuals discharged within set # of days after placement on RTT list; track extensions due to holidays/weekends	By 6/30/17 – 75% w/in 30 days By 6/30/18 – 85% w/in 25 days By 6/30/19 – 90% w/in 20 days; Report w/o goal of # extended due to holiday or weekend	51.7% w/in 30 days 41.6% w/in 25 days 30.1% w/in 20 days 4 extended 1 day due to weekend/holiday	***NOT IN COMPLIANCE*** % moving in right direction 60.90% w/in 30 days as of Q ending 6/30//17; 1 extended due to weekend/holiday
20 e. CCO members discharged consistent with OAR; OHA helping CCOs meet their obligations	Regs and Process Work with CCOs	Regs in process; work with CCOs in process	***PENDING*** OSH admission & discharge regulation revision underway

OPP PROVISION SECTION D NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data FY 2017 IC Report thru early 2018)
21. Preference for discharge w/in 72 hours of RTT	Preference Only; Track w/o reporting	Tracking	***IN COMPLIANCE*** Tracking; #s moving in right direction
22. Performance-based contracts w/ CMHPs, CCOs, etc., to pursue #s 20 – 21	Contracting	Revised Contracts w/ CMHPs by 7/1/17 and w/ CCOs by 1/1/19	***PENDING*** Contract revisions w/ CCOs underway for CY 2019; Law change to allow CCO membership to continue while in OSH
23a. i-ii. Everyone appropriate for ACT receives ACT or evidence-based alternative	Individuals discharged & appropriate for ACT receive ACT or evidence-based alternative (EBA); document efforts to address concerns of those who refuse ACT & offer EBA; data reporting re refusers	Referral criteria and draft universal tracking form in use No data re refusers available for CY 2015	***UNKNOWN*** Hospital/community forms, policies, tracking process, and documentation being improved; will be reviewed again later
23b. OHS individuals who meet ACT LOC discharged with services appropriate to needs	Services post discharge for individuals with ACT LOC	QPI process for post-discharge services tracking for ACT LOC individuals in discussion	***UNKNOWN*** Will be reviewed later
24. % OSH individuals discharged w/in 120 days	By 6/30/17 – 90% w/in 120 days	37.9% (89 of 235)	***NOT IN COMPLIANCE*** % moving in right direction; 46.7% as of Q ending 6/30/17
24 a – f. Clinical review when individual at OSH >90 days & every 45 days thereafter	Clinical review process; Documentation of continued stay justification or appropriate placement; Review best practices annually	Process & documentation in place for reviews at 90 days and every 30 thereafter	***PENDING*** Process is in place, but is changing to KEPRO effective April 2018; compliance w/ timelines will be reviewed later
25. Discharges to most integrated setting appropriate, consistent with goals, needs, and informed choice; not to SRTF unless clinically necessary and not w/o express approval of Dir of OHA or designee	Appropriateness of discharges documented Discharges to SRTF only w/ Dir or designee approval	Discharge form in use; Documentation in OSH data system; Contract w/ KEPRO to assure appropriate discharge setting	***UNKNOWN*** Will be reviewed later

OPP PROVISION SECTION D NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data FY 2017 IC Report thru early 2018)
26a – e. Interim, short-term, community-based housing for individuals discharged from OSH or SRTF no longer than 2 mo & no more than 5/unit	No more than 20 interim housing slots; # individuals placed in interim housing for no more than 2 mo & no more than 5/unit; By 7/1/19 – Slots converted to long-term integrated housing	No plans to discharge from OSH or SRTFs to interim housing	***IN COMPLIANCE*** No plans to discharge from OSH or SRTFs to interim housing; Slot conversion timeline not yet reached
Supported Employment			
45 a – b. # receiving supported employment (SE) services & employed in competitive integrated employment (CIE); # in CIE w/o receiving SE	Report w/o Targets	N/A	***IN COMPLIANCE*** Reporting occurring – 757 receiving SE and in CIE 110 in CIE no longer receiving SE
46. Monitor data to improve SE services	Monitor 45a – b data to improve SE services	Data not available OAR revision re SE in process	***IN COMPLIANCE*** Data being used for training and technical assistance

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