Oregon Performance Plan
Semi-annual Narrative Report
January 2018

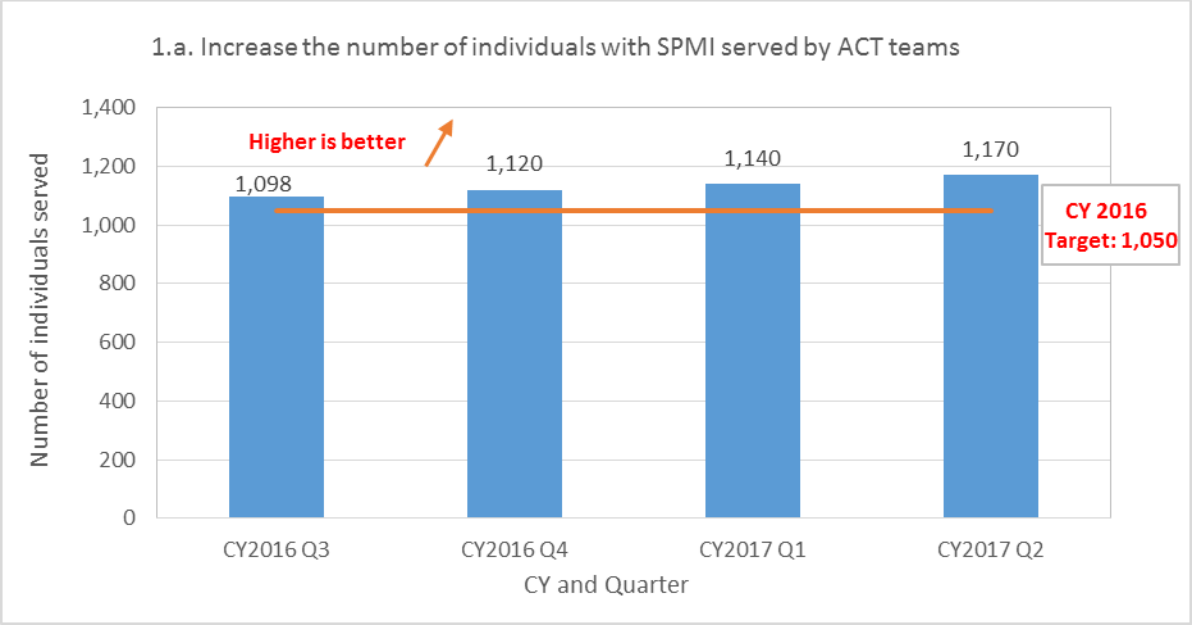
The Oregon Performance Plan (OPP) requires that Oregon Health Authority (OHA) provide data to USDOJ on a quarterly basis and a narrative report about the data every six months. This is the second semi-annual report about data.

For each of the data metrics, this report will describe the 2015 Baseline Data, the methodology for collecting the data, and the progress of each metric for the quarter ending 06/30/2017. At the end of each section, this report will describe the activities associated with the metric(s) in that section. This report does not review or discuss requirements related to OHA's implementation of various processes. However, those processes may be referenced if related to the data metrics. Some of the metrics in the OPP require baselines to be established since there are percentage improvement targets. The other metrics have baselines to inform the review of progress, and numeric annual targets are provided for a number of the metrics. While OHA has detailed implementation plans associated with the OPP, only some of the implementation activities are highlighted in this report.

This report includes graphs for those metrics that have established targets. Further information about the metrics is provided in Appendix A. All metrics are summarized in the Data Report spreadsheet, Appendix B to this report.

Assertive Community Treatment (ACT)

#1 (a-b) Number Served with ACT



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, 815 individuals were being served by ACT.

Comments on Methodology
The data regarding ACT services is received via Quarterly Reports from providers. OHA will identify the number of individuals served at the end of each fiscal year to determine if the performance outcome has been achieved.

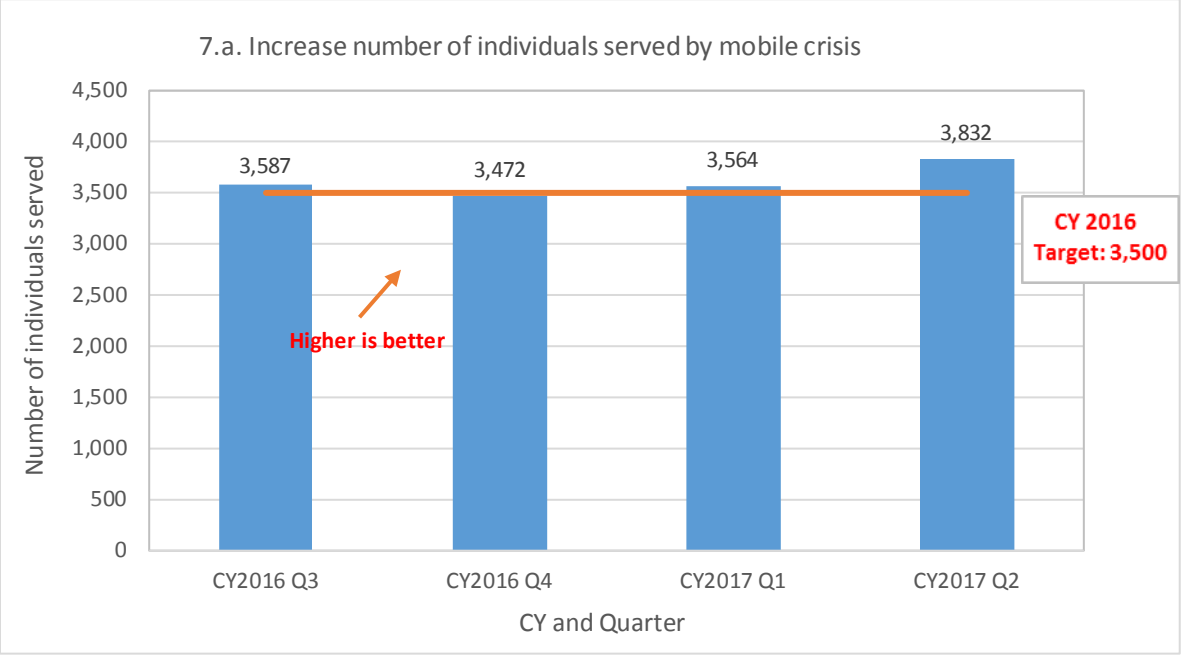
Comment on Progress
Pursuant to the OPP, OHA will increase the number of individuals with SPMI served by ACT teams. OHA will provide ACT services to everyone who is referred to and eligible for ACT, and will meet a metric so that 1,050 individuals will be served by the end of year one (June 30, 2017). As of 6/30/17, 1,170 individuals were being served by ACT. This exceeds the target of 1,050 persons served by the end of year one, by 120 individuals.

Activities Associated with Metric
OHA is partnering with the Oregon Center of Excellence for ACT (OCEACT) to ensure individuals eligible for ACT services receive ACT services. OHA is further

revising the Universal Referral and Tracking form with OCEACT and looking at opportunities to streamline the processes for referrals, refusals, acceptances, and denials. This will be reviewed with OCEACT to determine opportunities to align this with existing innovations.

Crisis Services

#7 (a-b) Number Served with Mobile Crisis



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, a total of 3,150 individuals received mobile crisis services.

Comments on Methodology
OHA captures mobile crisis services utilizing the Measures and Outcomes Tracking System (MOTS). The number of individuals receiving these services is unduplicated. For instance, if the same individual received mobile crisis services multiple times through the year, they are still only counted as one.

Comment on Progress

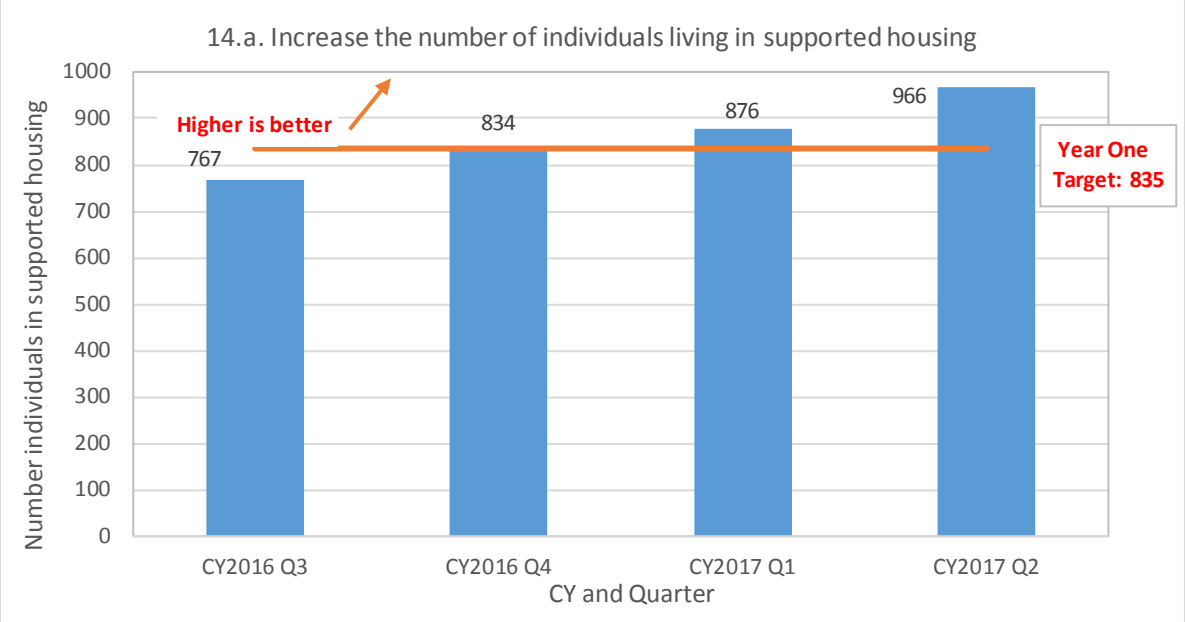
Pursuant to the OPP, OHA will increase the number of individuals served with mobile crisis services, so that during year one (July l, 2016 to June 30, 2017), 3,500 people will be served by mobile crisis. There were 3,832 individuals who received mobile crisis services for the quarter ending 6/30/17. This is 332 over the target of 3,500.

Activities Associated with Metric

The 2017 Legislature allocated $15 million to OHA to address the needs in the Oregon Performance Plan. Approximately $10 million of this $15 million will be used to increase mobile crisis to address statewide coverage. OHA is collaborating with the Association of Community Mental Health Programs regarding the distribution of funding.

Supported Housing

#14 (a-c) Number Living in Supported Housing



Baseline (Calendar Year 2015)

As of the end of calendar year 2015, there were 442 individuals living in Supported Housing.

Comments on Methodology

Supported Housing is calculated using a combination of Supported Housing units developed and occupied and individuals receiving rental assistance in existing affordable housing units that meet the definition of Supported Housing. The Rental Assistance provider reporting requirements were enhanced this year to distinguish individuals in Supported Housing and those in Supportive Housing. Only those in Supported Housing funded by the Rental Assistance program are included in the Supported Housing reported data.

Comments on Progress

Pursuant to the OPP, OHA's housing efforts will include an increase in the number of individuals with SPMI in Supported Housing, in year one (July 1, 2016 to June 30, 2017), so that at least 835 individuals will live in supported housing. As of 6/30/17 there were 966 people residing in Supported Housing, exceeding the first-year, June 30, 2017 target of 835 by 131 individuals. OHA also tracks the number of additional persons with SPMI receiving Supportive Housing, applying the definition for that term found in the November 2012 letter agreement with USDOJ. Supportive Housing is another form of housing support provided to the SPMI population. As of 6/30/17, there were 1,361 people with SPMI living in Supportive Housing.

Activities Associated with Metric(s)

OHA continues to work on increasing Supported Housing. OHA meets quarterly with the Technical Assistance Collaborative (TAC) to develop strategies and mitigate challenges.

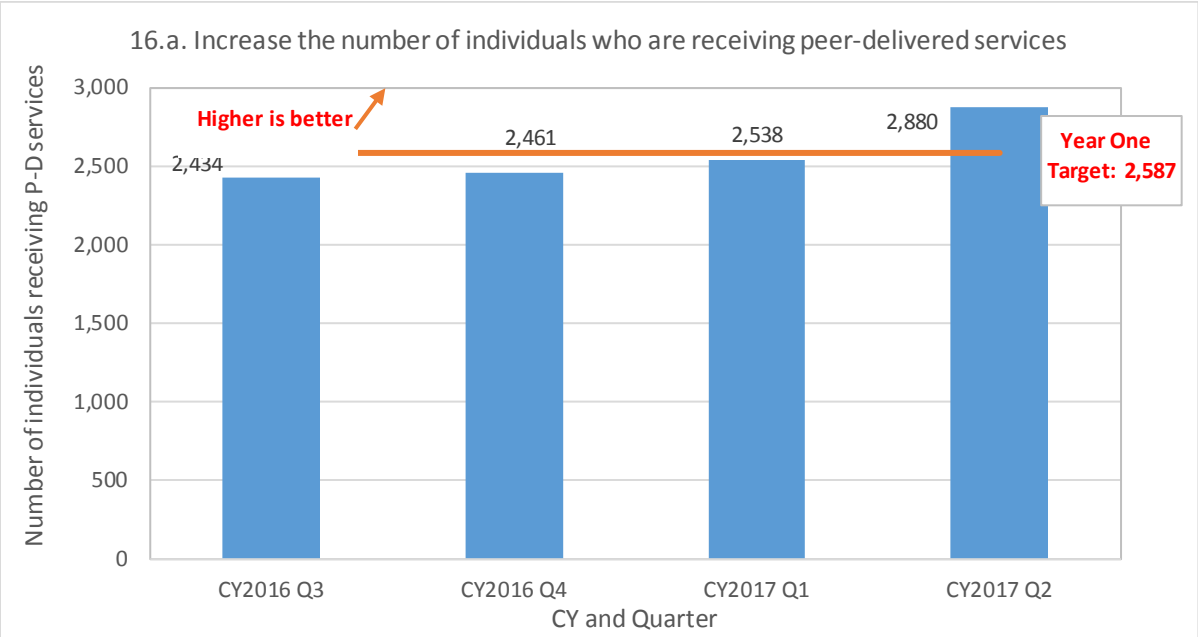
OHA continues to work with Oregon Housing and Community Services (OHCS) to increase Supported Housing opportunities. OHCS in collaboration with OHA has awarded $11.2 of the $20 million provided by the 2015 Legislature for development of Supported and Supportive Housing. A recent Veteran-focused Notice of Funding Availability will award $700,000 of the Mental Health Housing Fund to three Substance Use Disorder projects. To expend the remaining Mental Health Housing Funds, to serve SPMI populations, this spring OHA will support OHCS as it implements HB 3063 (2017) and stands up a stakeholder advisory committee to develop a plan to release the remaining funds.

In addition, OHA is also working to increase Supportive Housing as a necessary step to address the homelessness problem for individuals with SPMI. The Oregon Health Authority (OHA) and Oregon Housing and Community Services (OHCS)

are collaborating to sponsor a Statewide Housing Strategy Workgroup. The workgroup will advise OHA and OHCS on key program and policy considerations and develop an implementation framework to support the housing services and health service needs of homeless individuals or individuals at risk of homelessness. The workgroup will leverage legislative, local, and state agency (OHA and OHCS) investments to develop strategies for increased supported and supportive housing capacity across the state. This group convened in June 2017, and meets every other month. The group was inspired by work Oregon's state team undertook as a participant in the Medicaid Innovation Accelerator Program "Building State Medicaid-Housing Agency Partnerships" in 2016.

Peer Delivered Services (PDS)

#16 (a-b) Number Served with Peer Delivered Services



Baseline (Calendar Year 2015)
A total of 2,156 individuals received Peer Delivered Services (PDS) in the calendar year 2015.

Comments on Methodology
OHA continues to capture PDS utilizing the Medicaid Management Information System (MMIS) as agreed upon with USDOJ, and stated in the OPP.

Comments on Progress

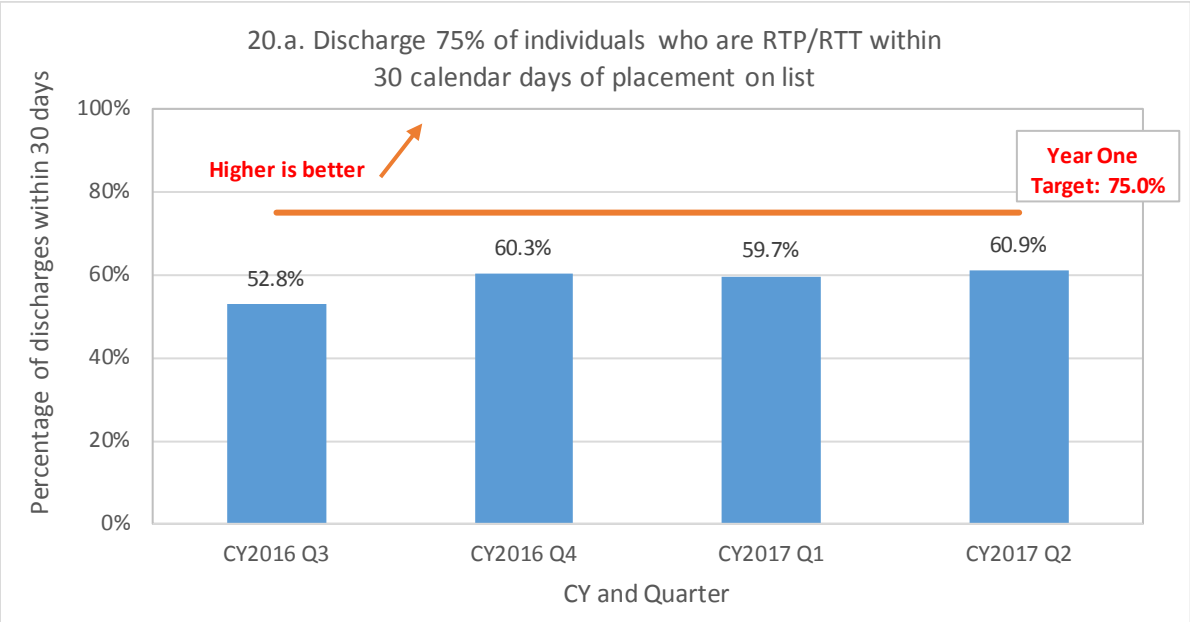
Pursuant to the OPP. OHA will increase the availability of PDS, in that by the end of year one (June 30, 2017), OHA will increase the number of individuals who are receiving PDS by 20%. As of 6/30/17, there were 2,880 individuals who received PDS. This exceeds the target for June 30, 2017 by 293 individuals.

Activities Associated with Metric(s)

OHA continues to work across stakeholder groups to increase opportunities for education regarding PDS and its outcomes.

Oregon State Hospital (OSH)

#20 (a-e) Percentage Discharged within Target of Ready to Transition



Baseline (Calendar Year 2015)

The cumulative percentage of civilly committed patients discharged within 30 days of being placed on the Ready to Transition (RTT) list was 51.7% for the 12 month period ending December 31, 2015. This includes one individual that was discharged shortly after the 30 days due to a weekend/holiday.

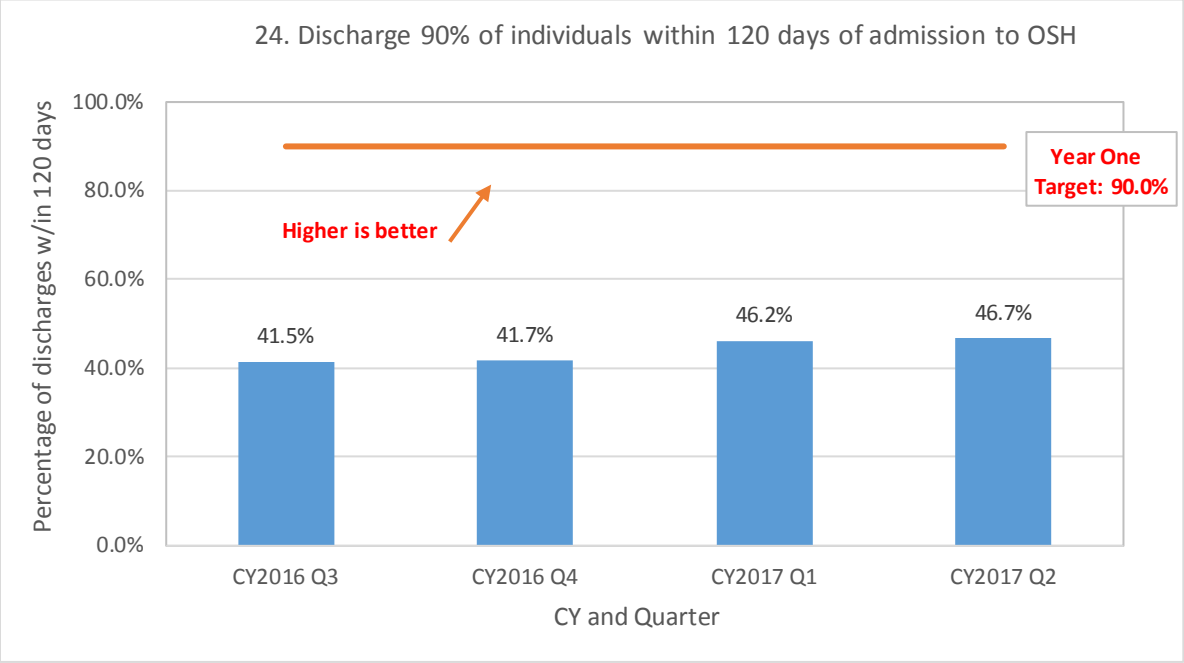
Comments on Methodology

In order to provide the most accurate RTT data possible, a new tracking system was developed and implemented as part of the OSH Electronic Health Record (Avatar) on July 1, 2016.

Comments on Progress

Pursuant to the OPP, by the end of year one (June 30, 2017), 75% of individuals who are Ready to Transition (RTT) will be discharged within 30 calendar days of placement on that list. As of 6/30/17, the cumulative percentage of those discharged within 30 days of being placed on the RTT list was 60.9%. Although this is short of the 75% target, there has been improvement as compared to the 2015 baseline of 51.7%. OHA continues to work internally with OSH and also externally with Choice program contractors. There have been several process improvements since the revision of the Choice contract, which incorporated these OPP metrics as incentive payments.

#24 Percentage Discharged within 120 Days



Baseline (Calendar Year 2015)
For calendar year 2015, the percentage of discharges within 120 days of being admitted to OSH was 37.9%.

Comments on Methodology
The percentage is calculated taking the number of patients that are civilly committed, pursuant to the OPP, who were discharged within 120 days of admission, divided by the total number of patients that are civilly committed who were discharged.

Comments on Progress
The OPP provides that, at the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission. As of 6/30/17, the cumulative percentage of discharges within 120 days of admission was 46.7%.

Activities Associated with Metric(s)
OSH is in the process of revising Oregon Administrative Rule 309-091, State Hospital Admissions and Discharges. The rule was brought to the OPP Stakeholder Advisory Team to gather input. The Long Term Care form, used to request admission to the state hospital, is being revised to better assist coordination of care and will include a tentative discharge plan at admission. OSH is also moving toward standardizing its schedule for Interdisciplinary Teams (IDT) meeting to maximize participation from community partners to help discharge patients more quickly.

OHA is currently revising the scope of work for one of its contractors to perform the 90 day and subsequent 45 day continued stay reviews on behalf of the OHA Director.

At USDOJ's request, OHA is providing a "Point in Time" count of all civilly committed individuals with SPMI residing in OSH on June 15, 2017. The breakdown for the number of days in OSH for the 130 individuals in residence on June 15, 2017 is as follows:

- Less than 120 days: 76 persons, or 58.5% of all civilly committed individuals residing at OSH on June 15, 2017.

- 120-365 days: 38 persons, or 29.2% of all civilly committed individuals residing at OSH on June 15, 2017.
- 366 days to two years: 9 persons, or 6.9% of all civilly committed individuals residing at OSH on June 15, 2017.
- Over two years: 7 persons, or 5.4% of all civilly committed individuals residing at OSH on June 15, 2017.

Acute Psychiatric Care

#29 Percentage Receiving Warm Handoff

Baseline (Calendar Year 2015)
This is a new process and metric, therefore there is no baseline information available.

Comments on Methodology
OHA has contracted with Health Insights to gather data to determine the number of warm handoffs that are occurring for individuals with SPMI in acute care. The contractor is reviewing records for all acute care discharges within each quarter to determine if a warm handoff occurred. This process will also identify any refusals for a warm handoff.

Comments on Progress
OHAs contractor is currently reviewing records for the time period of July 1, 2017 through September 30, 2017. This data will be provided in the April 2018 Data Report and in all subsequent reports.

#30 Percentage Receiving Follow-up within 7 Days of Discharge

Baseline (Calendar Year 2015)
For calendar year 2015, the percentage of follow up visits within seven days of discharge was 79.4%.

Comments on Methodology
The methodology to collect this data aligns with the methodology for reporting on other Coordinated Care Organizations (CCO) metrics.

Comments on Progress

The OPP provides that OHA will continue to require that individuals receive a follow-up visit with a community mental health provider within 7 days of discharge, and that OHA will report this data. As of 6/30/17, the percent of individuals receiving follow up within seven days was 74.2%. The percentage over the last four quarters is below baseline, however, it has been increasing each quarter. Oregon still continues to do well as compared to other states. According to the 2015 Benchmarks and Thresholds Report by the National Center for Quality Assurance (NCQA), the Medicaid national 90th percentile was 70%. Oregon's numbers continue to be above the 90th percentile.

#31 (a) Readmission Rates

Baseline (Calendar Year 2015)

The cumulative 30 day readmission rate to acute care psychiatric facilities for calendar year 2015 is 9.23%. The cumulative 180 day readmission rate to acute care psychiatric facilities for calendar year 2015 is 21.35%.

Comments on Methodology

Pursuant to the OPP, OHA will monitor and report the percentages of discharges with readmissions to Acute Psychiatric Care hospitals within 30 and 180 days of discharge, from hospitalizations for a psychiatric reason. The Data Specification Sheet has been updated to provide the methodology for collecting the readmission rate data by hospital. The readmission rate by hospital was reported based on the hospital where the first admission occurred. The second admission may have actually occurred at another hospital. This creates challenges in how the data by hospital is interpreted. See Appendix C for the breakout by hospital.

Comments on Progress

As of 6/30/17, the cumulative percentage rates of readmission at 30 and 180 days were 10.6% and 22.8% respectively. These percentages are slightly higher than the baseline data.

#35 Average Length of Stay

Baseline (Calendar Year 2015)
The cumulative average length of stay for Acute Psychiatric Care facilities, for calendar year 2015, is 8.89 days. For Calendar Year 2015: there were 4,431 discharges; 385 (8.7%) of them exceeded 20 days.

Comments on Methodology
The OPP provides that OHA will provide the cumulative average length of stay of individuals with SPMI for all hospitals, as well as the average length of stay by hospital. OHA will also provide a count of the number of individuals with a length of stay longer than 20 days.

Comments on Progress
As of 6/30/17, the cumulative average length of stay of individuals with SPMI discharged from Acute Psychiatric Care facilities was 11.24 days. When broken down by hospital, the range of length of stays at the 12 Acute Psychiatric Care facilities ranges from 6.81 to 16.12 days. See Appendix D for the breakout by hospital. Of the 4,217 discharges, the length of stay for 475 (11.3%) of them exceeded 20 days. This count has hovered around this amount without a trend for increase or decrease. Of the 475, 151 were on the OSH Waitlist, which is 32% of the total over 20 days.

Activities Associated with Metric(s)
OHA continues to work with the Acute Care Hospitals regarding the revised Oregon Administrative Rules addressing the Warm Handoff requirement. OHA is partnering with Metro Area Council on Acute Care, and will be providing an Olmstead presentation in February 2018. This is a great opportunity to engage with the acute care hospitals in the metro area.

Emergency Departments (ED)

#40 (a) Number Readmitted Two or More Times within 6 Months

Baseline (Calendar Year 2015)
During calendar year 2015, 1,067 individuals with SPMI were re-admitted to the ED two or more times in a six-month period.

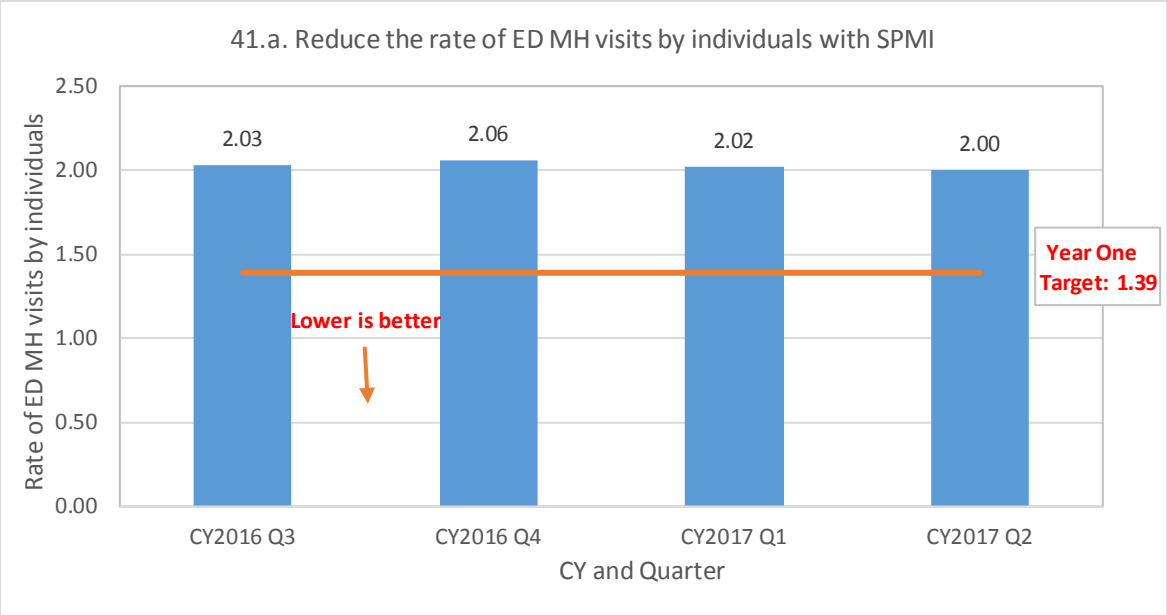
Comments on Methodology

The OPP provides that OHA will count individuals with three or more visits (admissions) to the ED (which is equal to two readmissions) within a six-month period of time. As discussed with Pam Hyde and shared with USDOJ during the November 2, 2017 meeting, OHA is providing this breakout by CCO in Appendix E.

Comments on Progress

As of 6/30/17, 834 individuals with SPMI were readmitted to the ED two or more times in a six-month period. There is no target associated with this metric. The number over the last 12 months has been steadily decreasing.

#41(a-b) Rate of ED Mental Health Visits



Baseline (Calendar Year 2015)

During calendar year 2015, the rate was 1.54 persons per 1000 OHP members who visited the ED for psychiatric reasons.

Comments on Methodology

The OPP provides that OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, and that by the end of year one (June 30, 2017), there will be a 10% reduction from the baseline.

The rate of ED visits for mental health reasons is the number of individuals with SPMI who had an ED visit for psychiatric reasons per 1,000 persons enrolled in Medicaid. The MMIS system does not have diagnostic information for everyone enrolled in Medicaid. However, OHA will review the methodology for possible narrowing of the patients in the denominator to individuals with SPMI.

Comments on Progress

As of 6/30/17, 2.0 persons per 1000 OHP members with SPMI visited the ED for mental health reasons. This number is short of the 1.4% target in the plan, and continues to be above baseline. OHA has been working with stakeholders to try and understand what is impacting the rate. OHA spoke with Portland Police Department (PPD) regarding this metric. PPD has made many efforts to improve police response to incidents involving individuals with a mental illness. The PPD acknowledges that one result of this may be officers taking individuals to an ED instead of to jails. However, Portland Police Bureau did not have data that would confirm this perception. It is also possible the increase is a result of increased Mobile Crisis Services, and increased Criminal Justice Diversions, resulting in more visits to the ED. Although there is an increase in the rate of ED visits, there is a decrease in readmissions to EDs as noted above. Other potential causes could also play a role.

Activities Associated with Metric(s)

The rise in ED usage, and the possible reasons (listed above) were discussed in the November 20, 2017 meeting of the Oregon Performance Plan Stakeholder Advisory Team. OHA is undertaking further research to try to understand why ED utilization is still above the target.

Supported Employment

#45 (a-b) Individuals Served with Supported Employment

Baseline (Calendar Year 2015)

The two Supported Employment data points being collected regarding Supported Employment are new data points; therefore, baseline data is not available.

Comments on Methodology

The data regarding Supported Employment services is received via Quarterly Reports. OHA will identify the number of individuals receiving Supported Employment who are employed in Competitive Integrated Employment (CIE), and the number of individuals who no longer receive Supported Employment services and are employed in competitive integrated employment without receiving supportive services from a Supported Employment specialist at discharge.

Comments on Progress

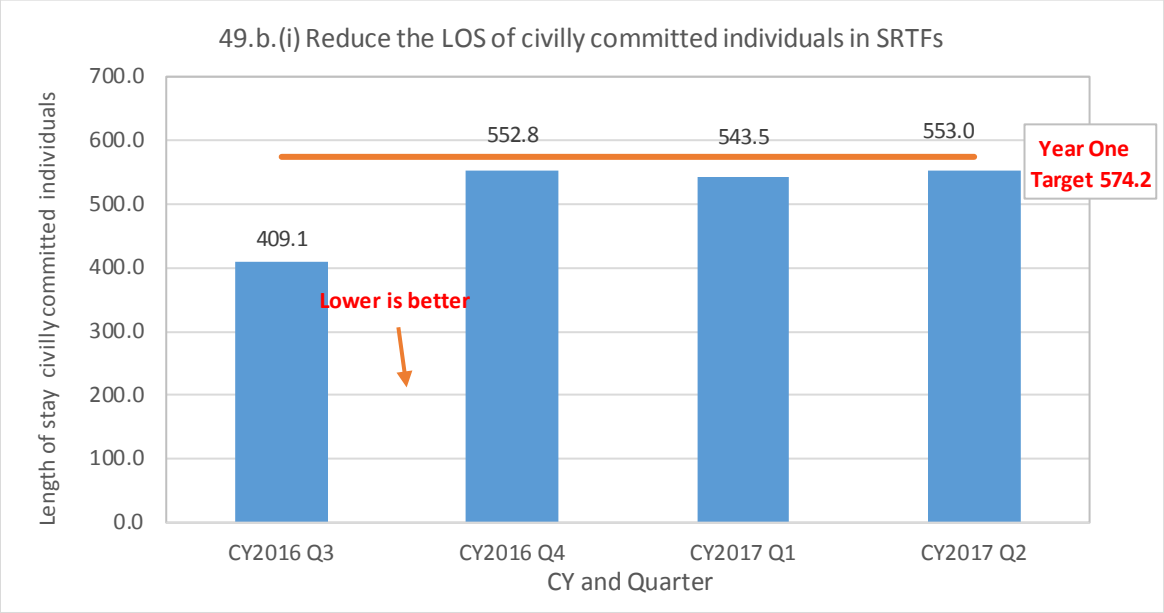
Pursuant to the OPP, OHA will report the number of persons receiving Supported Employment who are employed in CIE and the number of individuals who no longer receive Supported Employment and are employed in CIE. As of 6/30/17, 757 individuals were receiving Supported Employment services and employed in CIE. There were 110 individuals who no longer receive Supported Employment and are employed in CIE without currently receiving supportive services from a Supported Employment specialist.

Activities Associated with Metric(s)

OHA will continue to work with the Oregon Supported Employment Center of Excellence to monitor fidelity and provide technical assistance.

Secure Residential Treatment (SRTF)

#49 (b) (i-ii) Average Length of Stay in SRTFs



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, the average length of stay for an individual who was civilly committed and in a Secure Residential Treatment Facility (SRTF) was 638 days.

Comments on Methodology
The baseline data is calculated by dividing the total days by the number of individuals with SPMI civilly committed who have been discharged from SRTFs.

Comments on Progress
Pursuant to the OPP, OHA will seek to reduce the length of stay of civilly committed individuals in secure residential treatment facilities, in that by the end of year one (June 30, 2017), there will be a 10% reduction from the baseline. The baseline was 638 days. As of 6/30/17, the average length of stay for an individual who was civilly committed and discharged from an SRTF was 553 days, a decrease of 85 days, exceeding the first year target of 574.2 days by 21.2 days.

Activities Associated with Metric(s)
At USDOJ's request, OHA is providing a "Point in Time" count of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2017. The breakdown for the number of days in SRTFs for the 33 individuals in residence on June 15, 2017 is as follows*:

- Less than 120 days: 6 persons or 18% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2017.
- 120-365 days: 11 persons or 33% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2017.
- 366 days to two years: 8 persons or 24% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2017
- Over two years: 8 persons or 24% of all civilly committed individuals with SPMI residing in SRTFs on June 15, 2017.

*The percentage only adds up to 99% due to omitted repeating decimals.

In addition to ensuring a prior authorization is completed prior to admissions to SRTFs from OSH, OHA has been successful in using its contractor for continued stay reviews at SRTFs. OHAs contractor is performing utilization review and management for individuals currently receiving treatment at SRTFs. OHA anticipates improved utilization of this resource, and increased discharges to more integrated settings for these individuals.

Criminal Justice Diversion (CJD)

#52 (a) Numbers Served With Jail Diversion

Baseline (Calendar Year 2015)
In the last quarter of calendar year 2015, there were 1,409 individuals that received jail diversion services. The number of those that received services pre-arrest was 499 and the number post-arrest was 910.

Comments on Methodology
The data regarding jail diversion services is received via Quarterly Reports from jail diversion contractors. OHA will identify the number of individuals receiving Jail Diversion services as well as the number that were pre-arrest and post-arrest.

Comments on Progress

Pursuant to the OPP, OHA will continue to report the number of individuals with SPMI receiving jail diversion services and the number of reported diversions. As of 6/30/17, 2,499 individuals received diversion services, an increase over the baseline year of almost 1,100 persons. Of these 2,499 individuals, 515 were pre-booking and 1,984 were post-booking.

#52 (d) Number of Individuals Receiving Mental Health Services and Arrested

OHA has been keeping the Independent Consultant Pam Hyde apprised of the challenges in collecting this data. During the November 2017 annual meeting between OHA and USDOJ, OHA shared the challenges in collecting the data directly with USDOJ. The collection of this data is a complex process requiring data from both OHA and the Criminal Justice Commission (CJC). OHA is currently working with Oregon DOJ to work through the HIPPA issues related to establishing a partnership between OHA and the Criminal Justice Commission (CJC) so that data can be shared.

APPENDIX A

Many of the metrics identified refer to a rolling one-year period. (This information is identified in the Data Table in Appendix B – see the footnote note marked with an asterisk (*)). A rolling one-year period means the analyst looks at 12 months of data for each quarterly report. In the previous report, three quarters of data were included, and one new quarter has been added to this report. Doing this ensures adequate sample size for analysis, especially when there are small samples. The table below shows a rolling one-year schedule with a six-month lag period to ensure complete data submission.

Report Quarter	Previous Rolling One-Year Period
Q1 (January)	July 1 to June 30
Q2 (April)	October 1 to September 30
Q3 (July)	January 1 to December 31
Q4 (October)	April 1 to March 31

Oregon Performance Plan
January 2018 Data Report - App. B

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Quarter 3 ending 9/30/2016	Quarter 4 ending 12/31/2016	Quarter 1 ending 3/31/2017	Quarter 2 ending 6/30/2017
ACT*	1a	OHA will increase the number of individuals with SPMI served by ACT teams.	1,050 individuals will be served by the end of year one (June 30, 2017).	815	1,050	1,098	1,120	1,140	1,170
	1b		2,000 individuals will be served by the end of year two (June 30, 2018).	*Year Two Deliverable*					
Crisis	7a	OHA will increase the number of individuals with mobile crisis services, as follows:	During year one (July 1, 2016 to June 30, 2017), 3,500 people will be served by mobile crisis.	3,150	3,500	3,587	3,472	3,564	3,832
	7b		During year two (July 1, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis.	*Year Two Deliverable*					
Crisis*	8c	OHA will track and report the number of individuals receiving a mobile crisis contact.	By the end of year two (June 30, 2018), Oregon will report the number of individuals whose dispositions after contact with mobile crisis result in:	*Year Two Deliverable*					
			stabilization in a community setting rather than arrest						
			presentation to an emergency department						
			admission to an acute care psychiatric facility						
SH*	14a	OHA's housing efforts will include an increase in the number of individuals with SPMI in supported housing, as follows:	In year one (July 1, 2016 to June 30, 2017), at least 835 individuals will live in supported housing.	442	835	767	834	876	966
	14b		In year two (July 1, 2017 to June 30, 2018), at least 1,355 individuals will live in supported housing.	*Year Two Deliverable*					
	14c		In year three (July 1, 2018 to June 30, 2019), at least 2,000 individuals will live in supported housing.	*Year Three Deliverable*					
PDS	16a	OHA will increase the availability of peer-delivered services, as follows:	By the end of year one (June 30, 2017), OHA will increase the number of individuals who are receiving peer-delivered services by 20%.	2,156	2,587	2,434	2,461	2,538	2,880
	16b		By the end of year two (June 30, 2018), OHA will increase the number of individuals who are receiving peer-delivered services by an additional	*Year Two Deliverable*					
OSH	20a	Discharge from OSH will occur as soon as an individual is ready to return to the community, as follows:	By the end of year one (June 30, 2017), 75% of individuals who are Ready to Place/Ready to Transition will be discharged within 30 calendar days of placement on that list.	51.7%	75.0%	52.8%	60.3%	59.7%	60.90%
	20b		By the end of year two (June 30, 2018), 85% of individuals who are Ready to Place/Ready to Transition will be discharged within 25 calendar days of placement on that list.	*Year Two Deliverable*					
	20c		By the end of year three (June 30, 2019), 90% of individuals who are Ready to Place/Ready to Transition will be discharged within 20 calendar days of placement on that list.	*Year Three Deliverable*					
	20e		OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday.	*Baseline Not Applicable*	*Measure without Target*	0	2	1	1
OSH	24		At the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission.	37.9%	90.0%	41.5%	41.7%	46.2%	46.70%

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Quarter 3 ending 9/30/2016	Quarter 4 ending 12/31/2016	Quarter 1 ending 3/31/2017	Quarter 2 ending 6/30/2017
ACUTE	29a		By the end of year one, (June 30, 2017), 60% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Data Not Available*					
	29b		By the end of year two, (June 30, 2018), 75% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Year Two Deliverable*					
	29c		By the end of year three, (June 30, 2019), 85% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Year Three Deliverable*					
ACUTE	30		OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge, and OHA will report this data.	79.4%	*Measure without Target*	71.5%	72.0%	73.0%	74.20%
ACUTE	31a		OHA will monitor and report the 30 day rates of readmission, by acute care psychiatric facility.	9.2%	*Measure without Target*	10.9%	11.1%	10.3%	10.60%
			OHA will monitor and report the 180 day rates of readmission, by acute care psychiatric facility.	21.3%	*Measure without Target*	22.6%	22.6%	22.7%	22.80%
ACUTE	31b 32		Two or more readmissions to acute care psychiatric hospital in a six month period.	*Baseline Not Applicable*	*Data for Process Measure*	*Data Not Available*	346	280	284
ACUTE	35		OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital.	8.9	*Measure without Target*	9.6	9.6	11.0	11.24
	35		OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days.	385	*Measure without Target*	435	423	459	475
ED	40a	OHA will reduce recidivism to emergency departments for the psychiatric purposes, by taking the following steps:	OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, by hospital.	1,067	*Measure without Target*	924	919	865	834
ED	41a	OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, as follows:	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline.	1.5	1.4	2.0	2.1	2.0	2.0
	41b		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.	*Year Two Deliverable*					
ED	43	OHA is working with hospitals to determine a strategy for collecting data regarding individuals with SPMI who are in emergency departments for longer than 23 hours.	OHA will begin reporting this information in July 2017, and will provide data by quarter thereafter. OHA will report this information by region. OHA will pursue efforts to encourage reporting on a hospital-by-hospital basis.	*Year Two Deliverable*					

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Quarter 3 ending 9/30/2016	Quarter 4 ending 12/31/2016	Quarter 1 ending 3/31/2017	Quarter 2 ending 6/30/2017
SE*	45a		The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment…	*Baseline Not Applicable*	*Measure without Target*	680	697	628	757
	45b		The number of individuals with SPMI who no longer receive supported employment services and are employed without currently receiving supportive services from a supported employment specialist (but who may rely upon natural and other supports).	*Baseline Not Applicable*	*Measure without Target*	114	115	164	110
SRTF	49b (i)	OHA will seek to reduce the length of stay of civilly committed individuals in secure residential treatment facilities, as follows:	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline. (Mean)	638.0	574.2	409.1	552.8	543.5	553
	49b (ii)		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.	*Year Two Deliverable*					
SRTF	49c	OHA will regularly report on the number of civilly committed individuals in SRTFs, their lengths of stay, and the number of individuals who are discharged.	Starting with year two of this Plan (July 1, 2017), OHA will collect data identifying the type of, and the placement to which they are discharged.	*Year Two Deliverable*					
CJD*	52a	OHA will work to decrease the number of individuals with serious and persistent mental illness who are arrested or admitted to jail based on a mental health reason, by engaging in the following strategies:	OHA will continue to report the number of individuals with SPMI receiving jail diversion services.	*Baseline Not Applicable*	*Measure without Target*	1,553	1,610	1,736	2,499
	52a		OHA will continue to report the number of reported diversions. (Pre-Arrest)	*Baseline Not Applicable*	*Measure without Target*	284	385	346	515
	52a		OHA will continue to report the number of reported diversions. (Post-Arrest)	*Baseline Not Applicable*	*Measure without Target*	1,269	1,225	1,390	1,984
	52d		As of July 2016, OHA will track arrests of individuals with SPMI who are enrolled in services and will provide data by quarter thereafter.	*Baseline Not Applicable*	*Data Not Available*				

* Quarterly data for metrics marked with a "*" reflect 3 months of data for a given quarter. Quarterly data for other metrics are based on the past year's worth of data, reported on a rolling basis through the end of a given quarter.

Appendix C

Rates of Readmission by Acute Care Facility (31a)

2017 Q2 (July 1, 2016 – June 30, 2017)

Acute Care Psychiatric Hospital	Location	30-day	180-day
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	8.8%	20.9%
Bay Area Hospital	Coos Bay	11.6%	24.3%
Good Samaritan Regional Medical Center	Corvallis	9.1%	19.4%
*Legacy Emmanuel Medical Center/Unity	Portland	11.9%	21.9%
*Legacy Good Samaritan Medical Center	Portland	6.4%	19.7%
*Oregon Health Sciences University	Portland	9.6%	18.5%
Peace Health - Sacred Heart Medical Center	Eugene	9.2%	22.5%
*Portland Adventist Medical Center	Portland	11.9%	23.8%
Providence Portland Medical Center	Portland	12.9%	25.4%
Providence St. Vincent Medical Center	Portland	12.8%	26.2%
Salem Hospital	Salem	9.2%	22.5%
St Charles Health System Sage View	Bend	10.0%	21.8%

*Acute Care Psychiatric Facilities noted above will be closing their psychiatric units and transferring that capacity to Unity Center for Behavioral Health, effective January 1, 2017.

Appendix D

Average Length of Stay in Acute Care Facilities, by Facility (35)

2017 Q2 (July 1, 2016 – June 30, 2017)

Acute Care Psychiatric Hospital	Location	Average Length of Stay	Number of Individuals whose Length of Stay exceeds 20 days
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	9.3	28
Bay Area Hospital	Coos Bay	6.8	9
Good Samaritan Regional Medical Center	Corvallis	14.0	47
*Legacy Emmanuel Medical Center/Unity	Portland	16.1	84
*Legacy Good Samaritan Medical Center	Portland	9.1	12
*Oregon Health Sciences University	Portland	9.8	15
Peace Health - Sacred Heart Medical Center	Eugene	13.4	74
*Portland Adventist Medical Center	Portland	12.2	43
Providence Portland Medical Center	Portland	11.7	65
Providence St. Vincent Medical Center	Portland	9.6	42
Salem Hospital	Salem	12.2	38
St Charles Health System Sage View	Bend	7.4	18

*Acute Care Psychiatric Facilities noted above will be closing their psychiatric units and transferring that capacity to Unity Center for Behavioral Health, effective January 1, 2017.

Appendix E

Count of Individuals with 2+ Readmissions to ED in 6 Months (40a)

2017 Q2 (July 1, 2016 – June 30, 2017)

Coordinated Care Organization	2+ Readmissions within a Six Month Period
AllCare CCO Inc	17
Cascade Health Alliance LLC	5
Columbia Pacific CCO LLC	18
Eastern Oregon CCO LLC	10
FamilyCare CCO	95
Health Share of Oregon	279
Intercommunity Health Network	13
Jackson Care Connect	9
PacificSource Community Solutions Gorge	1
PacificSource Community Solutions Inc	8
PrimaryHealth Josephine County CCO	1
Trillium Community Health Plan	53
Umpqua Health Alliance DCIPA	13
Western Oregon Advanced Health	9
Willamette Valley Community Health	44
Yamhill Community Care	7
Fee-for-Service	252
Total	834