INDEPENDENT CONSULTANT REPORT #6

OREGON HEALTH AUTHORITY

ACTIVITIES TO IMPLEMENT

THE OREGON PERFORMANCE PLAN

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

March 2020
with June 2020 Revisions

ACKNOWLEDGEMENTS

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

In addition to Cissie Bollinger, Hanna Christensen, Michael Morris, Margie Stanton, Steve Allen, and Patrick Allen, other OHA staff helped advise and provide me with information and perspective. These staff include Alisa Campbell, Brandy Hemsley, Beau Rappaport, Michael Oyster, Brenda Dennis, Mick Mitchell, Sharon Hill, Rick Wilcox, Lisa Peetz, Elaine Sweet, Susan Lind, Lori Kelley, Shellee Madden, Kyleen Zimber, Anastasia Sofranac, Steven Ranzoni, Geralyn Brennan, Jon Collins, Stacey Schubert, Jackie Fabrick, Annaliese Dolph, Rusha Grinstead, Dana Hittle, April Gillette, and Tamara McNatt, among others. Oregon State Hospital (OSH) Superintendent Dolly Matteucci, along with Arthur Tolan, Della Hoffman, Chaseé Triller, Kerry Kelly, Cheryl Meyers, Rachel Bradbury, Tyler St. Clair, and Dr. Walker and Dr. Mobbs also continue to help me and my colleagues understand changes underway at OSH and how these affect individuals being admitted to and discharged from OSH. The staff of the Person Directed Treatment Team (PDTT) is doing incredible work with individuals fearful of leaving OSH helping them identify goals and strengths and make the transition to community living successfully. Kudos to this team for its work and for spending time with me and my colleague to help us understand their role and their challenges.

Stakeholders have continued to provide input in person or by phone, especially members of the Association of Oregon Community Mental Health Programs (AOCMHP). I appreciate all of these entities' and individuals' cooperation and assistance. The openness and commitment of all these Oregon staff and stakeholders bode well for the state's residents as Oregon continues to work to reach the goals committed to in the OPP.

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

Respectfully and with continuing gratitude,

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

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INTRODUCTION

CONTEXT AND PRIOR INDEPENDENT CONSULTANT REPORTS

This is the sixth Report[2] of the Independent Consultant (IC) regarding the Oregon Performance Plan (OPP) for Mental Health Services for Adults with Serious and Persistent Mental Illness (SPMI). The previous five IC Reports covered Oregon's efforts to implement various provisions of the OPP, specifically:

- *IC Report #1,* March 2017 – Context of the development of the OPP and all commitments by the State of Oregon represented in the provisions of the OPP
- *IC Report #2*, October 2017 – Contract and regulatory implications of the OPP
- *IC Report #3*, April 2018 – Peer-delivered services, supported employment, Oregon State Hospital (OSH), and Assertive Community Treatment (ACT) provisions [as of the end of fiscal year (FY) 2017 or OPP year one]
- *IC Report #4*, September 2018 – Mobile crisis services, criminal justice diversion, discharges from OSH, and supported housing provisions [as of the end of calendar year (CY) 2017, or half-way through the three years of the OPP]
- *IC Report #5*, August 2019 – Acute care psychiatric facilities (ACPFs), emergency departments (EDs), and secure residential treatment facilities (SRTFs) provisions [as of the end of CY 2018, or half-way through year three of the OPP].

SCOPE OF IC REPORT #6

This IC Report #6 addresses the Quality and Performance Improvement commitments in OPP Section E., as well as compliance overall with all provisions of the OPP. This Report describes the State's efforts and activities through the end of CY 2019 and in some cases into early 2020. However, Appendix B to this report summarizes the status of the State's efforts toward compliance utilizing data from OHA data and narrative reports dated January 2020 (revised in March 2020). These data reflect performance on quantitative metrics as of the end of year three of the OPP timeframe (FY 2019, through June 30, 2019).[3]

In this IC Report #6, narrative descriptions of new or upcoming Oregon activities and improvements or changes in performance are included where they add to or modify material in previous IC Reports. The

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

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

reader should refer also to the OPP itself and to prior IC Reports posted on OHA's website for descriptions of Oregon's behavioral health services, for prior compliance assessments with OPP efforts, for IC program and chart reviews, and for prior State of Oregon activities, especially for those areas in which OPP commitments were met at the time of those reports.

COMPLIANCE ASSESSMENTS AND TIMELINES

The OPP explicitly noted OHA's performance shall be measured by whether it substantially complies with OPP performance measures in Section D of the OPP and whether it establishes or maintains the quality improvement measures committed to in Section E of the OPP (Subsection E.6.).[4] The OPP also acknowledged the measures in the OPP are goals OHA aspires to meet, and OHA agreed to make diligent efforts to meet them. (Subsection A.7.) I have assessed and continue in this Report to assess compliance in this manner, that is, whether the State's activities and outcomes were in substantial compliance with its commitments as outlined in the OPP and whether OHA has made diligent efforts to meet the OPP goals.

Finally, the OPP indicated the Independent Consultant (IC) shall meet with OHA if OHA does not meet any particular goal or outcome measure at the time specified in the OPP. This meeting is intended to:

> "determine the underlying reasons why the outcome measure was not achieved, whether adjustments need to be made to that measure, whether the State has developed the infrastructure necessary to improve its performance and reach the outcome measure, whether to provide additional time for accomplishment of the measure, and whether to increase the term of [the OPP]. Any modification shall be in writing." (Subsection A.8.)

Meetings with me to assess these issues have occurred regularly throughout the three years of the OPP timeline. I have taken the position so long as diligent efforts are underway and progress is being made, the exact timelines in the OPP for various goals are less important than the trajectory toward those goals, including meeting identified quantitative goals and taking critical action steps. In addition, OHA's efforts to create and implement the Behavioral Health Quality Performance and Improvement Plan (BHQPIP) described in IC Report #5 and later in this Report were initially shared with me, and I have provided input to the goals and timelines in that initial BHQPIP. Therefore, the BHQPIP represents the written adjustments to those measures in the OPP that have not yet been met and for which OHA is planning to continue the path forward for the State of Oregon's efforts to meet or get closer to meeting the original OPP goals.

It should be noted OHA believes it has completed the OPP and the BHQPIP is now its plan to continue diligent efforts to improve performance on those OPP measures for which the goal has not yet been met. USDOJ on the other hand believes the OPP is not finished and indicated they feel they should have been involved in any decisions by me or OHA regarding changes to OPP measures. Hence, USDOJ requested the BHQPIP not be referenced in this Report. These differences in perspective will need to be discussed by the two entities when they meet later in the summer. Based on an initial draft agenda for a March meeting scheduled with USDOJ, it is clear OHA did intend to talk with USDOJ about its future plans, its quality improvement process going forward, and even its initial working draft work plans for implementation of the BHQPIP. However, the COVID-19 pandemic caused the March meeting to be rescheduled and most work plan efforts to be put on hold with a clear understanding those activities would resume as soon as the public health emergency management process allows.

USDOJ did send a letter to OHA dated December 20, 2019 indicating service areas for which the State was not meeting the OPP goal. I talked orally with one of the USDOJ representatives about the BHQPIP, indicating good overlap between USDOJ's concerns and OHA's BHQPIP plans going forward while acknowledging the frustration of not yet having seen the State's draft work plans. This work in progress has been disrupted by the COVID-19 response as described elsewhere in this Report, but is still on the agenda for the rescheduled USDOJ meeting with OHA in the summer.

In the meantime, since Subsection A.8. gives the IC authority and responsibility to make the assessments noted above, and Section E. of the OPP committed OHA to developing and implementing a quality and performance improvement system for the OPP population and services going forward, I believe it is critical to

[4] All references in this Report to Subsections are to the OPP unless otherwise noted in the text.

include in this Report a description of the current BHQPIP and to understand the State's plans for the future as best they are identifiable at this point in time. The BHQPIP is an important part of the State of Oregon's future efforts so is described and referenced throughout this Report. If OHA requests or proposes to change the timelines or goals in the current (February) version of the BHQPIP, I will have to make an assessment at that point whether the analyses in Subsection A.8. have changed and whether the proposal meets the criteria described in the OPP or whether a different decision is then in order.

Making system improvements in Oregon as in any jurisdiction is not a static activity with a specific start and stop time. System improvements are rarely "done." Rather, they are an on-going part of the role of high-quality leadership of any system of services and supports. OHA's current leadership – at the highest levels and for behavioral health in particular – has demonstrated commitment to continuing improvement of Oregon's services and outcomes for adults with SPMI. The BHQPIP is evidence of that on-going effort and offers Oregonians and other interested individuals the ability to watch and track those activities and changes over time, especially over the next couple of years.

IMPACT OF COVID-19 PANDEMIC AND REPORT REVIEW PROCESS

The timing of this IC Report #6 is unique in that it was drafted prior to the intense efforts undertaken by the State of Oregon and the rest of the country to address the incredible population health impacts of the COVID-19 pandemic. As required by Subsection F.3. of the OPP, USDOJ and OHA were originally provided a draft of this Report and were given 30 days in which to comment. During that 30-day period, OHA and USDOJ were originally scheduled to meet to discuss the status of Oregon's OPP-related efforts and the draft IC Report. However, due to the lockdown and intense efforts by every state in the country to help control the spread of the novel coronavirus, that meeting was cancelled and has now been rescheduled for later this summer. As a result, the two entities were given additional time to comment on this Report, through mid-May. However, the March date of this report with some revisions in June is based on the date it was initially drafted by me as IC and recognizes the month it was finalized after the extended review time period for OHA and USDOJ. The COVID-19 pandemic efforts by Oregon – especially by OHA – have resulted in significant changes and uncertainties for OPP-related efforts going forward. To the extent these are known at this time, they are noted in this Report. Otherwise, readers will have to track how budget challenges and other changes impact OHA's future efforts and engage as stakeholders in those processes.

As with prior IC Reports, this Report is the IC's work product and represents my judgments as IC. It has been revised to reflect comments of USDOJ and OHA determined by me to be appropriate to improve the accuracy of the report, with the intent of all involved to aid in the resolution of this matter, as directed in the OPP. (Subsection F.3.)

OPP SECTION A. RECITALS

In this section of the OPP, OHA noted several critical concepts to help interpret Oregon's commitments in the OPP, specifically:

- "The OPP is intended to better provide adults in Oregon with SPMI with community services that will assist them to live in the most integrated setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization." (Subsection A.1.)
- Oregon understands and is committed to compliance with the Americans with Disabilities Act (ADA). (Subsections A.1.– 4.)
- "The measures in [the OPP] are goals that OHA aspires to meet, and OHA agrees to make diligent efforts to meet them." (Subsection A.7.) This Subsection also noted OHA's previous efforts and investment of substantial funds and the State's goal to make additional system reforms during the three-year term of the OPP.
- If OHA does not meet any particular goal or outcome measure, OHA agrees to meet with the IC to determine the underlying reasons why, and "whether adjustments need to be made to that measure, whether the State has developed the infrastructure necessary to improve its performance and reach the outcome measure, whether to provide additional time for accomplishment of the measure, and

whether to increase the term of the Plan." Any of these modifications are to be made in writing. (Subsection A.8.)

While the OPP acknowledges the State of Oregon "aspires" to meet the goals in the OPP, they are largely achievable in my view, although perhaps with more time and resources committed to their accomplishment. Many of the goals have been achieved although some have not yet been reached; the State does appear committed to the OPP goals and commitments and to implementation of the ADA for adults with SPMI in particular; and OHA has discussed openly and with transparency those areas in which achieving the goals within the OPP timelines has been difficult or impossible to date.

As indicated in the Introduction to this Report, OHA's development and commitment to continued efforts to reach these goals are captured in its Behavioral Health Quality and Performance Improvement Plan (BHQPIP) described more fully later in this Report. The initial BHQPIP was shared with me and was revised from initial drafts based on my input. When first drafted and shared with me and with USDOJ, I believed that document would serve as further testament to Oregon's on-going effort to make improvements for this population and serve as a timeline and on-going goals beyond the OPP timeline. However, as of June of 2020, it is clear the initial BHQPIP will need to be revised due to the State's COVID-19 pandemic response and related budget challenges. Workplans for the BHQPIP goals were drafted but have not yet been finalized, and the initial timelines and activities described in those draft workplans may end up being adapted to Oregon's and especially OHA's current budget and workload realities. Stakeholders as well as USDOJ are encouraged to follow OHA's and the entire State of Oregon's continuing efforts through the BHQPIP process, to hold them and the behavioral health system accountable, and to ensure Oregon does in fact continue to make progress for this population.

OPP SECTION B. GENERAL TERMS AND DEFINITIONS

Section B. of the OPP included general terms such as the effective date of the OPP (July 1, 2016), definitions of terms critical to understanding the intent behind provisions of the OPP, and a statement the OPP shall not be enforceable in any court proceeding and noncompliance shall not be actionable in court. This Section also indicated the obligations in the OPP shall run to any successor agency of OHA's should any responsibility and oversight of mental health services be transferred to another State agency. In particular, two Subsections are important in determining compliance with the commitments in the OPP, as described below.

SUBSECTION B.2. COMMITMENT TO ADVOCATE

In this Subsection, OHA committed to advocate to the Oregon Health Policy Board and the Oregon Health Plan Quality Metrics Committee to develop additional metrics consistent with the performance outcome measures in the OPP. Evidence of OHA's advocacy with the Oregon Health Policy Board can be found in the new CCO 2.0 contract language regarding behavioral health in general and services for adults with SPMI in particular.[5] In addition, evidence of OHA's advocacy with this Board can be found .
on OHA's website. [6] This Board's 2018 CCO 2.0 behavioral health workplan included a specific reference to the OPP, identifying the goals of expansion of mobile crisis services, access to Assertive Community Treatment (ACT), increasing peer-delivered services (PDS), and increasing access to housing and employment services. OHA's advocacy resulted in better provisions, expectations, and metrics for individuals with SPMI in the CCO 2.0 contract, and is expected to have implications for regulation revisions OHA worked on in the fall and winter of 2019 and about which it is planning further activity later.

However, I have seen little evidence of advocacy with the Oregon Health Plan Quality Metrics Committee. In fact, when I have asked about such advocacy, I have been consistently told this Committee cannot add many metrics to the CCOs' responsibility and this Committee generally tends to consider Health

[5] See https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-Awardees.aspx and https://www.oregon.gov/oha/OHPB/CCODocuments/Work%20Plan%20-%20Behavioral%20Health.pdf.
[6] See https://www.oregon.gov/oha/ERD/Pages/HealthPolicyBoardAdoptsPolicyRecommendationsThatShapeOregonHealthPlanFuture.aspx.

Effectiveness Data and Information Set (HEDIS) measures which are not particularly helpful for the specific outcomes sought for individuals with SPMI. As of January 2020, only 13 CCO incentive measures were selected, and only two pertained to adults with mental illness, i.e., screening for clinical depression and follow-up plan, and emergency department (ED) utilization among members with mental illness.[7] The former is not an OPP measure, and the latter is a disparity measure, i.e., to determine whether a difference is observed among disparate members (e.g., by race, sex, etc.). Both of these measures pertain to any member with a mental illness, not just to adults with SPMI, so they are unable to be utilized for OPP purposes as they stand. Likewise, a previous measure specifically consistent with an OPP measure, i.e., follow-up after hospitalization for mental illness was eliminated as an incentive measure because OHA argues Oregon continues to be in the 95th percentile nationally on this measure.[8]

In May 2019, the OHA OPP Project Director did provide testimony requesting the Metrics and Scoring Committee to add the rate of ED visits for psychiatric reasons by adults with SPMI to the list of CCO incentive measures. This Committee did not accept the addition of this measure. This is the only evidence I have been able to find or been provided regarding advocacy with the Metrics and Scoring Committee. Hence, OHA is only ***in partial compliance*** with this commitment in Subsection B.2.

The new CCO 2.0 contract completed in late 2019 for the 2020 – 2024 timeline originally included in Exhibit M a list of behavioral health related measures on which CCOs would be required to report annually. However, these were eliminated in the final contract language with simply a requirement to report on measures affecting adults with SPMI and based on a list of data requirements to be provided by OHA. OHA made this change in part to provide more flexibility regarding what metrics to require of CCOs separate from data OHA already has available in its MMIS or other data or reporting systems. OHA has developed and discussed with CCOs a list of Behavioral Health Metrics for all populations which includes a specific subset of metrics for adults with SPMI based on OPP commitments. This list is a work in progress and will guide reports by and about CCOs for the first CCO 2.0 year, i.e., 2020, to be developed and released in early 2021.

Since OHA has done part of the advocacy described in Subsection B.2. but not all of it, the State is ***in partial compliance*** with this commitment. OHA will need to assure appropriate measures, data collection, and incentives (financial or otherwise) are incorporated into required reports, public dashboards, compliance assessment processes, and regulations as well as its overall quality assurance and improvement system in order to be successful for the OPP population going forward.

SUBSECTION B.3. COLLECTION, MAINTENANCE, AND AVAILABILITY OF DATA AND RECORDS

This Subsection committed OHA to collect and maintain data and records on each provision of the OPP to document the provisions of the OPP are being properly implemented, and to make such records reasonably available to USDOJ and the IC. OHA initially assigned a fulltime Project Director for this purpose who has worked with a team of staff from across OHA to assure progress was being made on OPP provisions, to identify work plans and impediments to getting actions accomplished, and to assure the IC and USDOJ have the information, data, and reports committed to in the OPP. This Project Director, along with many other OHA staff, have been generally available to me throughout the OPP timeframe to provide data and information, discuss possible approaches, and help me understand barriers and impediments as well as take suggestions about how to overcome those impediments. When information or data are not available, the Project Director has helped me understand why and estimated timelines for such information or data becoming available.

Even the OHA Behavioral Health Director(s), the Health Services Division Director(s), and the OHA Director(s) themselves have been available by phone or in person when I have requested time with them to discuss OPP related issues. While turnover among these positions has been experienced since July 1, 2016 and the Project Director has recently been assigned other duties in addition to OPP facilitation, I perceive all involved to be committed to successful OPP outcomes and to assuring USDOJ and I have the data and

[7] See https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-CCO-incentive-measures.pdf.
[8] See https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/CCO-All-Measures-Matrix.pdf for a comparison of incentive and non-incentive measures for Oregon's CCOs 2019 and 2020.

information we need to assess compliance or understand where Oregon stands on OPP implementation. Hence, OHA is ***in compliance*** with this OPP commitment in Subsection B.3.

OPP SECTION C. FUNDING LIMITATION

Section C. notes the OPP is subject to Oregon law and constitution regarding liabilities or monetary obligations of the State of Oregon. However, this Subsection did commit "the State [to] make diligent efforts to obtain the funding, appropriations, limitations, allotments, or other expenditure authority necessary to implement the terms of [the OPP]." I assess Oregon to be ***in compliance*** with this commitment at this time, which is not to say more cannot or should not be done in terms of seeking and securing funding for services for the OPP population in the future.

In the biennium preceding the beginning of the OPP and in the subsequent two biennial budgets, significant financial investments of Oregon General Fund dollars were sought and made to enhance services for this population. See **TABLE 1** below. In addition, OHA worked with CMHPs to assure funding formula issues in the 2017 – 2019 biennium did not impact funding for community services. This funding formula issue came up again during the 2019 legislative session considering the 2019 – 2021 biennium. This resulted in the set aside of a significant portion ($9 million) of the CMHP budget while funding formula issues are in discussion.[9] Loss of these dollars would be a significant hardship for community behavioral health services in general and specifically for those with SPMI.

The Oregon legislature directed OHA to work with stakeholders to develop recommendations to address this funding formula issue. In his January 17, 2020 letter to the Oregon Interim Joint Committee on Ways and Means, OHA Director Patrick Allen submitted the Interim Workgroup Report #1 from the Budget Note direction on this matter. Director Allen indicated Oregon's behavioral health system is changing and acknowledged three populations should be considered "mandated" due to the court-ordered nature of the services required to be provided, i.e., people who have been civilly committed (such as the OPP population), people found guilty except for insanity, and people arrested and found unable to aid and assist in their own defense. Director Allen's report also indicated the Workgroup's recommendation to "pause" community mental health budget adjustments for this biennium. The Workgroup's other recommendations include the Workgroup continuing to meet throughout 2020 to work on data validation and pricing models, IT system and data source improvements (e.g., OHA's MOTS system), consideration of other fund sources and protocols for distributing contract funds, and recommendations regarding funding adjustments for the future. The report indicated the Workgroup will develop caseload forecasts and funding models for the three populations identified as "mandated" with a goal to ultimately reduce such mandated caseloads. The Workgroup report also noted the current formula provides disincentives for preventing higher levels of care and does not include pre-commitment work for the civil population (and does not currently include the aid and assist population at all). The Workgroup report indicates they will also evaluate value-based payment methods or other policy options to help reduce the numbers of people reaching higher levels of need and hence being mandated into services by Oregon's courts.

The following **TABLE 1** provides program-based tracking of new General Fund investments allocated by the Legislature over four biennia for services needed for the OPP population. Most of these funds were advocated for by OHA as well as other constituencies. Other than the housing development funds, these are not one-time appropriations, but rather continue as recurring funds into succeeding biennia.

[9] See also Footnote 90 later in this Report.

TABLE 1: New Adult Community Mental Health Investments 2013 – 2021 (in Millions)

Adult Services	2013-2015	2015-2017	2017-2019	2019-2021	Total New Funding
Crisis Services[10]	$ 10.55	$ 9.33	$ 10.00		$ 29.88
Jail Diversion Services	$ 3.99	$ 8.67			$ 12.66
Services Associated with Supported/ive Housing Units (including Peer-Delivered Services)	$ 16.20	$ 9.33	$ 5.00[11]	$ 4.50[12]	$ 35.03
Supported Employment Services	$ 2.00				$ 2.00
ACT	$ .32[13]			$ 4.00[14]	$ 11.32
Tribal Set Aside	$ 2.40				$ 2.40
Supported/ive Housing Development[15]	$ 5.00	$ 20.00[16]			$ 25.00
TOTAL FOR ADULTS	**$ 47.46**	**$ 47.33**	**$ 15.00**	**$ 8.50**	**$ 118.29**

In addition to the General Fund investments indicated in **TABLE 1** above, significant increases have occurred in Medicaid and other fund sources (e.g., federal Mental Health Block Grant) for behavioral health services, especially for peer-delivered services, supported employment programs, Assertive Community Treatment, and clinical services billable to Medicaid. During the 2020 legislative session, OHA's Director reported a growth in overall behavioral health spending by OHA from $2.278 billion in the 2013 – 2015 biennium to $3.214 billion planned for the current 2019 – 2021 biennium. This is an increase of over 40 percent. While these funds are not solely for adults with SPMI, certainly the commitment by the State of Oregon and specifically OHA to invest in behavioral health service needs of its population overall is evident.

The information in **TABLE 1** and recent developments suggest the commitment to fund OPP related services may be shifting somewhat. Recent requests in the 2019 and 2020 legislative sessions by OHA or the Governor have been about community-based services for other populations (e.g., persons with substance use disorders, children/youth/families, or those unable to aid and assist in their criminal defense[17]) or about opening additional units within Oregon State Hospital, specifically for the aid and assist population. Recent concerns regarding individuals in local criminal justice systems who are in need of competency restoration in order to "aid and assist" in their defense have resulted in additional funding for community restoration services for this population, including the possibility of housing. While this population includes some adults with SPMI, not all individuals characterized as "aid and assist" are diagnosed as SPMI.

[10] NOTE: Oregon unfortunately has experienced the number of COVID-19 cases making the State eligible to apply for additional crisis services funding through the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Local programs are applying for these funds through the State now. How much additional federal funding becomes available for these services and which jurisdictions/programs receive this funding is expected to be known by August.

[11] This funding was allocated in the 2017-19 biennium but will not be spent until the 2019-21 biennium.

[12] This is permanent "supportive" housing funds for rental assistance with support services. Planning has yet to happen to determine how this funding will be utilized, although OHA indicates all or part of it may be spent for individuals in "supported" housing units and primarily for services for adults with SPMI. The funds currently are being held by the legislature until the units are developed by OHCS.

[13] This new funding was reduced to $5 million for the 2019-21 biennium.

[14] This funding is from savings in OHA's budget due to the Residential Rate Standardization process.

[15] Housing development funding is one-time funding and could be for supportive or supported housing for individuals with SPMI or other behavioral health conditions.

[16] This was funding in OHCS budget and administered in collaboration with OHA, to develop housing units. An additional $50 million for additional housing development was appropriated for OHCS for 2019 – 2021; however, not all of these units will be for adults with SPMI and not all will be for supported housing approaches.

[17] $7.6 million was added in the 2019-2021 budget to provide additional residential and shelter options for people receiving community competency restoration services, some of which could be individuals with SPMI.

Similarly, due to the COVID-19 pandemic response, the State's economic outlook is very different now than it was in March with significant reductions in revenue expected for the current biennium (ending June 30, 2021). A special legislative session is expected to be called for later in the summer to determine how to handle a significant shortfall in anticipated State revenues. According to the June forecast released in late May by the Oregon Office of Economic Analysis:

> General Fund and other major revenues have been reduced relative to the March forecast by $2.7 billion in the current biennium and $4.4 billion in the 2021-23 budget period.[18] Fortunately, Oregon is better positioned than ever before to weather a revenue downturn. Automatic deposits into the Rainy Day Fund and Education Stability Fund have added up over the decade-long economic expansion and stood at $1.6 billion in April. In addition to dedicated reserve funds, the General Fund had over one billion dollars in projected balances before the recession hit.

While Oregon has experienced economic expansion for several years resulting in reserves that may provide some cushion in this process, Oregon is also a state more dependent on income tax revenue and revenue from economic activity (i.e., sales) than some other states. Hence the economic closure necessitated by the COVID-19 public health emergency could impact the State of Oregon's revenues for years to come.[19]

To address this budget challenge and be ready for the special legislative budget session, Oregon's Governor requested all State agencies to submit scenarios to reduce their budgets by 8.5 percent for the second year of the biennium (effectively a 17 percent budget reduction for the biennium). This represents a $372 million total reduction ($226 million general fund) for OHA. While OHA leadership makes clear this is currently an exercise dealing with possibilities and not final decisions by the Governor or the legislature, the types of reductions being considered could have a significant impact on the OPP population and services. For example, OSH's possible scenarios include significant reduction in beds and workforce as well as reductions in some programmatic offerings. The Health System Division's (HSD's) possible scenarios impacting behavioral health include – among other things – reductions in funding for the Rental Assistance Program (RAP), Choice provider contracts, expanded ACT services, and local community behavioral health programs, Possible reductions in recently increased Medicaid rates for behavioral health services would also have a big impact on community-based behavioral health services.[20] Should this occur, OHA indicates it will have to revise CCO 2.0 contracts – possibly including Exhibit M and other behavioral health requirements – after negotiation with CCOs. Such changes could have adverse impacts on community-based services for adults with SPMI. While OHA is advocating regarding the negative impact these possible reductions would have on hospital and community-based services for persons with SPMI, the ultimate outcome has not yet been determined. Some of these reductions can be implemented by the Governor; some require Legislative approval.

The $4.5 million allocation for OHA for 2019 – 2021 was for supportive services associated with individuals in housing units being developed by the Oregon Housing and Community Services Department (OHCS). These could be for individuals in housing units fitting the definition of supported housing in the OPP and according to OHA staff are likely to be in whole or in part for adults with SPMI. In addition, these funds were set aside and were not to be released by the legislature until additional housing planning and development by OHCS is accomplished. However, these funds are also now in jeopardy of reduction or elimination entirely.

Finally, Oregon was one of several states implementing a federal pilot program to create Certified Community Behavioral Health Clinics (CCBHCs)[21] allowing additional federal Medicaid funding for CCBHCs

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[18] With associated federal and other revenue, the overall shortfall could be as much as $10.5 billion.
[19] See Oregon Office of Economic Analysis information about the impact of COVID-19 at https://oregoneconomicanalysis.com/ and https://www.oregon.gov/das/oea/Pages/Index.aspx.
[20] See https://www.youtube.com/watch?v=WHx1h7i73Jc&feature=youtu.be for a May 11, 2020 video recording of OHA behavioral health leadership explaining possible budget reductions impacting adults with SPMI and other populations. See also https://www.oregon.gov/gov/Documents/Oregon-Governors-Office-Proposed-Budget-Reductions.pdf for details of possible budget reduction scenarios being considered by Oregon's Governor. Governor Brown is reportedly finalizing a list of $150 million in general fund savings for this biennium, but it is not yet clear what the source of these savings will be. It also appears a special session regarding budget for the current biennium will be called sometime this summer to address additional budget reduction possibilities. See The Lund Report article on June 16, 2020 entitled *Governor Calls June 24 Special Session for COVID-19, Police Reforms.*
[21] See https://www.thenationalcouncil.org/wp-content/uploads/2017/11/What-is-a-CCBHC-11.7.17.pdf.

meeting certain nationally established standards. This project has been stalled across the country while Congress determined the budget for Federal Fiscal Years 2020 and 2021. Some states held back on funding the state portion of this critical pilot program until Federal Financial Participation (FFP) was assured. Oregon held its General Fund for one quarter, July through September 2019, but re-established this funding effective October 1, 2019 (part of FY 2020). With FFP, this could have meant a loss of as much as $60 million for community behavioral health services across participating Oregon programs, some of which are programs and services for adults with SPMI. However, the President's recent budget submission does include significant continuation and increased funding for this program.[22] Some Oregon counties or CCBHCs self-funded the required match using local funds in order to obtain the FFP funding pending state or federal action. During the 2020 legislative session, the Oregon legislature considered a proposal to provide an additional $15 million to the State's Medicaid program to provide a total of $80 million in state and federal funding for CCBHCs. Unfortunately, the Oregon legislature adjourned without reaching agreement on any budget. With the current budget challenges, OHA is indicating CCBHCs will have to self-fund the local match if they wish to continue as a CCBHC and receive FFP to do so. Given other potential reductions, it seems unlikely many of Oregon CCBHCs will be able to do so.

As noted earlier in this IC Report, Subsection A.1. of the OPP stated the intention is to "better provide adults in Oregon with [SPMI] with community services that will assist them to live in the most integrated setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization." In order to meet this overall goal, Oregon will have to do more than what is in the OPP. While the OPP included significant commitments regarding community-based service needs of adults with SPMI (e.g., ACT, supported housing, crisis services, supported employment, peer-delivered services, etc.), it does not address all the community services needed for this population. Other fund sources such as the formula issue described above as well as other state and federal grants help with these service needs but are not adequate to prevent, treat, and support rehabilitation and recovery for the OPP population, much less for all populations in Oregon in need of such services. States always experience funding issues as programs evolve and budget circumstances and leadership change. However, the State of Oregon's leadership has recognized the need to do more going forward specifically for adults with SPMI in order to meet the "diligent efforts" commitment to obtain funding and appropriations (and expenditure authority) necessary to implement the OPP in its entirety and reach all of its commitments and goals.

Therefore, OHA worked last year with the Governor's Office to create by executive order a Governor's Behavioral Health Advisory Council.[23] This Council was created in October 2019 and according to OHA's website is tasked with working through December 2020 to develop recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorders. The Council is directed to recommend to the Governor and legislative leadership specific actions and investments necessary to improve access to behavioral health care that is responsive to people's individual needs and characteristics and improve health outcomes, building on rather than replicating previous efforts to improve the behavioral health system. Among other things, workforce is one of the issues to be considered and addressed by the recommendations from this Council. OHA's Behavioral Health Director co-chairs this Council.

OHA has agreed to discuss the submission of its 2021 – 2023 budget request to determine what requests for adults with SPMI are appropriate and needed, especially given the increase in Medicaid expenditures OHA indicates has occurred for this population as well as Oregon Health Plan (OHP) members as a whole. (See earlier description in this Report.) However, any such request for this next biennium will not occur until the 2021 legislative session, with planning underway in early to mid-2020. Given the budget challenges described earlier, it is possible budget planning for this upcoming biennium will continue to include discussions of budget reductions rather than additional budget requests.

[22] See statement released February 10, 2020 from the National Council for Behavioral Health at https://www.thenationalcouncil.org/press-releases/statement-from-chuck-ingoglia-on-trump-administrations-fy-2021-budget/.

[23] See https://www.oregon.gov/oha/HSD/BHP/Pages/BHAC.aspx for the Governor's October 18, 2019 Executive Order No. 19-06 and information about the Council's meetings and activities.

In the 2019 legislative session, S.B. 973 was passed to create a $10+ million grant program called the Improving People's Access to Community-based Treatment, Supports, and Services (IMPACTS). This law also created a grant review committee in the Oregon Criminal Justice Commission (OCJC) to oversee this grant program.[24] Included on the committee are the directors of OHA, Oregon Housing and Community Services Department (OHCS), Oregon Department of Corrections (ODOC) and OCJC, along with the Chief Justice of the Oregon Supreme Court and 14 other designated types of individuals. OHA's Behavioral Health Director Steve Allen represents OHA's Director and co-chairs this grant review committee with the Executive Director of the OCJC. The committee is established and was in the process of designing and releasing the RFP for these grants which will be available for CMHPs, behavioral health providers, and others, submitted through the Local Public Safety Coordinating Council (LPSCC) in the county to be served. The IMPACTS program is designed to address the growing need for resources for individuals with mental illness and/or substance use disorders who have frequent criminal justice system involvement. The Senate bill indicates the IMPACTS program is established in "recognition of the shortage of comprehensive community supports and services for individuals with mental health [sic] or substance use disorders, leading to their involvement with the criminal justice system, hospitalizations and institutional placements."[25] This grant program is in line with the State's and OHA's commitments in the OPP although not limited only to the population of adults with SPMI. The Grant Application for this program was released in May with applications due June 12, and funds expected to be awarded for use beginning July 1, 2020 (FY 2021).[26]

In early February 2020, the Oregon legislature's House Behavioral Health Committee (with support from the Chair of the Senate Committee on Mental Health) introduced HB 4082 to create a joint legislative commission charged with creating a roadmap for addressing the state's mental health needs. The commission would include lawmakers from both chambers as well as stakeholders identified by legislative leaders. The commission would have "create[d] a response for how the state moves forward in policy and fiscal with all the right people at the table."[27]
In addition, the Speaker of the Oregon House introduced HB 4001 which would put $41 million toward the state's shortage of emergency shelter beds for individuals who are homeless along with $140 million toward efforts to add and preserve existing affordable housing. Another bill (HB 4002) would direct a study by the fall of 2020 of the costs and benefits of a long-term rental assistance program for people struggling to pay their rent and could end up homeless without such assistance. Possible legislation could come of such a study for the 2021 legislative session.[28] While these legislative efforts are not entirely about the needs of the OPP population, they could have yielded positive results to address the state's behavioral health and housing needs,[29] and therefore some of the needs of adults with SPMI.[30]

These activities and commitments to identifying specific action steps and needed financial investments is additional evidence of the State's diligent advocacy efforts. However, the proof will be whether recommendations are in fact forthcoming, are detailed, and are adopted and implemented and whether new grants make a difference in outcomes for individuals served, specifically for adults with SPMI. With the

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[24] See https://www.oregon.gov/cjc/impacts/Pages/default.aspx.
[25] The full Senate bill is at https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB973/Enrolled.
[26] As of June 5, 2020, OHA indicated the IMPACTS Grant Program is proceeding with a simplified application process and expedited application review time in order to get funds disbursed quickly. Applications were due June 12, 2020. See https://www.oregon.gov/cjc/impacts/Pages/default.aspx. Possible budget reduction scenarios might include a reduction in the $10 M available for these grants, but not an elimination of the program. The program implementation committee, which includes OHA's Behavioral Health Director, is currently moving forward with review and approval of applications assuming the full $10 M originally allocated will be available.
[27] Reported February 4, 2020 by Ben Botkin in The Lund Report article entitled *Oregon Lawmakers Plan Roadmap for Behavioral Health Needs*.
[28] See The Lund Report article by Ben Botkin entitled *Speaker Kotek Adds $20 Million to Homelessness, Affordable Housing Proposal*, February 12, 2020.
[29] An article posted by The Oregonian/OregonLive on January 20, 2020 indicated Kaiser Permanente – one of a dozen partner organizations associated with the Regional Supportive Housing Impact Fund overseen by CCO Health Share of Oregon – announced it plans to donate $5.1 million to finance an initiative to find permanent housing for 300 people age 50 and older who are homeless and have disabilities. Many of these individuals are likely to have SPMI.
[30] As of March 3, 2020, both the Oregon House and Senate Republican legislators walked out in order to prevent a quorum in protest of a non-health related bill they contend should go to the voters rather than be acted on by the legislature. This walkout left both houses unable to conduct any business or votes on pending budget or legislation, including the health bills described here. As of March 5, the legislative session ended without action on the State budget or on any of pieces of legislation that would have impacted behavioral health services, homelessness, or housing.

budget challenges and proposed reductions described earlier, it is currently uncertain whether any of these advocacy efforts will have the positive impact hoped for when initially begun. Stakeholders and advocates will need to continue to work with OHA, the Governor's office, and the legislature to prevent as many reductions as possible to services for the OPP population and to set the stage for increasing assistance for community-based services for SPMI adults in the future.

OPP SECTION D. PERFORMANCE OUTCOMES

SUBSECTIONS D.1. – 5. ASSERTIVE COMMUNITY TREATMENT (ACT) [See Also IC Report #3]

ACT is defined in Subsection B.6.b. and similarly in regulation at Oregon Administrative Rule (OAR) 309-019-0226. OPP Subsections D.1. – 5. included numeric and process commitments by OHA to increase availability and access to ACT teams meeting national standards for this evidence-based service. Subsection D.23. also included specific commitments for referral to and receipt of ACT services for individuals discharged from Oregon State Hospital (OSH) and eligible for ACT. These commitments are discussed below.

Numeric Goals and Data Commitments Regarding Individuals Receiving ACT Services

Subsection D.1.a. – b. committed OHA to increase the number of individuals with SPMI served by ACT teams, specifically to assure 2,000 individuals would be served by the end of year two (FY 2018), after which a waitlist process would be implemented. OHA reported as of the end of OPP year three (FY 2019) 1,325 individuals received ACT services, an increase from the baseline of 815 in CY 2015. While OHA has not yet reached the OPP goal of 2,000 receiving ACT services and therefore is ***not in compliance*** with this commitment, significant efforts have been taken and additional efforts were underway during CY 2019 to increase the number of individuals receiving ACT services. These efforts are included in the initial version of the BHQPIP. However, the potential budget reduction scenarios described elsewhere in this Report may have an adverse impact on these future expansion efforts.

OHA has been working through OCEACT to increase the number of ACT teams meeting fidelity standards to assure sufficient capacity is available. As of November 26, 2019, 33 ACT teams were serving adults with SPMI in all but four Oregon counties. These teams ranged in capacity from 10 individuals to 115 with a total capacity for serving 1,449 individuals statewide. This compares to no teams certified as meeting fidelity in 2012, and approximately 10 teams certified as meeting fidelity by June 30, 2015 with several more in development.[31] Accordingly, the growth in ACT teams and ACT capacity is significant but not yet sufficient. Consequently, $4.0 million in funding for additional ACT teams and services and for non-Medicaid eligible individuals had been committed by OHA to be up and running by FY 2021 with a goal in the BHQPIP to reach 1,750 individuals served by the end of FY 2021. However, budget reduction scenarios described earlier in this Report may reduce or eliminate the growth in ACT programs and services. Pursuant to Subsection A.8., I have agreed to revised goals for a three-year period from July 1, 2019 (FY 2020) through June 30, 2022 (FY 2022) in a revision to the BHQPIP in process. It should be noted, however, the unmet need statewide is estimated by OCEACT to be over 1,500 additional individuals beyond the 1,242 being served at the point in time they most recently provided me with ACT team capacity and numbers served (November 2019).[32]

Subsection D.4. committed OHA to gather certain specified data regarding individuals with SPMI receiving ACT services, e.g., of those served, the percentage each quarter who have stable housing or are homeless, receiving supported employment services, were employed in competitive integrated employment, use an emergency department, are hospitalized, or in jail during the quarter. These data were 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 has reported these metrics to USDOJ and

[31] The OCEACT contract to conduct fidelity assessments began July 1, 2013 and was renewed with additional terms and responsibilities in 2018.

[32] NOTE: This number is a little lower than the numbers reported by OHA in its data report as the OCEACT number constitutes the number being served at a particular point in time whereas OHA reports the number of individuals who received ACT services over the course of a year.

the IC separately to supplement the primary OPP data and narrative reports beginning in April 2018 and most recently in June 2020 for FY 2019 (OPP year three). Hence the State is ***in compliance*** with this commitment. These data are obtained through program submissions to OCEACT and are utilized by OCEACT to identify areas for technical assistance and training as committed in this Subsection.[33]

While OHA did make significant changes to the regulations governing ACT services to better align requirements of these programs with the OPP language, other changes are still needed. One of these changes is inclusion of requirements to report to OCEACT quarterly. While this reporting requirement is not specified in the OPP in this way, the OPP did commit OHA to certain reporting on ACT service recipients, and OHA has indicated program reporting to OCEACT is the source of this information. Hence, without a specific requirement for the programs to do such reporting OCEACT, it is unclear whether the State can count on having this information fully available in the future. Some of the needed regulatory changes were proposed but not completed in last year's regulation review process. This process was suspended to allow time for additional work with stakeholders. Given this suspension and the current COVID-19 pandemic response, changes to these and other 309 series regulations are uncertain at this time.

OHA Commitments Regarding ACT Admission Criteria, Referrals, and Denials

Subsection D.1. and D.2. committed OHA to provide ACT services to everyone who is referred to and eligible for ACT similar to Subsection D.23.a. which committed the State to provide ACT services for everyone discharged from OSH who is appropriate for ACT (or an evidence-based alternative). See the discussion of these OSH and ACT issues in the section about OSH later in this report.

In Subsection D.1.c., OHA committed 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 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). The implementation of this commitment was to have begun after June 30, 2018 (OPP year two). OHA has undertaken several activities to determine who and how such waitlist(s) should be managed and is working to assure all system players understand their responsibilities to make this happen. However, it is not yet being done consistently.[34]

Subsection D.3. also committed 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. Since ACT is a Medicaid-eligible service for those on the Oregon Health Plan (OHP), OHA has worked extensively with CCOs to set expectations and help them understand their responsibility to determine eligibility for ACT and make this service available for those eligible as well as to track denials and those waiting for such services. OHA began use of an ACT tracking document (see further discussion in the OSH section of this Report) and has been collecting data regarding the number and percentage of referrals ACT teams have refused to accept. The percentages of refusals by teams to accept persons referred have been high – from one-third to one-half of all referrals in some reporting periods.

To address this issue, OHA had been meeting with CCOs regarding how to handle these refusals by ACT teams separately from determinations of ineligibility for ACT services. Waitlist requirements have not been included specifically in the final CCO 2.0 contract language (Exhibit M) because federal Medicaid regulations do not allow waitlists for individuals in need of and eligible for Medicaid covered services. However, CCOs have been provided clarification regarding their responsibility to assure individuals who are denied eligibility for ACT are assisted with filing a Notice of Adverse Benefit Determination (NOABD) and receive help in requesting a hearing regarding this NOABD. For those who are determined eligible but for whom a team has refused to accept the individual, CCOs have been given expectations orally regarding their responsibility to assure alternative services are provided but only until ACT services can be arranged and not as an on-going service alternative.

[33] For these and other data re ACT services and outcomes, by team, for the last several quarters, see https://oceact.org/outcomes/.

[34] See, for example, November 20, 2019 article re Multnomah County audit regarding ACT and other services at https://www.thelundreport.org/content/audit-blasts-multnomah-county%E2%80%99s-handling-millions-taxpayer-dollars-mentally-ill. See also https://multco.us/auditor-mcquirk/mental-health-audit-report for the audit report itself.

Similarly, Choice contractors have a role in helping to arrange ACT referrals and services and advocate for those found eligible for such services. OHA was meeting regularly with Choice contractors and CCOs, along with OCEACT as needed, to assure roles and responsibilities were clear and being met. Since the CCOs have only had the current contract since January 2020, data about such denials, refusals, and alternative services have not yet been made available. Likewise, while no CCO has yet been held accountable through a corrective action plan for such issues, this type of data is being considered for regular reporting when the first full year of data is available for the new CCO contract period, as well as for the Dashboard OHA has begun to design for public reporting purposes.

In addition, a new ACT-experienced staff person has been added to OHA specifically to focus on ACT services. This staff person is working with stakeholders and other OHA staff to develop written guidance for all system players which was initially expected to be released in 2020. This staff person will also be providing technical assistance to system players about ACT service expectations and responsibilities. ACT regulatory changes are still being considered as well and if implemented, will assist with clarification of responsibilities and expectations regarding ACT services.

These actions, along with the additional $4.0 million for new teams and services described earlier, should help to increase the state's ACT capacity as well as the numbers of those being provided with ACT services, although any reduction or elimination of these additional dollars because of the COVID-19-related budget challenges will stymie these efforts. The number of individuals receiving ACT services is included in OHA's revised BHQPIP described throughout this Report, with goals of 1,400 receiving ACT services during FY 2021 and 1,750 during FY 2022. OHA was working toward compliance but is currently ***not in compliance*** with OPP commitments in Subsections D.1.c. and 2.

Regulatory Issues Regarding ACT

Subsections D.1.e. committed 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. committed OHA to incorporating those admission criteria into administrative rules. As indicated earlier in this Report and in IC Report #3, OHA has incorporated such criteria into administrative rules, but the criteria and the regulation need additional changes and clarifications and the regulatory revision process at the moment has been suspended without clarity regarding when it will begin again. Similarly, OHA's work to revise the County Financial Assistance Agreement (CFAA) language for CMHPs is still in process. 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 ensure they are not overbroad according to national standards, OHA is currently ***in partial compliance*** with these OPP commitments.

SUBSECTIONS D.6. – 13. CRISIS SERVICES [See Also IC Report #4]

Mobile crisis services[35] were defined in Subsection B.6.j. of the OPP as:

> . . . mental health services for people in crisis, provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible, and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration."

Subsections D.6. – 13. of the OPP described the State of Oregon's commitments to:

- expand mobile crisis services so they are available statewide by the end of year two (June 30, 2018) (Subsection D.6.);

[35] It should be noted that while the Subsections of the OPP concerning these services are titled "crisis services," the specific commitments in these Subsections are all about "mobile" crisis services (except for Subsection D.13. regarding standards for hotline services and county crisis lines). This distinction is critical for the OPP as many other types of crisis services are funded by the State and are being provided in a crisis center or other location where treatment services are provided rather than in locations "in the community where the crisis arises" as specified in the OPP definition.

- increase the number of individuals served with mobile crisis services (Subsection D.7.);
- track and report the number of individuals receiving a mobile crisis contact and their dispositions (Subsection D.8.);
- assure mobile crisis teams respond within specified time periods, and for frontier and rural areas, provide a person trained in crisis management to call the person within one hour (Subsections D.9. – 12.); and
- develop and enforce uniform standards for hotline services and county crisis lines (Subsection D.13.).

The status of achievement on these commitments is described below.

Mobile Crisis Services Expansion Statewide and Numeric Goals

OHA has provided additional funding to Oregon Counties for mobile crisis services throughout the three years of the OPP. As reported in IC Report #4, as of July 1, 2018 all Oregon Counties have some form of mobile crisis service able to respond to a crisis at a location in the community and as of the beginning of January 2019, all Counties had full mobile crisis response services available. Therefore, OHA is ***in compliance*** with this OPP commitment.

According to OHA's latest data report covering the 12-month period through June 30, 2019 (OPP year three), 8,905 individuals received mobile crisis services. This number is significantly above the goal of 3,700 to be served during year two and year three of the OPP. Therefore, OHA is ***in compliance*** with this OPP commitment.

OHA was also able to track and report dispositions of those receiving a face-to-face mobile crisis service, hence the State is ***in compliance*** with this reporting commitment as well. For the last quarter of OPP year three ending June 30, 2019, OHA reports in 3,202 events, 2,667 individuals were stabilized in the community setting, 472 of these events ended in the individual presenting to an emergency department (ED) and only 63 resulted in the individual being admitted to an acute care psychiatric facility. Significantly, the percentage of these events in which individuals did not interact with the criminal justice system remains high at over 83.3 percent. Likewise, the numbers who presented to an ED or were admitted to an inpatient unit remain low even as the overall number of mobile crisis events continues to increase. Clearly the increase in mobile crisis services over the last three years is helping Oregon with its criminal justice diversion goals as well as helping to reduce use of ED and acute care admissions for adults with SPMI.

Standards for Mobile Crisis Response Times and Hotline Services/County Crisis Lines

As described in IC Report #4, Subsections D. 9. – 12. included specific timelines for mobile crisis team face-to-face response times, i.e., within one hour for areas that are "not rural or the frontier" (i.e., urban and suburban areas – identified by OHA in contract and regulatory language as simply "urban"); within two hours in rural areas; and within three hours in frontier areas. For both rural and frontier areas, OHA committed to having a person who is trained in crisis management (such as a person from a crisis line or a peer) call the individual in crisis within one hour if the mobile crisis response has not yet occurred. With few exceptions, most calls are responded to within one hour statewide and in fact on average within 30 minutes. While average response times are not part of the OPP per se, the average response times are instructive. These average response time for reported mobile crisis events for the four quarters of year three of the OPP are shown in **TABLE 2** below.

TABLE 2: Face-to-Face Mobile Crisis Response Time Averages Statewide FY 2019

QUARTER	Average Response Time (in Minutes)
July – September 2018	0:24:22
October – December 2018	0:27:15
January – March 2019	0:23:12
April to June 2019	0:25:27

A quick review of the raw data for 3,209 face-to-face mobile crisis events for the quarter ending June 30, 2019 indicated only 114 events (3.6 percent statewide) were responded to in over the designated response times.[36] In most of these cases, the time was only a few minutes over the allotted designated time. In many cases, especially in urban areas, programs indicate they try to respond even sooner than the designated time (within 30-45 minutes). Outliers can be because of weather, traffic, unusual distance, staff availability due to multiple crises occurring at once, the process for determining what the individual needs and who is with him or her, or local law enforcement processes for assuring the situation is safe before crisis workers can begin their interactions with the person in crisis. Statewide, Oregon is ***in compliance*** with meeting OPP committed response times for mobile crisis events.

As of March 1, 2018, OHA revised State regulations regarding crisis services[37] requiring community mental health programs (CMHPs) to provide crisis services 24 hours per day, seven days per week, to assure capacity for telephone or face-to-face screening within one hour of notification of the crisis event and to conduct an assessment and develop a plan to assist the individual and family to stabilize and transition to the appropriate level of care. For those needing a mobile crisis response, the OPP timelines for face-to-face response by geographic area are included in the regulation. This same regulation requires by July 1, 2018 (or when the CMHP is contracted to provide the service) the CMHP or designee to provide mobile crisis services as a component of crisis services for individuals experiencing a mental health crisis in their geographic area. The goals are noted as being to reduce acute psychiatric hospitalization of individuals experiencing a mental health crisis and reduce the number of individuals with mental health diagnoses who are incarcerated as a result of mental health crisis events involving law enforcement.

OHA regulations at OAR 309-019-0150(7)(a) require response times to be tracked somewhat differently than is committed to in the OPP. In the OPP, OHA committed to no more than a three-hour response time in frontier areas; a two-hour response time in rural areas; and a one-hour response time in areas that "are not rural or the frontier." The latter term is not the same as "urban" which is the term utilized in the regulation, although OHA has consistently indicated its use of the word "urban" includes suburban areas and any non-rural or non-frontier area must meet the shorter one-hour response time. These clarifications were not included in either the latest CFAA language for CMHPs nor in the most recent proposed regulations which have now been suspended pending further discussion with stakeholders. However, OHA utilizes the "urban" designation as it is consistent with federal designations for other purposes based on population density and generally does include suburban areas surrounding urban areas where population is relatively dense.[38] While clarifying this use of terms in regulation or CFAA language would be more consistent with the OPP, it has not changed the outcomes seen in the data or the program reviews which showed substantial statewide compliance with response times during the OPP timeframe.

Similarly, requirements and expectations for CMHPs providing crisis services (including mobile crisis services) are further delineated currently in MHS 25, a Service Element that is part of the County Financial Assistance Agreement (CFAA) with OHA. This Service Element has undergone revision for the first 18 months of the 2019 – 2021 time period, and is now clearer regarding expectations but is not yet totally consistent with OPP commitments. However, OHA has issued written guidance to mobile crisis programs consistent with the OPP and programs used this guidance in reporting crisis response for the OHA data reports. This CFAA Service Element language is now under review as part of the entire CFAA language revision process, but much of this work has been suspended or pushed into CY 2021 or beyond due to COVID-19 pandemic response. This process will offer an opportunity to clarify expectations and reporting

[36] NOTE: 86 of the response times over the time required for the specific county area were in Multnomah County, with 8 in Marion, 8 in Washington, 5 in Columbia, 3 in Josephine, and 1 each in Deschutes, Douglas, Lake, and Polk counties. OHA may want to do further analysis and work with Multnomah County to determine why they are experiencing a disproportionate number of response times beyond the designated time, why some of them are longer outliers than most other mobile crisis events, and whether a corrective action plan for this service area is in order to assist in bringing down the number of such outliers for this County and hence statewide.

[37] See OAR 309-019-0150.

[38] See https://www2.census.gov/geo/pdfs/reference/GARM/Ch12GARM.pdf and https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html for discussion of urban, urban area, "urban fringe" and other geographic designations by the U.S. Census Bureau. See also for discussion of the designation of areas as frontier, see https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/NRHAFrontierDefPolicyPaperFeb2016.pdf.aspx. See more about these designations in Oregon at https://www.ohsu.edu/oregon-office-of-rural-health/about-rural-and-frontier-data.

requirements as indicated above for the next CFAA to assure these are clear either in the CFAA or in regulations referenced therein.

Oregon currently designates each county as frontier, rural, or urban and OHA utilizes these designations even though more than one area type could exist in any given county. In some counties designated as frontier or rural, a population center exists in which response times may need to be faster than the frontier parts of the county (e.g., Ontario in Malheur County, Baker City in Baker County, Klamath Falls in Klamath County, Albany in Linn County, Grants Pass in Josephine County, or Pendleton in Umatilla County). The analysis described above of actual response times in 2019 in all geographic areas indicates programs are able to respond in most cases well under the designated timeline. Similarly, some less densely populated areas in "urban" counties may realistically require a little longer than one hour for a mobile crisis team member to respond. Regulations or designations may need to be considered for adjustment to accommodate these differences. However, this issue may be less of a concern now since most programs try to respond in well less than one-hour regardless of the county designation. Therefore, I find OHA is currently ***in compliance*** on this commitment of setting mobile crisis response times and standards.

OHA developed and revised OAR 309-019-0300 through 309-019-0320 regarding requirements for crisis line services, effective March 1, 2018. OHA enforces all of its regulatory requirements through its provider licensing and certification processes. OHA's unit doing this work has developed a checklist and tool to assure audits of these regulatory requirements are considered as CMHP interviews and program and chart reviews occur. This checklist and audit tool have been revised and updated based on staff's experience doing these audits and on input provided by me in December 2019. Hence, OHA is ***in compliance*** with this OPP commitment as it has the standards and enforcement mechanisms in place.

SUBSECTIONS D.14. – 15. SUPPORTED HOUSING [See Also IC Report #4]

Supported housing is defined in Subsection B.6.o. as:

> . . . permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site housing. To be considered supported housing under this Plan, for buildings with two or three units, no more than one unit may be used to provide supported housing for tenants with SPMI who are referred by OHA or it [SIC] contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for tenants with SPMI who are referred by OHA or it [SIC] contractors. Supported housing has no more than two people in a given apartment or house, with a private bedroom for each individual. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported housing does not include housing where providers can reject individuals for placement due to medical needs or substance abuse history.

In Subsection D.14., OHA committed to specific numeric goals about increasing the number of adults with SPMI in supported housing (recognizing that individuals may decline housing offered to them), and making best efforts to match individuals to housing that meets their needs and individual choices.

The metrics regarding persons with SPMI in supported housing include:

- At least 835 individuals with SPMI living in supported housing in year one (July 1, 2016 to June 30, 2017);
- At least 1,355 individuals with SPMI living in supported housing in year two (July 1, 2017 to June 30, 2018); and
- At least 2,000 individuals living in supported housing in year three (July 1, 2018 to June 30, 2019).

In Subsection D.15., OHA committed to:

- collect data regarding the housing stock or inventory available for individuals with SPMI;
- track the number of individuals with SPMI receiving supported housing; and
- use this information to make a budget request for affordable housing for individuals with SPMI in OHA's 2017 – 2019 budget.

Performance on these various commitments is described below.

Numeric Goals for Supported Housing

OHA exceeded its first-year goal of 835 individuals with SPMI living in supported housing in FY 2017. Since that time, the number of new individuals reported as living in supported housing grew very slowly until the most recent data report in which 1,903 individuals were reported to be living in such housing. The reason for this significant increase has to do with the efforts OHA has undertaken to count additional individuals living in supported housing beyond just those being supported through the OHA funded Rental Assistance Program (RAP) described in IC Report #4. That Report noted the likelihood of significantly more individuals living in supported housing whose rent is being paid through other means (HUD, individual resources, family resources, other program resources, etc.). Hence OHA has engaged in significant and appropriate efforts to count some of these additional individuals by working with RAP programs to learn who has remained in the housing provided but who have transitioned to HUD vouchers or other payment sources for the rent. OHA has also worked with the state's ACT programs to determine the number of service recipients who are living in housing meeting the OPP supported housing definition. These two sources alone accounted for much of the increase in the number of individuals reported living in supported housing throughout the state. Eventually, other methods of counting even more individuals living in supported housing units may be determined and undertaken. OHA's efforts to be aware of and track those living in supported housing regardless of fund source will enhance their ability to encourage the use of and grow this resource for adults with SPMI in need of such housing.

While the State of Oregon is not yet in compliance with the commitment to have at least 2,000 individuals with SPMI living in supported housing, at 1,903 individuals living in supported housing, it was at 95% of the OPP goal and hence was well on its way as of June 30, 2019. OHA has included additional efforts in its revised BHQPIP to reach this original OPP goal by the end of FY 2022 (June 30, 2022). Additional efforts to bring on more ACT teams and services would also help the state meet this goal as additional individuals with SPMI are provided support in the community through ACT program services. Hence, Oregon is ***working toward compliance*** with this OPP commitment.[39]

OHA is tracking and reporting the number of adults with SPMI living in supported housing as committed to in the OPP; hence OHA is ***in compliance*** with this reporting requirement and continues to refine its data collection efforts to assure these numbers are correct and incorporate additional individuals living in supported housing units throughout the state.

Data Re Housing Stock and Inventory and Adults with SPMI Living in Supportive[40] Housing

OHA tracks the number of housing units available for persons with SPMI by tracking housing inventory as described in IC Report #1. As of July 2019, 57,495 such affordable housing units were available in Oregon. This compares to 53,323 such units reported by OHA as available at Baseline (CY 2015). Hence these numbers are growing. However, these affordable housing units are not all supported housing and not all of

[39] While this is true for the time period ending June 30, 2019, and was a commitment in the initial BHQPIP, current budget reduction scenarios due to the economic impact of the COVID-19 pandemic response suggest housing support and ACT programs could be in jeopardy and therefore these numbers could backslide or it could be more difficult to meet the original 2,000 person goal at some point in the future.

[40] NOTE: Subsection B.6.o. defines "supported housing" in a very specific way. All data provided by the State for individuals living in supported housing meet this OPP definition although as indicated in IC Report #4, likely others live in such housing and are not able to be counted by the State for this purpose. Even though not required to do so and in addition to providing data regarding the number of housing units "available" for persons with SPMI, OHA has provided for each reporting period the number of individuals with SPMI the State is aware of living in "supportive" housing, i.e., housing with rental assistance and/or supportive services but which does not meet the specific OPP definition of "supported" housing.

these units are available solely to adults with SPMI. OHA makes the inventory of these affordable housing units available on its website.[41]

The number of individuals receiving supportive housing services in units that may not fit the definition of supported housing is reported by OHA as 1,873 compared to 1,361 reported for the period ending June 30, 2017. OHA tracked and reported these data and hence is ***in compliance*** with this OPP commitment in Subsection D.15.

Legislative Request for 2017 – 2019 and Other Efforts to Expand Supported Housing

OHA committed in the OPP to utilize the housing unit data it had to make a budget request for affordable housing (supportive and supported) for individuals with SPMI in connection with OHA's 2017 – 2019 biennial budget. This request was made in the 2017 legislative session with the result being $15 million in additional funding to meet OPP commitments, about $2.5 million of which was used to expand the rental assistance program beyond the initial $2.5 million invested during CY 2016. In 2015, $20 million was provided to Oregon Housing and Community Services (OHCS) for capital development of additional supportive and supported housing units statewide. OHA participated on and helped staff an interagency housing task force[42] to address some of the housing needs of individuals for whom OHA provides services. Housing development is a slow process and takes significant time, but does result in new available units. OHCS was provided an additional $50 million in the 2019 legislative session for development of additional housing designated as permanent supportive housing units (which can include supportive and supported housing types). These funds have resulted in an additional 65 units of supported housing for adults with SPMI being in development and expected to be completed from this OHA collaboration with OHCS by June 2022, most by June of 2021.[43] The legislature has also allocated but set aside an additional $4.5 million for OHA to use to provide support services for individuals occupying these and other OHCS developed units once they are built and filled. OHCS has also created a Permanent Supportive Housing Institute, running from November 2019 through March 2020, to assist 10 entities with project planning and development.[44]

In the meantime, some OHA RAP programs have been able to expand their efforts and could use additional funds to house and support additional individuals while other programs have underspent their allocations. Consequently, OHA has revised its approach to funding these programs to create flexibility to move funds to areas of the state where additional RAP funds are needed from those areas not able to utilize the funds available. The goal of this approach is to maximize the use of available RAP funds to serve the most individuals possible with the available funding.

While OHA is ***in compliance*** with its commitment regarding the 2017 legislative request and is working collaboratively with OHCS to develop more supported housing units, housing remains a challenge in most areas of Oregon. The State – including the legislature – will have to and was working to do more as described earlier in this Report regarding OPP Section C. Unfortunately, the Rental Assistance Program (RAP) providing much of the funding for current supported housing efforts is among those programs for which possible reduction scenarios are being considered. If RAP funding is reduced, it is unlikely the State will be able to meet its commitment of 2000 adults with SPMI living in supported housing, and may even see the number living in such housing now be reduced, especially as rents continue to rise in many geographic areas. OHA will have to make additional requests in future years (2021 and beyond) if the need for supported housing for adults with SPMI is to be met and keep up with growing housing costs in Oregon.

In addition to legislative requests and maximizing available RAP dollars, OHA has identified a staff person with significant experience working with this population and with housing in particular to head up efforts to increase funding for and provision of services to address social determinants of health (SDOH). A guidance document has been developed and posted on line regarding the use of and payment for health-related

[41] See https://www.oregon.gov/oha/HSD/AMH/Pages/Affordable-Housing.aspx.
[42] See https://www.oregon.gov/ohcs/DO/docs/Priorities/PSH%20Priority.pdf for the OHCS Statewide Housing Plan for Permanent Supportive Housing 2019 -- 2023, some of which may be supported housing units.
[43] OHA indicated on June 5, 2020 these units are still anticipated to be completed as planned as this capital funding has not been reduced.
[44] See press release at https://www.oregon.gov/ohcs/DO/newsreleases/2019/10-15-2019-Oregon-Supportive-Housing-Institute-Participants.pdf.

services by CCOs to address housing needs as one of the SDOH.[45] This document includes references to supported housing. OHA has committed to developing and posting an appendix to this document specifically about supported housing. An SDOH Spending Reference Guide is also in process, and OHA indicates supported housing will be specifically addressed in this document as well. Since many in Oregon do not clearly understand the difference between supported, supportive, and affordable housing and since the need for any kind of housing is a large issue in Oregon, especially in urban areas, OHA will need to do these and additional educational efforts and set clear expectations for behavioral health and political leaders to assure continued attention to this type of housing and services for adults with SPMI.

The CCO 2.0 contract references supported housing and makes clear these types of units should be an option for individuals with SPMI along with the behavioral health support services needed to make these living arrangements successful. However, neither the current CMHP CFAA language nor the related regulations are as clear as they should be about the use and priority for supported housing. The initial BHQPIP working draft workplans included efforts to increase the use of supported housing by educating, better counting and tracking, and maximizing funding for this type of resource for adults with SPMI. These draft workplans are under revision and are expected to be shared with USDOJ for its input prior to the meeting between OHA and USDOJ rescheduled for this summer.

SUBSECTIONS D.16. – 18. PEER-DELIVERED SERVICES [See Also IC Report #3]

Subsections D.16. –18. of the OPP described the State of Oregon's commitment to increase the availability of peer-delivered services (PDS) as defined in Subsection B.6.k.

Discussions with peers within OHA central office, at OSH, at Advisory Committee meetings, and during program visits indicate peers are helping to engage adults with SPMI in treatment and helping to support such adults with community living needs, getting to appointments, negotiating public benefits and community interactions, and engaging in person-centered planning – at OSH and in the community. A Peer Bridger position has been created at OSH to help individuals leaving the hospital with their transition to the community. PDS worker positions are required in the Rental Assistance Program (RAP) providing supported housing for adults with SPMI and in the ACT programs within the state. 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 has significantly exceeded these goals by increasing the number receiving PDS from 2,156 at baseline in 2015 to 4,038 as of June 30, 2019, a total increase of 87.3 percent. Thus, OHA is ***in compliance*** with its commitment in this area.

Subsection D.17. and D.18. indicated OHA will measure the number of individuals receiving PDS by using Medicaid billing data, noting that "many individuals receive peer-delivered services which are billed under another Medicaid billing code [for example, ACT or crisis services], and which are not captured by this methodology [for example, at OSH]." OHA indicated in the OPP a belief the Medicaid billing system "significantly undercounts" the number of persons actually receiving PDS in Oregon. Hence, the OPP specifically noted in Subsection D.17. it will continue to explore better and more accurate ways to count PDS, and if a more accurate way is identified, OHA may modify the methodology to track the provision of PDS. 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 have received training as a peer but are not recognized as a Medicaid eligible practitioner – including community mapping in coordination with specific counties – to develop a more comprehensive database of all PDS.

OHA's Office of Consumer Activities (OCA) estimates 15 to 25 peer-run organizations (PROs) in Oregon also provide services for adults with SPMI but are not billing Medicaid for these services. OCA currently provides technical assistance for these PROs. Once Oregon's pending substance use disorder (SUD) waiver is approved by CMS,[46] OCA plans to assist interested PROs to complete the application process to become a Medicaid provider for individuals with SUD as well as successfully maintain billing and accounting processes with fidelity to the peer model. In the meantime, OCA is trying to compile and keep up to date a list of PROs in Oregon. While OCA receives quarterly reports from many of these organizations, they are not

[45] See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf.
[46] See https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/SUD-Waiver.aspx.

sufficiently consistent to be a source of data reporting at this time. In addition, many of these PROs have a concern about data reporting due to the diagnostic information requested which may conflict with peer values about not seeing individuals as "consumers" or even "peers" but rather first as human beings. Hence, these efforts have not yet resulted in an accurate statewide methodology for capturing additional PDS being provided beyond those billed to Medicaid. Therefore, the Medicaid billing system most likely will continue to be the best method for capturing and reporting comparable cross-year data on PDS for the foreseeable future.

However, OHA has designed a data collection and reporting form regarding all PDS data in the Medicaid Management Information System (MMIS) and is also collecting data in the Measures and Outcomes Tracking System (MOTS), which will be undergoing a platform revision in the next couple of years.[47] OCA also reports some of Oregon's tribal communities are asking for training regarding delivery and billing/funding for PDS and about development of PROs for tribal peers. OHA is using federal Block Grant dollars for this effort currently. Time will tell, but these efforts are also likely to increase PDS and PDS reporting in Oregon.

OHA recognizes and has demonstrated substantial commitment to the value of PDS in transforming the behavioral health system to one based on the principal of recovery. Hence, in addition to the activities described in IC Report #3, OCA indicates it works with consumers, survivors, stakeholders, and Oregon's peer network to accomplish three goals:

- Develop strategies to increase the use and availability of PDS;
- Influence health policy and improve enrollment and use of peers in expanded insurance options and integrated health care programs; and
- Promote the development of PDS training programs and certified peers representing Oregon's diverse population, including those with military experience and young adults.

In order to accomplish these goals, OHA hired a new PDS Coordinator (PDSC) staff position in November 2018. This PDS Coordinator's role is to consolidate and communicate with all the different groups and councils within OHA and the broader peer networks addressing PDS in order to have productive feedback loops and lines of communication established. The work of this PDS Coordinator is to increase the coordination among groups on strategies, community involvement, policy development, rulemaking from a peer perspective, and recommendations to OHA regarding expansion of PDS. The position is filled by a person with lived experience as a behavioral health services recipient and professional experience as a provider in the peer workforce.

OCA works with the Peer-Delivered Services Core Team (PDSCT) which meets monthly and is facilitated by the PDSC. This group serves as a steering committee and innovation hub in Oregon. Some of the topics currently being addressed include awareness of community trends, peer supervision (competencies and training), standards for PDS training, and proposed Medicaid changes to expand use of PDS statewide.

Oregon currently has nine Medicaid billing codes for PDS, more than many states in the country. More PDS billing codes allow for more billing of qualifying PDS services. OHA worked with PDSCT, the Oregon Consumer Advisory Council (OCAC),[48] and community stakeholders on a Medicaid 1915i State Plan Amendment (SPA) to expand the list of billing codes for PDS and integrate PDS into broader aspects of care, including allowing PROs to bill Medicaid. However, the federal Centers for Medicare and Medicaid Services (CMS) indicated Oregon could not make the requested changes via a SPA or as part of the current 1915i waiver, but rather would have to request an 1115 demonstration waiver in order to test these

[47] OHA OCA indicates these data sources show significant numbers of people being told about the availability of PDS. In 2014, 8,017 clients were told and in 2016 11,980 were told. While more recent data are not currently available, the new CCO 2.0 contract includes a requirement for CCOs to inform Members and encourage utilization of PDS by providing Members with a description of the types of PDS available and how to access these services, as well as an explanation of the role of the PDS provider and ways PDS can enhance Members' care. See CCO 2.0 Contract, Exhibit M, 9.a. and b.

[48] OCA representatives informed me the OCAC is also supported by the PDSC and has recently created four subcommittees on the following topics: a) trauma-informed systems; b) tools, technology, and access; c) wellness and health practices/peer support; and d) PDS development (supervision, salaries, etc.). For more information on OCAC and its workplan, see https://www.oregon.gov/oha/HSD/AMH/Pages/OCAC.aspx.

approaches for individuals with SPMI. OHA is currently developing an 1115 waiver for individuals needing SUD services, given this federal input.[49]

The OCAC workplan also includes promoting the identification of a peer coordinator in every Oregon county; developing recommendations to expand peer services in future CCO contracts; and developing recommendations for peer supervision standards. Together, the PDSCT and OCAC have identified two core strategies:

- Identification of current workforce strengths, needs, gaps, and a plan to build a quality PDS workforce, including trainings for supervisors; and
- Identification of changes to administrative rules necessary to support the increase of people receiving PDS.

For this second strategy, OHA supported HB 2304 which defined and added Peer Support Specialists (PSS) to Oregon statutes along with Peer Wellness Specialists (PWS). This bill passed in 2017 and was effective January 1, 2018. Other legislation was introduced for the expansion of PDS throughout the state. OHA worked with communities and councils to provide bill analysis and consistency of language as this legislation was considered.

OHA implemented these changes in Oregon law by changing several of its regulations to include:

- Requiring PDS to be provided by CMHPs;
- Defining Peer Supervisor and co-supervision of PSS and PSW positions;
- Requiring co-supervision of PSS/PWS by experienced certified PSS/PWS; and
- Updating the definitions of peers to include specific family and youth clarifiers.

In addition to PDSC and OACA, the OCA works with the OHA Office of Equity and Inclusion (OEI) which staffs and supports the Traditional Health Workers (THW) Commission. This Commission meets monthly and includes representatives of all seven types of THWs recognized in Oregon, including PSSs and PWSs, as well as medical professionals, educators, CCOs, and unions. The Commission's workplan includes to:

- Improve communication, brand awareness, messaging, registry, and technology;
- Expand and improve education, community engagement, system engagement, and workforce engagement; and
- Invest in and launch research and data collaborations.

The THW Commission has created a registry of various types of THWs throughout Oregon.

OHA has also been working with the Oregon Department of Veterans' Affairs in a joint workgroup focused on improvement of behavioral health services for veterans. This workgroup has created a Veterans' PDS Pilot Project for which funds have been awarded to the Deschutes, Yamhill, and Jefferson CMHPs with a separate fund set aside for Oregon Tribes wishing to implement PDS programs in their communities.

All in all, the State of Oregon has put considerable effort into increasing the quantity and quality of PDS provided for adults with SPMI and others in multiple venues. While more needs to be and can be done, OHA and OCA should be commended for its work in this area.

SUBSECTIONS D.19. – 26. OREGON STATE HOSPITAL [See Also IC Reports #3 and #4]

The OPP committed the State of Oregon, acting through OHA, to changes in Oregon State Hospital's (OSH's) admission and discharge processes and set some goals regarding timelines specifically for civilly committed adults with SPMI.[50] The OPP also committed the State to assure the appropriateness of services

[49] See Footnotes 46 and 131. While this waiver will no doubt provide for some SUD services for individuals with SPMI, it is not specifically about this OPP population or services needed specifically for individuals with SPMI.
[50] OPP Subsection D.19. specifically noted that paragraphs D.20. to D.26. apply only to civilly committed adults at OSH, except to the extent specifically noted in Subsection D.26. Those adults with SPMI who are on a "voluntary by guardian" or forensic status are not part of this section of the OPP but may be impacted by some of the other OPP commitments

for the OPP population upon discharge from OSH,[51] especially referral to and provision of ACT services for those appropriate and eligible.

OPP Numeric Provisions Regarding OSH

The OPP focused on two main numeric goal areas:

- timelines for discharge of civilly committed adults with SPMI admitted to OSH once they are ready to transition (RTT) (Subsections D.20.-22. and D.24.); and
- proportion of civilly committed adults with SPMI discharged within 120 days of admission (Subsection D.24.).

Other commitments involve processes OHA – and specifically OSH – have implemented to move toward meeting these numeric goals and assure documentation of appropriateness of services upon discharge.

OHA/OSH has not yet met and therefore is ***not in compliance*** with the goal of 90 percent of individuals being discharged within 20 days of being placed on the RTT list. For this goal area, the length of time decreased while the percentage to be released within that length of time increased each year. OHA/OSH was not able to meet any of the three years' timelines even though the proportion being released within 30 days of being placed on the RTT list has been improving some over this time. As of the end of OPP year three, 45.8 percent of individuals were discharged within 20 days of being determined RTT while 51.9 percent were discharged within 30 days of RTT that year.[52] These percentages initially declined and then increased to be about the same as the 2015 baseline of 51.7 percent released within 30 calendar days of RTT determination.

OSH has continued to report the number of discharges that extended to and occurred on the business day following a weekend day or holiday. This number remains low, reported as three for the twelve-month period ending June 30, 2019. Because this provision calls for reporting -rather than a specific outcome, OSH continues to be ***in compliance*** with this commitment.

OHA/OSH has also not yet met and therefore is ***not in compliance*** with the OPP goal of 90 percent of all civilly committed patients discharged within 120 days of admission. While they were at 61.4 percent at the end of OPP year three, well above the 2015 baseline of 37.8 percent and even above each of the prior 11 quarters, they are still far from the original OPP goal for this metric. Hence this metric is also included in the revised BHQPIP with goals of 65 percent for FY 2021 and 70 percent for FY 2022.

OHA/OSH has undertaken significant efforts to increase their performance on these two metrics, many described in detail in IC Reports #3 and #4. Hospital leadership is:

- tracking performance by county and by hospital unit;
- working with community programs from those counties with lower percentages discharged in a timely fashion;
- engaging Choice providers and CCOs more explicitly regarding their responsibilities in the discharge process;
- meeting weekly with the Independent and Qualified Agent (IQA) regarding RTT, length of stay, and discharge decisions;

regarding community-based services. Given recent changes and increased units at OSH for individuals unable to aid and assist in their criminal defense, the OSH population of civilly committed adults with SPMI on OSH's two campuses is now even less than the previous amount of only about 20 percent of the total population.

[51] Subsection D.26. gave the State 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.

[52] NOTE: This percentage is not reported by OHA in its most recent data report dated January 2020 because the goal at that point was about discharge within 20 days rather than within 30 days of becoming RTT.

- utilizing a specialized Person-Directed Transition Team (PDTT) for those with long stays and/or fear of leaving the hospital;[53]
- continuing to update forms, policies, and information technology systems to better communicate and track discharge plans and referrals; and
- changing the culture of the hospital and the community to be clear individuals served at OSH are the communities' patients with the hospital stay being simply an episode of care.

OHA has also revised the State's regulation regarding OSH admission and discharge to be more explicit about discharge planning required before application for admission and about community responsibility upon discharge.[54] OHA has also included clear requirements in the CCO 2.0 contract for CYs 2020 – 2024 regarding CCOs' responsibilities for its members in OSH and indicated CCOs will be required to share financial risk with the State about such Members' care at OSH beginning in CY 2022 (FY 2021).[55] The CFAA and Choice provider contracts also include clear language regarding performance expectations for discharge planning with OSH and ACT referrals. Hence, OHA is currently ***in compliance*** with the OPP language in Subsection D.22. regarding entering into performance-based contracts with CMHPs, CCOs, or other entities to help it meet its OPP commitments regarding discharge timelines.

However, it should be noted the CFAA language for transferring State funding to counties for CMHP responsibilities and services is undergoing significant revision and will not be completed until 2021 or later. (See earlier description in this Report re OPP Section C. and later re OPP Section E.) The final language for this process could affect the State's performance regarding OPP Subsection D.22. Likewise, while corrective action language is included in these various contract documents, how this possibility will be used is not yet known. Given OHA's efforts to assure CCOs comply with the new contract requirements are just beginning, the OAR chapter 309 regulations revision process is on hold, and the CFAA language covering CMHPs is undergoing revision, these processes bear watching over the next few years to assure OHA holds its contractors to performance expectations set in these areas.

Even with all this effort to decrease OSH lengths of stay and discharge individuals more quickly after an RTT determination, OHA/OSH has not been able to meet these goals for discharge timelines but will continue to work toward those goals as indicated in the revised BHQPIP. After discussion with me as part of the IC's OPP Subsection A.8. responsibility and authority, OHA/OSH plans, through the revised BHQPIP, to try to reach by the end of FY 2022 the OPP year one goal of 75 percent discharged within 30 days of being placed on the RTT list. Likewise, OHA/OSH plans to try to reach a goal of 70 percent of all civilly committed individuals with SPMI being released within 120 days of admission. I agree these are appropriate interim goals for the three years following the OPP time period.

Notwithstanding this continuing commitment and effort, OHA/OSH may have difficulty reaching even these revised goals. As OSH has released those able to move to community settings sooner and assured only those with the most extensive treatment needs are admitted, it will be harder for OSH to reduce the length of stay and discharge individuals more quickly. As changes have occurred to assure individuals with SPMI are treated more fully and appropriately in local inpatient units before being transferred to OSH,[56] and as some individuals have waited longer for transfer due to OSH having to cease admissions of such individuals for a period of time during late 2019, individuals now being admitted to OSH from acute care facilities have tended

[53] As of August 28, 2019, the PDTT had served 100 of 114 referred individuals who met PDTT criteria from six of the Salem campus' units. Of these 84 had been discharged of which 10 readmissions were deferred. As of that time, the PDTT was only able to serve less than 20 clients at one time. OSH was planning on increasing staff for this team in 2020 to increase its service capacity as well as its ability to help with the culture shift in the hospital by training and modeling approaches to engagement and discharge planning for other hospital staff.
[54] See OPP Subsection 20.f. and OAR 309-091-000 to 0050.
[55] See OPP Subsection D.22. and CCO 2.0 Contract, Exhibit M, 13; This contract can be found at https://www.oregon.gov/oha/OHPB/CCODocuments/Updated-draft-CCO-contract-terms.pdf. Actual and final contract terms for each CCO can also be found on this OHA website.
[56] As part of Oregon's COVID-19 pandemic response in March, OSH stopped all admissions of civilly committed individuals meaning such individuals are currently being served exclusively in local inpatient units. Given possible budget reduction scenarios currently being considered, it is unclear when or even whether such admissions will resume although current plans are to begin such admissions again in July assuming no spike in aid and assist orders, continued discharges from OSH, no COVID-19 positive cases in the three admission monitoring unit cohorts, and no reduction in funding causing OSH to reduce bed capacity. A written update to community partners was released earlier in June.

to have more intense needs requiring longer or more intense care and/or having more substantial needs to be addressed upon discharge from OSH. OHA/OSH's continuing efforts to help individuals reach RTT status as soon as feasibly possible and OHA with OSH's help continuing to be clear about expectations of community partners regarding their roles and responsibilities in arranging for individuals to have discharge plans in place for appropriate treatment and living options after discharge even before application for admission to OSH are important steps

It should be noted the OPP identified the preferred discharge timeline to be within 72 hours of RTT determination. The percentage of discharges occurring within three days of being placed on the RTT list at baseline (CY 2015) was 2.4 percent and has increased to 4.9 percent for FY 2019. While this percentage is headed in the right direction, the specific individuals who were 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 being low and probably fluctuating over time.

The average daily population of civilly committed adults with SPMI being treated in OSH at any one time has declined over the last few years, from 139.7 in the baseline year (CY 2015) to 107.2 in OPP year three (FY 2019). The number of such individuals discharged has increased from 192 in FY 2015 to 251 in year three of the OPP (FY 2019 ending June 30, 2019).[57] The average length of stay (LOS) of this population has also decreased from 233.4 days in FY 2015 to 181.2 days in FY 2019. Similarly, the median[58] LOS has also decreased from 163.5 days to 107.0 days in this time period. As noted above, the percentage of those discharged within 120 days has increased from 37.8 percent in FY 2015 to 61.4 percent in FY 2019.

These numbers and percentages show OSH has moved in the right direction, even though it was ***not in compliance*** with the commitments in the OPP as of the end of FY 2019. However, OHA and OSH were making good-faith and meaningful efforts to meet the OPP commitments regarding timeliness of OSH discharges as described earlier in this section.[59] (See also IC Reports #3 and #4 for fuller descriptions of many of these efforts.)

OPP Commitments Regarding Linkages to Appropriate Services Upon Discharge

OPP Subsection D.23. committed OHA to assure "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 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 committed OHA to "provide data to USDOJ about individuals by quarter who are offered ACT services and refused." These data for individuals in OSH have not been kept consistently and have not yet been provided to USDOJ. However, September 2019 chart reviews by an IC Review Team colleague showed almost 90 percent of the sample of those discharged during six months from January to June 2019 were engaged about or offered ACT services, even though follow-through and actual referrals were not as well documented in this set of charts.

Subsection D.23.b. committed 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]

[57] The number discharged in year one was 271 and in year two it was 281. The decrease in year three is likely a reflection of the lower average daily population in OSH over this time.
[58] "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.
[59] However, see footnote 56 above regarding challenges in meeting these commitments.

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."[60]

At this point, OSH keeps track of individuals scheduled for discharge and referred to ACT services. However, reviews in September 2019 of the ACT tracking matrix along with a review of some OSH 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 regarding engagement about an ACT referral or with an individual who may first refuse ACT services. OSH staff were working to improve chart documentation while Choice contractors and staff were being provided direction by OHA staff regarding how to assure and report appropriate ACT referrals. The ACT tracker was also being updated with better direction regarding how to incorporate information consistently. Similarly, OSH social work staff have been specifically identified to be the person(s) to assure ACT referrals and engagement of refusers are well and consistently documented in the OSH charts. While not yet completed during the three-year OPP timeframe and not yet in place when the tracker was compared to charts in September 2019, OHA now has the ACT tracker built into its Avatar client record system with a dropdown menu to prompt documentation and activity for individuals considered appropriate for ACT referrals. This system was reported to be scheduled for use beginning in late 2019 or early 2020.[61]

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" continues to be confusing for OSH and community providers. However, OHA staff was working with Choice providers, CCOs, and CMHPs to be sure they understand whatever alternative services are provided for individuals referred to ACT who either refuse initially or who have not yet been accepted by an ACT team are services to be provided only temporarily while engagement and an ACT team is identified for the ACT-eligible individual.

As part of the revised BHQPIP effort, OHA plans to finalize a written guidance document regarding ACT referrals, the roles of each community partner, and how to handle individuals who are eligible but not yet engaged in ACT services. OHA should still consider including in this guidance document definitions of the concept of "alternative evidence-based intensive services" along with possible options. As indicated in a prior IC Report, these might include services such as critical time intervention;[62] 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; or 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.[63]

OHA also committed in this subsection to document efforts to provide ACT for individuals 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 was 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 of and opportunity for ACT services upon discharge. Specifically, OSH was working to add intervention regarding ACT to the Treatment Care Plan document and for all Interdisciplinary Treatment Teams (IDTs) in 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

[60] The Director's designee is OHA's IQA which was KEPRO until the beginning of FY 2021. The IQA contract has undergone a new RFP process with a new entity and new contract language with Comagine taking over this role beginning July 1, 2020 with transition planning underway this spring.
[61] I was planning to review the status of this ACT tracker and related documentation in OSH charts when onsite in March 2020. However, since that site visit was cancelled due to COVID-19 pandemic response, OHA and I are trying to determine a method for me to review the status of the tracker and related documentation from a distance.
[62] See Center for Advancement of CTI at https://www.criticaltime.org/cti-model/.
[63] 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/.

occur upon discharge.[64] 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. OHA was also clarifying when and how an individual referred for a short stay in a residential treatment program can also be provided ACT services as part of the process of assisting individuals to move from a residential treatment setting to a more independent living setting. Form revisions as well as documentation instructions to IDTs and hospital staff were being included in this process re-engineering.

As a consequence of OHA/OSH's efforts underway and improvements made, OHA was ***working toward compliance*** with this part of the OPP about ACT referrals and documentation of refusals. They were taking the process seriously and were working toward putting into place better engagement of individuals at OSH as well as better forms and processes to meet and document activities committed to in the OPP. It is unclear to me at this time whether these efforts have continued or have stalled due to the COVID-19 pandemic response and closure of OSH admissions for civilly committed patients. These efforts will need to continue or begin again as part of the revised BHQPIP activity for this goal area.

Discharges from Oregon State Hospital (OSH)

As indicated earlier, Subsection D.25. described specific OHA/OSH commitments regarding civilly committed adults with SPMI when they are discharged from OSH.
Subsection B.6.e. defines discharge planning as:

> . . . a process that begins upon admission to the Oregon State Hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting.[65] Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. Discharge planning teams at OSH include a representative of a community mental health provider from the County where the individual is likely to transition.

Summary of Review of OSH Charts for Individuals Discharged in the Last Half of FY 2019: In September 2019, a sample of OSH charts for individuals discharged in January through June 2019 was conducted by myself and a Review Team colleague who helped with the program reviews in 2018 for those discharged in Q4 of 2016 and Q4 of 2017. (See also IC Report #4) The purpose of this 2019 chart review was to determine whether any changes had occurred in year three of the OPP since the prior two years of the OPP, and to ascertain whether discharges in the last six months of the OPP timeframe met the commitments in Subsection D.25. of the OPP. The number of discharges, charts reviewed, and disposition types are listed in **TABLE 3** below.

[64] See also earlier 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 the earlier section of this Report regarding ACT.
[65] "Integrated setting" is defined in the Choice contract as "a setting that enables Individuals with disabilities to interact with non-disabled persons to the fullest extent possible. Integrated settings are those that provide Individuals with disabilities opportunities to live, work, and receive services in the greater community, like Individuals without disabilities. Integrated settings are: (1) located in mainstream society; (2) offer access to community activities and opportunities at times, frequencies, and with persons of an Individual's choosing: (3) afford Individuals choice in their daily life activities; and, (4) provide Individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible."

TABLE 3: Dispositions of Those Discharged and Those Whose Charts Were Reviewed[66]

DISCHARGE DISPOSITION	TOTAL (119 Discharged)	JUNCTION CITY (12 Charts Reviewed of 37 Discharged)	SALEM (23 Charts Reviewed of 82 Discharged)
SRTF[67]	11	3	2
RTF	44	3	8
RTH	13	0	4
AFH	17	1	4
Respite	4	2	0
Motel/Hotel	2	2	0
Independent	21	1	1
Supportive Housing	1	0	1
Supported Housing	3	0	3
PAITS	1	0	0
Jail[68]	2	0	0

The review tool utilized in September 2019 was similar to the one utilized in 2018 with a couple of revisions based on experience from the prior review. The tool directed the Reviewer to identify whether a person-centered plan was completed; the date the individual was determined to be Ready To Transition (RTT), evidence of the individual's choices/preferences upon discharge, eligibility and referral to ACT if appropriate; the setting to which the individual was discharged; and if discharged to a SRTF, evidence of clinical necessity and review by OHA Director's designee (the IQA). Prior and subsequent admissions and discharges were also noted to the extent the information was available. From this information, the Reviewer made a judgment regarding whether the individual's preferences were considered and met, whether the discharge setting seemed integrated and consistent with the individual's preferences and treatment needs, and whether the person might have been eligible for ACT and was appropriately referred.

A summary of the documentation within all charts reviewed from the final six months of the OPP timeline is provided in **TABLE 4** below. This summary is based on the documentation available in the chart and is not necessarily a complete account of the individual's situation or treatment interactions at all times pre- and post- this admission to OSH.

[66] NOTE: The meaning of the acronyms in **TABLE 2** can be found in Appendix A and residential facilities are described on OHA's website at https://www.oregon.gov/oha/HSD/AMH-LC/Pages/RT.aspx.
[67] An additional six charts of individuals discharged to SRTFs (three from Junction City and three from Salem) were reviewed just to ascertain whether documentation of the IQA approval was in the chart. Documentation was inconsistently available in these charts. See discussion later in this Report.
[68] These two charts were reviewed just to ascertain the circumstances for which the individual was sent to or returned to jail to assure these were not individuals who were in the aid and assist or guilty but mentally ill populations who were inadvertently included in this civil population group. They were not.

TABLE 4: Characteristics of Documentation in OSH FY 2019 Charts Reviewed

AREA OF REVIEW	SALEM (23 Charts)	SALEM (%)	JUNCTION CITY (12 Charts)	JUNCTION CITY (%)	TOTAL (35 Charts)	OVERALL (%)
Average # of Days from Placement on Ready-to-Transition List to Discharge	43.1	NA	25.1	NA	37.3	NA
Person-Centered Plan in Place	12	52.2%	12	100%	24	68.6%
Evidence of Person's Preferences	23	100%	11	91.7%	34	97.1%
Evidence of CCO/Choice Provider Involvement	20	87%	11	91.7%	31	88.6%
Engaged/Offered Client ACT Services	21	91.3%	10	83.3%	31	88.6%
If Refused, Evidence of Effort to Accommodate or Re-engage	2/4	50%	3/3	100%	5/7	71.4%
# Receiving ACT Services	4	17.4%	3	25%	7	20%
Discharges – Most Integrated/Appropriate	23	100%	8	75%	31	88.6%
Discharges – Consistent w/ Client Choices	12	52.2%	10	83.3%	22	62.9%
SRTF Discharges – IQA Approval	3/3	100%	3/3	100%	6/6	100%
SRTF Approval w/in Timeframe	1/3	33.3%	2/3	66.7%	3/6	50%
Hospitalizations/ED Prior to Admission	19	82.6%	10	83.3%	29	82.9%
Mobile Crisis/Jail/CJD Events Prior to Admission	8	34.8%	6	50%	14	40%
Admission/Discharge w/in 12 Months Before or After This Admission/Discharge	12	52.2%	2	16.7%	14	40%

Once again, as in 2018, the OSH charts regarding treatment planning, social work and psychiatry notes, and discharge summaries were generally thorough and complete, with more and more information and forms consolidated into the hospital's Avatar client records system. Documentation regarding client engagement is also significant. However, multiple parties continue to be involved (Choice contractors, CCOs, CMHPs, the IQA, ACT providers when appropriate, and often other entities when referrals to residential treatment facilities are made). Hence, it continues to be difficult to get a complete picture of any one individual's care prior to admission, their OSH stay, and discharge planning and decision-making processes just from OSH's records alone.

That said, the chart reviews summarized above tell a story about some well-documented issues and some needing additional attention by OSH and community partners. For example, the charts from the Junction City campus and the Salem campus showed some differences, especially on things such as whether a person-centered plan was in place, whether clients were offered ACT services, whether those who refused ACT were engaged to accommodate their concerns and then re-referred, appropriateness of discharges to clinical needs, and consistency with client choices. Often, but not always, Junction City charts showed significantly or slightly better documentation in these areas. OSH has begun to bring Junction City and Salem staff together to learn from each other and exchange ideas about best practices to help the hospital as a whole increase performance where it is needed. Similarly, since Salem has a unit on which many civilly committed individuals with SPMI have co-occurring medical or disability-related issues making discharge planning more complex due to intensity of needs following discharge, OSH has also committed to working

with unit, social work, and psychiatric staff along with community and other responsible partners on the particular needs of these individuals. Consequently, OSH is working closer with the Oregon Human Services Department's Aging and People with Disabilities Division[69] (APD) and other community partners to improve the discharge processes for those patients with complex mental and medical issues. OSH is also working to identify a provider to create a PDTT capacity to serve individuals at the Junction City campus who have complex needs.

In some cases, both campuses did well, with overall percentages averaging high. For example, overall, evidence of the person's preferences is in almost all charts. Evidence of CCO and Choice provider involvement and the percentage engaged regarding and/or offered ACT services is high (both just under 90 percent). Discharges being integrated and appropriate to clinical needs is high overall (just under 90 percent), although this is an area in which the Salem campus records showed better documentation and efforts than the Junction City campus records.

Of the charts reviewed for all issues, evidence of the IQA designee approvals of discharges to SRTFs were documented in 100 percent of the client's records. However, additional review of a few additional charts of individuals discharged to SRTFs were inconsistent in documentation of IQA approval. A discussion with OHA, OSH, and IQA staff indicated the IQA approval letter may have been taken by the Choice provider or sent to the SRTF provider without a copy retained in the OSH records. An SRTF cannot receive Medicaid payment if they do not have evidence of IQA approval for admission so the likelihood of this approval not existing is low. Hence, OSH staff indicated they would work to assure copies of IQA approval letters are retained in client records at OSH for those discharged to SRTFs.

About half of these records showed SRTF approvals were not made within the required timeframes. The process of IQA timeliness and residential facilities' time to review, interview, and make decisions about acceptance of referrals or not has been described in prior IC Reports (#2 and #5). In my view, so long as residential treatment providers are allowed to make the decision regarding whether they will accept someone or not, and so long as the CCOs are not at risk for OSH or residential treatment services, the timeliness of discharge from OSH or other inpatient facilities for those needing SRTF services will continue to be difficult to achieve. Increased collaboration with the new IQA beginning in July 2020 could help improve this timeliness issue as well.

In the FY 2019 charts reviewed, identification of those eligible for ACT and referrals for this service were clearly improving with close to 90 percent of the individuals whose charts were reviewed engaged and offered ACT services. The Salem campus charts showed slightly better documentation about this than the Junction City campus charts. About 20 percent of the individuals whose charts were reviewed already were receiving ACT services while in OSH, with the Junction City percentage a little higher, which may account for why their percentage offered ACT services was a little lower. Unfortunately, documentation of efforts to engage individuals who initially refused ACT services was significantly lower at the Salem campus (50 percent) compared to the Junction City campus (100 percent). OSH will need to determine if this is a documentation issue at the Salem campus or a failure to engage those who refuse ACT initially.

As described above, OHA/OSH was ***working toward compliance*** with Subsection 23.a.ii. regarding offering alternative evidence-based intensive services appropriate to the needs of individuals who refuse ACT and are discharged from OSH. The work OHA was doing to educate, provide guidance to, and set expectations for OSH staff, CCOs, and community partners regarding ACT services and the work to increase availability of ACT services in high need areas – described earlier in the section of this Report about ACT – are efforts that will definitely help to improve the overall provision of ACT services and help OSH achieve its commitments in these parts of the OPP.

OSH is also not discharging individuals at high enough levels consistent with the individual's choices and preferences (overall about two-thirds of charts showed this consistency, higher at Junction City than at Salem). Since evidence of individuals' choices and preferences were in almost all charts, and consistency with clinical needs is high (almost 90 percent), the inconsistency between an individual's choices and preferences and their clinical needs may be unable to be overcome upon initial discharge. OHA and OSH will need to ascertain whether those choices and preferences continue to guide treatment planning as

[69] See https://www.oregon.gov/dhs/seniors-disabilities/Pages/index.aspx for more information about APD.

community-based care is delivered or whether OSH can do more (especially at the Salem campus) to help the individual make choices and identify preferences that are able to be accommodated within the planning being done to address their clinical and treatment needs upon discharge.

Overall, OSH is substantially ***in compliance*** with discharge planning commitments in Subsection D.23.b. and 25. albeit with some continuing improvements to be made in documentation and timing of SRTF approvals. I continue to impress on OHA system players the importance of OHA's intention to shift risk for residential and OSH services to CCOs during the CCO 2.0 time period (currently planned for CY 2022) to align all these discharge planning commitments so individuals with SPMI are adequately served after local inpatient or OSH episodes of care. The CCOs need to own and be responsible for all services needed by their Members, not just those other than residential or institutional settings, in order to coordinate their Members overall behavioral health services and outcomes.

SUBSECTIONS D.27. – 36. ACUTE PSYCHIATRIC CARE [See Also IC Report #5]

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

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

Such facilities are licensed or certified by the State and are regulated by Oregon Administrative Rule (OAR)[70] and are critical to the infrastructure serving civilly committed adults with SPMI as such individuals in need of inpatient care must be served first in a local ACPF before they will be considered for admission to Oregon State Hospital (OSH).[71]

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

- All individuals with SPMI who are discharged from ACPFs (not including OSH) will have documentation of linkages to appropriate behavioral and primary health care in the community prior to discharge (Subsection D.27.);
- OHA shall continue with its process to enroll all or substantially all indigent individuals with SPMI not yet enrolled in Medicaid prior to discharge from ACPFs (or emergency departments), consistent with state law (Subsection D.28.);
- All individuals discharged from an ACPF will be presented a "warm handoff" to a community case manager, peer bridger, or other community provider prior to discharge and OHA shall require ACPFs to report to OHA all individuals who refused a warm handoff on a quarterly basis, and shall report this information to USDOJ beginning October 1, 2016, by ACPF(Subsection D.29.);[72]
- 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 (Subsection D.30.);
- OHA will reduce recidivism to ACPFs and will monitor and report the 30 and 180 day rates of readmission, by ACPF, as well as provide a management plan for contacting and offering services to individuals with two or more readmissions to an ACPF in a six-month period designed to assist the individual to avoid unnecessary readmission in acute care hospitalization (Subsection D.31.);
- OHA will identify individuals with SPMI who are homeless and who have had two or more readmissions to an ACPF in a six-month period, and either directly or through another system participant will connect these individuals to a housing agency or mental health agency with access to housing in order to work to ensure such individuals are linked to integrated housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice (Subsection D.32.);

[70] OAR 309-032-0800, et seq.; and 309-033-0700, et seq. It should be noted there are other acute inpatient units for those with geropsychiatric issues, that is, mostly cognitive perhaps with some behavioral aspects (e.g., dementia). Generally, individuals served in such facilities would not meet the definition of SPMI, with a primary diagnosis of such, although may have some underlying behavioral health issues and/or diagnoses. These units are not considered or reported as part of the acute care facilities available for persons with SPMI pursuant to the OPP.
[71] OAR 309-091-0000, et seq.
[72] This Subsection goes on to define the warm handoff process, which is discussed later in this Report.

- OHA will work with ACPFs, CCOs, and CMHPs to seek to ensure that individuals with SPMI discharged from ACPFs are discharged to housing that meets a particular individual's immediate need for housing, OHA will establish requirements for ACPFs to assess the housing needs of individuals with SPMI and require that, for all individuals with SPMI who are CCO members, ACPFs shall consult with the individual's CCO in developing the assessment which will be documented in a plan for integrated housing that is part of the individual's discharge plan and the ACPF will notify the individual's community provider regarding that housing plan in order for the provider to facilitate the implementation of that plan for housing (Subsection D.34.); and
- OHA will measure the average length of stay of individuals with SPMI in ACPFs, by hospital and report the number of individuals with SPMI in each ACPF whose length of stay exceeds 20 days (Subsection D.35.).[73]

Each of these commitments and the status of the quantitative and qualitative goals related to each were discussed at length in IC Report #5 along with some recommendations about ways to improve performance on commitments in the OPP. This discussion and those recommendations will not be repeated here. However, the reader is encouraged to review them while considering this OPP area. Not all the commitments in these Subsections have been met (see below and Appendix B). However, the parts still in need of improvement are included in the revised BHQPIP for further work in FY 2021 and FY 2022.

Quantitative Commitments re Acute Psychiatric Care

The OPP includes four types of quantitative commitments about acute psychiatric care:

1) to 'present" all individuals discharged from an ACPF a "warm handoff" and eventually reach a goal of 85 percent of those discharged receiving a warm handoff prior to discharge (Subsection D.29.a. – c.) and to report the number who refused such assistance (Subsection D.29.);
2) to require and report the proportion of individuals receiving a follow-up visit with a community mental health provider within 7 days of discharge (Subsection D.30.);
3) to reduce recidivism as well as to monitor and report rates of readmission (Subsection D.31. and D.31.a.); and
4) to measure and report average length of stay (ALOS), by hospital, and the number of individuals with SPMI whose length of stay exceeds 20 days. (Subsection D.35.)

Warm Handoffs: Progress on the first of these goals continues but OHA is ***not in compliance*** with the 85 percent commitment as of the end of OPP year three. OHA reported 43.3 percent of adults with SPMI received a warm handoff during the quarter ending June 30, 2019.[74] This percentage has increased in most of the quarters of the three-year OPP timeframe. As described in IC Report #5, OHA has hired staff specifically to work with acute care facilities, has issued (and is updating) guidance documents, and has worked extensively to be sure ACPFs know about the expectations regarding this requirement. OHA has included the warm handoff requirement in the new CCO 2.0 contract language along with a responsibility for CCOs to begin tracking this warm handoff information for Members across various hospitals with which CCOs contract. In addition, OHA provided a webinar for CCOs regarding this expectation on January 13, 2020.[75] However, because of the suspension in reviewing and revising the 309 series regulations, these requirements are not yet clearly in regulations affecting acute care facilities[76] or in regulations or contract language guiding community providers who need to assist with this effort.

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

[74] 51.4 percent of 1,007 individuals discharged were offered a warm handoff, including those who refused. Hence, not only are more warm handoffs needed, but more individuals being offered such warm handoffs is a necessary activity to meet the goals committed to in the OPP.

[75] See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Warm-handoff-supplemental-slides-CCO-approaches.pdf for the PowerPoint presentation utilized for this webinar.

[76] See OAR 309-032-0860 and 0870 where the requirement to offer and document a warm handoff is included, but the definition of warm handoff is not completely consistent with the OPP. These regulations were last updated in 2016. Similarly, the definition in the new CCO 2.0 Contract, Appendix A, is also not totally consistent with the OPP.

Similarly, neither the confidentiality toolkit to clarify the use of telehealth and other efforts to engage patients, acute care facility staff, and community staff, nor the analysis of payment options and laws regarding the use of telehealth for behavioral health purposes has been completed, although significant work and webinars on such issues generally have been conducted as part of the COVID-19 pandemic response based on changes in federal Medicaid and Medicare billing allowances. Currently, telehealth visits are allowed to be conducted and paid at the same rate as in-person services through December 31, 2020. However, some stakeholders are asking for this date be extended to allow the legislature time in its 2021 regular session to revise state law to make telehealth services more available permanently. Many of the observations and recommendations in IC Report #5 remain unaddressed. Hence, more work is needed to continue the progress in this area. OHA has included this area in its revised BHQPIP for the FY 2021 and FY 2022 timeframe with goals of 50 percent and 60 percent respectively.

The number of individuals who refuse a warm handoff continued to be reported and is low. Only 81 (about 8 percent[77]) refused this assistance in the three-month period ending June 30, 2019. Since this is a reporting requirement rather than a percentage goal and especially since it appears refusals are less of an issue than actually providing and documenting the receipt of warm handoffs, OHA is ***in compliance*** with this reporting commitment.

Seven (7)-Day Follow-Up Visits: The second quantitative commitment was to continue to require and to report the proportion of adults with SPMI discharged from ACPFs who receive a follow-up visit within 7 days of discharge. This commitment did not have a specific goal associated with it. OHA reported 74.3 percent having received such a follow-up visit during FY 2019. While this percentage has bounced around a little and is somewhat lower than year two percentages and also lower than the 2015 baseline percentage, it was still within the 95th percentile nationally, indicating Oregon did better than most other states on this measure during FY 2019. OHA also requires this 7-day follow-up visit in its new CCO 2.0 contract for adults leaving an ACPF and even requires a follow-up visit within three (3) days if the Member is involved in Intensive Care Coordination services.[78] Because it does continue to require this action and because it has reported as was committed, OHA is ***in compliance*** with this Subsection of the OPP. This said, simply doing better than most other states is not the measure Oregon or the OPP identified as important. Also, OHA has chosen to take this measure out of its financial incentive measures list for CCOs in the first year of the CCO 2.0 contract. Hence future performance on this measure could be at risk without the incentives in play, so OHA should monitor the system's performance on this measure and determine whether moving it back to the financial incentives list would be called for at some point.

Reduce Recidivism/Monitor Readmission Rates: The third quantitative commitment was one to reduce recidivism to ACPFs and to take some specific steps regarding monitoring and reporting 30- and 180-day rates of readmission, by ACPF. OHA has continued to monitor and report these rates statewide and by hospital facility. However, the rates have risen rather than been reduced. The 30-day readmission rate has risen from 9.2 percent in the 2015 baseline year to 10.7 percent in the rolling 12-months of FY 2019. However, this rate is less than most of the prior quarters of the OPP. While there are not national numbers specifically for comparison for the SPMI population broadly, the current rate in Oregon seems to be within the range for those with schizophrenia[79] nationally. Similarly, the 180-day readmission rate has increased from 21.3 percent in the 2015 baseline year to 22.5 percent in the 12 months of FY 2019. However, as with the 30-day rate, the FY 2019 rate is less than many of the prior rolling 12-month periods of the OPP. OHA is ***not in compliance*** with the commitment to reduce readmissions to ACPFs, but is ***in compliance*** with the commitment to monitor and report, by facility. Given the increase in numbers of individuals served by CCOs and the new CCO 2.0 contract requiring additional expectations about behavioral health services and especially inpatient utilization, time will tell if these rates improve. In the meantime, OHA has included this area in its revised BHQPIP to try to make progress in the rates of readmissions to ACPFs and to try to get back to or under the baseline rates.

[77] Preliminary data for the first quarter of FY 2020 (July 1 – September 30, 2019 indicate the proportion of individuals offered warm handoffs who refuse them was even lower at 6.5 percent).
[78] CCO 2.0 Contract, Exhibit M, 17.g.
[79] NOTE: The OPP is about adults with SPMI more broadly which includes many diagnoses other than schizophrenia.

OHA has continued to track and report the number of adults with SPMI with two or more readmissions to an ACPF in a six-month period. Positively, the number of such individuals has continued to decline, from 346 in the 12-month period ending December 31, 2017 to 277 in the period ending June 30, 2019. This decline flattened with the prior quarter's rolling 12-month number, which was also 277. Nevertheless, the number of those with multiple admissions has declined over the three-year OPP timeframe. Additionally, OHA has included a specific definition of and requirement for CCOs to produce an individualized management plan for those with SPMI with two or more readmissions in a six-month period. (See discussion below.) Hence, OHA is ***in compliance*** with the commitment to track and report these data.

Average Length of Stay: The fourth quantitative commitment regarding acute psychiatric care concerns measuring the average length of stay (ALOS) of those in ACPFs, by hospital, and reporting the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. OHA has continued to track and report these numbers, hence is ***in compliance*** with this commitment. Over the OPP timeframe, the ALOS bounced around from 8.9 days in baseline 2015 to 10.9 days in the 12-month period ending June 30, 2019. This number of days is lower than several of the prior periods, but all rolling 12-month periods of the OPP show an ALOS higher than baseline. Likewise, the number of individuals with ALOS of longer than 20 days has increased from 385 during baseline year 2015 to 435 for FY 2019. This number is higher than some prior reporting periods and lower than some. Interestingly, it is exactly the same as the rolling 12-month period reported for September 30, 2017.

This ALOS is often impacted by availability of other options such as transfers to OSH or other appropriate facilities or living situations. OHA recently changed its regulation regarding admissions to OSH[80] to be more explicit about criteria for admissions, time on appropriate medication for an adequate time period while in a local ACPF, and appropriate discharge plans before admission to OSH in order to assure an individual is adequately treated locally rather than being transferred to a more institutionalized setting with even longer average lengths of stay. Likewise, the recent halt in December 2019 of admissions to OSH[81] of voluntary patients (i.e., civilly committed but not forensic) due to the needs of the aid and assist population has caused a backlog of civilly committed individuals on the waiting list for OSH admission. Likewise, the cessation of admissions of civilly committed individuals in March due to the COVID-19 pandemic response, may result in longer lengths of stay in local ACPFs. However, a somewhat longer stay in a local facility is preferable to a longer stay at OSH, often outside the community in which the individual lives and will return, as is generally the case once an individual is admitted to OSH. Hence, this ALOS in local facilities is important, but in and of itself should not be a bell weather about whether the system is operating as it should.

Process and Qualitative Commitments Regarding Acute Psychiatric Care

In addition to monitoring and reporting readmission data with the goal to reduce recidivism, OHA also committed in Subsection 31.b. to "provide a management plan for contacting and offering services to individuals with two or more readmissions to an acute care psychiatric hospital in a six-month period designed to assist the individuals to avoid unnecessary readmission in acute care hospitalization." OHA has specifically included a requirement in its CCO 2.0 contract stating CCOs must "develop and implement a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an [ACPF] in a six-month period."[82] OHA has also hired an Acute Care Coordinator who is working on developing and monitoring of management plans by CCOs. Hence, OHA is ***in compliance*** with this commitment. However, it is not yet clear how OHA will oversee the development of CCOs management plans or these required data or utilize them to assure CCOs and the system as a whole are meeting desired goals. These efforts will need to be monitored as CCO 2.0 compliance efforts are implemented.

Subsection D.34. committed OHA generally to work with ACPFs, CCOs, and CMHPs to seek to ensure individuals with SPMI who are discharged from ACPFs are discharged to housing that meets the individual's immediate needs for housing. OHA committed to establish requirements for ACPFs to assess the housing needs of individuals with SPMI and the assessment to be documented in a plan for integrated housing as part of the individual's discharge plan. OHA also committed to require ACPFs to consult with the individual's

[80] See OAR 309-091-000, et. seq.
[81] See The Oregonian December 17, 2019 article at https://www.oregonlive.com/health/2019/12/oregon-state-hospital-halts-civil-admissions.html.
[82] CCO 2.0 Contract, Exhibit M, 17.d. The definition of such a plan is in Exhibit A, the definitions section.

CCO in developing the assessment and notify the individual's community provider regarding the plan for housing in order for the provider to facilitate the implementation of the plan.

HealthInsight Assure[83] reported 85.8 percent of 1,007 individuals discharged from ACPFs during April through June 2019 had a housing plan as part of their discharge plans. This ranges from 78.4 percent to 94.4 percent across nine ACPFs.[84] These percentages are higher than the most recent previous quarters. Cumulatively, HealthInsight Assure data show 90.4 percent of 6,071 individuals discharged over the time period they have been doing these chart reviews had housing plans as part of their discharge planning process. While these percentages suggest housing is included in discharge plans in the vast majority of cases and therefore OHA is ***in compliance*** with this commitment, additional efforts by OHA and/or ACPFs may be able to continue to improve the results in this performance metric.

It is not clear from the HealthInsight Assure reviews or from my earlier interviews whether housing assessments were being shared consistently with CCOs or community providers. However, OHA has included in its CCO 2.0 contract the specific OPP language and all aspects of their commitments regarding housing assessments and collaboration with providers to assure housing is facilitated pursuant to the individual's housing assessment and plan.[85] Many of these commitments are also included in regulations governing ACPFs.[86] OHA has also developed and posted a guidance document for CCOs to explain how and encourage CCOs to utilize health related services funding to support individuals in finding and/or maintaining housing.[87] However, the CFAA with CMHPs is not yet specific about this expectation to do and share housing assessments. As the CFAA agreement and regulations are revised (see description earlier in this Report regarding OPP Section C.), this issue may need to be addressed more explicitly. OHA has clearly done significant work in this area and therefore is ***in compliance*** with this OPP commitment.

HealthInsight Assure also reported 100 percent of the 1,007 individuals discharged during April – June 2019 had a CCO assigned. This indicates the system was continuing the process of enrolling in Medicaid all or substantially all indigent individuals prior to discharge, hence OHA is ***in compliance*** with this commitment in Subsection D.28. It is likely CCOs are mostly being engaged regarding the housing and discharge plans for these individuals as they are responsible for payment for services during inpatient stays and upon discharge. However, additional work to assure this connection by OHA staff and by CCOs' Intensive Care Coordinators (ICCs) will continue to improve performance on this commitment. The new CCO 2.0 contract language specifically includes language about these housing commitments as described elsewhere in this Report.

In Subsection D.32., OHA further committed to specifically "identify individuals with SPMI *who are homeless and who have had two or more readmissions . . . in a six-month period . . .* [and] OHA or another system participant will connect these individuals to a housing agency or mental health agency with access to housing, in order to work to ensure those individuals are linked to housing in an integrated setting, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice." As indicated above, this process is largely working for most individuals discharged. An analysis of HealthInsight Assure data regarding those who were homeless and did not have a housing plan was even smaller than those discharged without a housing plan overall, i.e., just 7.2 percent of 2,872 discharged whose records were reviewed from the nine-month period from October 1, 2018 through June 30, 2019 (207 individuals). Of these, only 19 were individuals readmitted two or more times over a six-month period. This means over 99 percent of those who were homeless and who had two or more readmissions within a six-month period had a housing plan upon discharge. Therefore, OHA is ***in compliance*** with this commitment regarding this subpopulation.

In addition to the above commitment, OHA committed in Subsection D.27. the following: "All individuals with [SPMI] who are discharged from [ACPFs] (not including OSH) will have documentation of linkages to timely, appropriate behavioral and primary health care in the community prior to discharge." As reported in IC

[83] This entity's name has recently changed. It is now Comagine.
[84] NOTE: OHA indicated in its most recent narrative report (January 2020) a tenth facility, Cedar Hills Hospital, is now billing Medicaid and will therefore be included in these reports going forward.
[85] CCO 2.0 Contract, Exhibit M, 17.i.
[86] OAR 309-032-0870 includes all aspects of the State's commitments in Subsection D.34. except the specific requirement that ACPFs consult with the individual's CCO in developing the housing assessment.
[87] See https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx.

Report #5, a review of charts of persons discharged from ACPFs indicated good and timely connection to follow-up psychiatric care, but less clear and timely connection to physical health care. However, OHA has clearly included in the CCO 2.0 contract a responsibility to assure both behavioral health and primary health care follow-up is in place for those being discharged from ACPFs.[88] To the extent OHA assures CCOs fulfill this responsibility, this area should improve. Hence, OHA is ***in compliance*** with this commitment regarding documented linkages to behavioral health care, but ***in partial compliance*** regarding documented linkages to primary health care. Regulations have not yet been revised to be clear about the expectation for making this linkage and to documenting it for those being discharged. OHA needs to consider additional guidance to ACPFs and CCOs either in regulation or in guidance documents about this expectation. CCOs could also be requested to look for this specific documentation in future chart reviews they undertake of their Members' care.

SUBSECTIONS D.37. – 44. EMERGENCY DEPARTMENTS [See Also IC Report #5]

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

Efforts to Address Boarding

In Subsections D.37. and D. 43., OHA committed to work with hospitals to collect data regarding individuals with SPMI who present to emergency departments for mental health reasons and to analyze issues related to individuals staying in emergency departments (EDs) for over 23 hours, identify reasons for these long stays (often referred to as "boarding"), and provide proposals for solutions to address this issue. OHA also committed to presenting this analysis to the Legislature in the 2017 legislative session as well as provide it to USDOJ. OHA further committed to initiate additional community-based strategies to address this issue, beginning in the fall of 2016.

As described in detail in IC Report #5, OHA did engage the Oregon State University College of Public Health and Human Services to do a study of boarding in EDs which was released to the legislature in early 2017 along with a Report Briefing including recommended action steps and "next steps" to be taken to address the issue. However, this study was not just about adults with SPMI and utilized a combination of data systems that are not comparable with data available going forward and were from 2014, so no longer recent enough to provide a picture of current boarding issues.

The OHA Report Briefing to the Legislature described several actions steps to address boarding. OHA has made progress on several but not all. For example, expansion of community mental health services beyond mobile crisis services has not yet occurred.[89] The original boarding study also recommended improvements in psychiatric services for individuals in EDs, provision of additional alternatives to inpatient care, more supportive services such as supported employment, promotion of insurance and health services reimbursement changes to incentivize community services, and increased transparency of waitlists for inpatient and OSH beds. Many of these issues are being addressed in various ways (including a recent workgroup and regulatory changes regarding admission to OSH). Without regular data and reports specifically about boarding over 23 hours for adults with SPMI, it will be impossible to know whether any such changes have impacted boarding for the OPP population. To further address the issue, OHA has added ED Boarding, especially initial and consistent data collection followed by strategy development based on that data, as elements of its revised BHQPIP over FY 2021 and FY 2022. Similarly, Exhibit M of the CCO 2.0

[88] CCO 2.0 Contract, Exhibit M, Section 17.f.

[89] The CFAA budget for CMHPs was reduced by a total of $9 million and the funds were set aside because of the caseload methodology currently utilized to provide this funding. Recommendations for a new funding formula methodology is expected to be developed in conjunction with CMHPs and other stakeholders prior to OHA requesting the release of these set aside funds. (See further description earlier in this Report regarding OPP Section C.) However, $7.6 million in funding was added to provide additional community competency restoration options for individuals found unable to assist in their own defense. In addition, the OCJC received over $10 million for a new IMPACTS grant program to increase community based behavioral health services to assist in preventing individuals with behavioral health needs from landing in the criminal justice system. OHA is co-chairing the group that developed and released the grant applications notice for these funds.

contract contains language requiring CCOs to develop remediation plans with hospitals with significant numbers of ED stays longer than 23 hours.

As described in IC Report #5, a bill to require consistent data reporting by hospitals (SB 23) did pass in the 2019 legislative session with the support of Oregon's hospitals after an attempt to pass such legislation in the 2017 legislative session did not pass due to opposition from hospitals. The Oregon Association of Hospitals and Health Systems (OAHHS) is now collecting data about individuals in all Oregon EDs, including by diagnosis, age, and entrance and exit times, and will be working with OHA to share and analyze these data beginning in CY 2020. This will be a good source for data reporting going forward, with an analysis by diagnosis and age and common understandings regarding when boarding begins, to help OHA meet its OPP commitments in this area. From this data, OHA has stated in its revised BHQPIP it will develop and pursue strategies to address the boarding issue, with EDS, CCOs, and other system partners.

Given the status of these various efforts, OHA is ***in compliance*** to analyze data initially and present this analysis to the legislature. However, it has not yet begun regular data reporting and monitoring, and therefore is not yet able to use these data to initiate strategies to address the boarding issue for the OPP population. However, OHA is ***working toward compliance*** by agreements with OAHHS to begin receiving data and by implementing some strategies and working on others to address the emergency and crisis needs of adults with SPMI. (See also, IC Report #4.) In addition, OHA has included specific requirements regarding CCOs working with EDs on the boarding issue for the 2020-2024 contract period.[90] However, it is not yet clear how OHA will oversee or hold CCOs to these requirements.

Efforts to Reduce Recidivism to EDs for Psychiatric Purposes

In Subsection D.40., OHA committed to reducing recidivism and to track ED admissions of individuals with SPMI by hospital, monitor the number of individuals with SPMI with two or more readmissions to an ED for psychiatric reasons in a six-month period, continue to work with CCOs and CMHPs to better address the needs of these individuals in less institutional settings, and implement plans to address the needs of such individuals. Specifically, OHA committed to seek contract amendments to CCO contracts in 2018 that will require ACPFs to develop and implement plans to address the needs of such individuals in less institutional settings. As described above, some of these contract changes are included for CCOs in 2020 – 2024. Since CMHPs do not generally pay for inpatient or emergency department care, the CFAA for CMHPs does not adequately describe community providers' role in reducing ED use for psychiatric purposes or in addressing boarding issues. However, CFAA language regarding CMHPs' role in providing crisis services and the increases in such services should help to alleviate emergency room use.[91]

OHA has provided data regarding the number of individuals with SPMI with two or more readmissions to an ED for psychiatric reasons. In its most recent data and narrative reports, OHA indicated these numbers at baseline and throughout the OPP period have been re-analyzed due to significantly more claims data being provided by ACPFs/CCOs. At baseline, during 2015, 810 adults with SPMI were reported to have met these criteria. Unfortunately, this number has increased in most quarters since then but has declined somewhat since the 12 months ending September 30, 2017. In that period, 1,093 individuals were reported to have experienced these multiple admissions, declining each rolling 12-month period reported by quarter through September 2018 to 757. However, in the final three rolling 12-month periods of OPP year three, the numbers began to increase again with 838 reported for the last 12-month period ending June 30, 2019.[92] As a consequence, OHA is ***in compliance*** with monitoring these data, and should be given credit for re-analyzing the data as they changed even when the outcome was not favorable to the OPP reporting process. However,

[90] CCO 2.0 Contract, Exhibit M, 14.

[91] It should be noted the CFAA language covered only the first 18 months of the usual two-year time period – through December 2019 – to allow OHA and CMHPs an opportunity to revise the language based on outcomes of the 2019 legislative session and to deal with formula issues affecting CMHP funding. (See also, Footnote 90 and description of OPP Section C. earlier in this Report.) Due to COVID-19 pandemic response, only minor revisions regarding financial matters are anticipated for 2020 and possible further efforts in 2021 for contract period 2022 and beyond.

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

OHA has indicated it will continue to monitor this number in its revised BHQPIP work on reducing the rate of visits to EDs by adults with SPMI, and in its work with CCOs to address behavioral health metrics during CCO 2.0.

OHA committed in Subsection 40.a. and b. to continue to work with and enter into collaborative efforts with CCOs and CMHPs to develop and implement plans to address the needs of individuals with SPMI with multiple ED admissions and meet their needs in less institutional settings where appropriate. To address this issue, OHA has included specific requirements for CCOs in 2020-2024 regarding ED utilization with goals to reduce repeat visits to EDs, reduce the length of time Members spend in EDs, provide data on ED utilization for behavioral health reasons, and ensure Members with SPMI have appropriate community-based services to prevent utilization of EDs, including a follow-up visit from the CCO's Intensive Case Coordinator (ICC) within three (3) days.[93] OHA had originally included use of EDs for psychiatric reasons by individuals with SPMI as an incentive metric for CCOs in its initial Sample Contract for CCO 2.0. However, this appears now to be a metric regarding reduction in the use of EDs in general and is listed as a disparity metric. (See description of Section E. later in this Report.) Nevertheless, CCOs are required by the CCO 2.0 contract to develop an individualized management plan for individuals admitted to an ED or ACPF two or more times in a six-month period to help avoid unnecessary readmissions and to better address the needs of these CCO Members in settings other than institutional settings. The definition of and content required for these individualized management plans is included in the CCO 2.0 contract.[94]

As with other CCO 2.0 issues, how OHA will hold CCOs accountable to the new requirements is not yet totally clear. Currently, CMHP CFAA language and Choice provider contracts include requirements regarding in-reach and other work to address ED readmission issues by providing mobile crisis services and assuring individuals in ACPFs (including EDs) remain connected to community-based services. Hence, OHA is ***in compliance*** with this set of OPP commitments. However, as described elsewhere in this report, the CFAA language which transfers and guides requirements for funding to counties for CMHPs is undergoing minor revision in 2020 with more extensive revisions to be considered in 2021 for 2022 and beyond. Consequently, the development of this new language will need to be monitored to assure it includes appropriate requirements regarding those with SPMI in EDs as well as ACPFs.

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

OHA committed in Subsection D.41. to reduce the rate of visits to general EDs[95] by individuals with SPMI for mental health reasons, as follows:

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

Data reported by OHA indicates the baseline rate in CY 2015 was 1.54 admissions per Member month.[96] Therefore, the goal for the end of year one was 1.39 and 1.25 for the end of year two. Rather than declining, the rate actually increased to 2.07 by the end of year one, but did decline somewhat to 1.88 by the end of year three. However, the rate began to inch up again during year three from the rate of 1.82 at the end of year two. Hence, the State is ***not in compliance*** with the commitment to reduce the rate of ED visits for the OPP population. OHA is including continuing efforts and goals regarding this rate of visits to EDs by adults with SPMI in its revised BHQPIP covering FY 2020 through FY 2022 with goals of 1.80 and 1.60 respectively in the latter two years of the revised BHQPIP timeframe. The revised BHQPIP will include monitoring the

[93] CCO 2.0 Contract, Exhibit M, 14.a.
[94] CCO 2.0 Contract, Exhibit A and Exhibit M, 14.b. and 17.d.
[95] Not including specialty psychiatric emergency services such as Unity Center in Portland. (OPP Footnote 3, page 14.)
[96] NOTE: As reported in IC Report #5, OHA calculates the rate as the number of visits to general EDs by Member months. USDOJ has indicated it would prefer this be reported by the number of individuals with SPMI who are Members of CCOs but there is currently not a way to obtain diagnoses on all CCO Members since a person's diagnosis may not be available unless or until the individual is seen for a psychiatric emergency or other mental health service. Also, the comparison of facilities is somewhat misleading because OHA uses the latest admission to describe where the individual was readmitted. However, a particular individual could have been admitted to one ED and then readmitted into a different ED during the six-month period.

number of individuals with SPMI with two or more ED readmissions in a six-month period for a psychiatric reason.

Meetings with Independent Consultant re Emergency Room Use

Finally, in Subsection D.42., OHA committed to meeting with me, the IC for the OPP, to discuss the use of EDs by individuals with SPMI who present to EDs for mental health reasons. They have done so and continue to be willing to do. Hence, OHA is ***in compliance*** with this OPP provision.

SUBSECTIONS D.45.—48. SUPPORTED EMPLOYMENT [See Also IC Report #3]

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

- The number of individuals with SPMI who receive supported employment (SE) services [as defined in Subsection B.6.n.] who are employed in competitive integrated employment (CIE)[97] [as defined in Subsection B.6.d.];
- 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 has continued to be ***in compliance*** with these commitments.

OHA requires SE programs to meet fidelity standards as defined in Subsection B.6.g. in order to receive either Medicaid or State general fund resources even though no State funds for SE services were available during the OPP timeframe (FY 2017 through FY 2019). OHA uses quarterly reports from SE programs as the source for the OPP data reported. As of June 30, 2019 (end of OPP year three), 769 individuals were reported by OHA as receiving SE services and employed in CIE. This compares to 757 as of the end of year one (June 30, 2017) and 762 as of the end of year two (June 30, 2018). Likewise, the number reported to have graduated and in CIE has risen modestly from 110 as of June 30, 2017, to 137 as of June 30, 2018, and to 139 as of June 30, 2019 (after some slowdown in this number for the few quarters before). It should be noted these SE numbers are quarterly (three-month) numbers rather than numbers for the prior 12 months. Since OHA is reporting on these two elements, it is ***in compliance*** with these OPP provisions.

The Oregon Supported Employment Center for Excellence (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. As indicated in IC Report #3, 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. OSECE is also required to provide subject matter expert assistance for SE to OHA as required. OSECE remains a part of the national SE/IPS learning collaborative (formerly through Dartmouth).

OSECE utilizes and the Oregon outpatient behavioral health services regulations[98] require use of the Individual Placement and Support (IPS)[99] 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.

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[97] OPP Subsection D. 48. Indicated an understanding regarding receipt of SE services not guaranteeing a job or work for a specific number of hours. Therefore, this number is those so employed for any number of hours.
[98] See OAR 309-019-0270 through -0310 for this requirement and the requirement of providers of SE services to meet IPS SE fidelity requirements.
[99] 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 at www.osece.org.

Therefore, all individuals reported as receiving SE services and employed are in CIE employment. OSECE indicates just over 40 percent 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. Approximately 1,800 individuals were receiving SE services as of June 30, 2017, and approximately 1,830 as of June 30, 2019.

OSECE lists 37 IPS SE programs serving 35 of Oregon's 38 counties. SE programs in three counties (Clatsop, Lincoln, and Jefferson) are working toward fidelity and have hired staff. Only one county (Lake) does not yet have an SE program.[100]

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

SUBSECTIONS D.49. – 50. SECURE RESIDENTIAL TREATMENT FACILITIES [See Also IC Report #5]

Subsections D.49. and 50. included specific commitments regarding the length of stay (LOS) and the discharge process for civilly committed adults with SPMI who are receiving services in secure residential treatment facilities (SRTFs). Performance on the LOS for such individuals for OPP year three is described below. Performance on the discharge process for such individuals is described more fully in IC Report #5 and updated briefly in this Report.

Quantitative Commitments re Individuals with SPMI Leaving SRTFs

Subsection D.49.b. enumerated quantitative goals about the LOS of such individuals in SRTFs. Specifically, by the end of year one (June 30, 2017), the goal was a 10 percent reduction from the 2015 baseline of 638 days (therefore, the goal was 574.2 days); and by the end of year two (June 30, 2018), the goal was a 20 percent reduction from the 2015 baseline (or 510.2 days). Statewide, this number was decreasing through the middle of year two (501.8 days) but then began to increase and bounce around over the next five reporting periods (through March 31, 2019 at 665.7 days). In the last reporting period, the number began to come down slightly (656.1 days for the 87 individuals discharged in the 12-month period ending June 30, 2019). While this number is still above baseline and therefore OHA is ***not in compliance*** with this commitment to reduce LOS, the reporting methodology utilized by OHA to report these data appear to be working against them. The data provided by OHA are calculated as an average LOS (ALOS) based only on those individuals who are discharged in a given time period. OHA made the case this was the best way to calculate these numbers as otherwise the number could change literally daily if the LOS of all individuals with SPMI who are in SRTFs is included and would therefore be meaningless. However, by calculating ALOS on only those discharged, the LOS reported in any given time period will fluctuate depending on how long those particular individuals were in the SRTF before being discharged. This approach to calculating and reporting the ALOS means OHA's late 2018 and 2019 focus on ensuring individuals who no longer need to be in an SRTF are released to more appropriate settings actually resulted in higher ALOS for OPP reporting purposes. This focus has led to an increase in the number of individuals released who had long lengths of stay (in some cases, literally years or even a decade or longer) and who are stable and could live in more integrated community settings. But it has also led to higher reported ALOS for those periods even while the system seems to be doing the right thing by focusing on discharges for the longest stay individuals.

Another way to look at this issue of LOS was provided in the January 2020 OHA narrative report (as revised in March) by looking at all civilly committed individuals with SPMI in SRTFs at a point in time each year and is summarized in **TABLE 5** below.

[100] Accessed on OSECE website June 23, 2020 at https://osece.org/supported-emp-programs/.

TABLE 5 – Lengths of Stay of Individuals in Residence in SRTFs on June 15, Annually[101]

# in Residence	# Persons in Residence < 120 Days	# Persons in Residence 120 – 365 Days	# Persons in Residence 366 Days – 2 Yrs (730 Days)	# Persons in Residence > 2 Yrs (731 + Days)
June 15, 2017 – 33	7 (18%)	10 (33%)	8 (24%)	8 (24%)*
June 15, 2018 – 29	9 (31%)	5 (17%)	5 (17%)	10 (34%)
June 15, 2019 – 47	15 (32%)	14 (30%)	10 (21%)	8 (17%)

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

These data suggest the number and proportion of individuals in SRTFs for the shortest period of time less than 120 days) was growing. While OHA is ***not in compliance*** with the commitment to reduce LOS using OHA's original approach to counting this number for the three-year OPP timeframe, a point-in-time analysis may prove a better way going forward to track changes in this LOS. In the revised BHQPIP, OHA has included reduction in LOS in SRTFs for civilly committed adults with SPMI utilizing a counting mechanism to be calculated as a point-in-time ALOS for those in SRTFs at that point. With this new counting approach, the baseline ALOS for the 47 individuals in SRTFs on June 15, 2019 was 517 days, far less than the ALOS of those discharged over the course of a year. From this baseline, OHA can track the system's progress from FY 2020 through FY 2022 in a more consistent way.

Subsection D.49.c. committed OHA to report regularly on the number of civilly committed individuals in SRTFs, their lengths of stay, and the number of individuals who are discharged; and starting July 1, 2017 (the beginning of year two of the OPP), the type of, and the placement to which such individuals are discharged. OHA did track and report these data. OHA's latest data report (Appendix F of the January 2020 report) showed the dispositions of the nine civilly committed adults with SPMI discharged from SRTFs in the last quarter of year three of the OPP timeframe (April 1, 2019 – June 30, 2019). These data indicate two discharges each to an ACPF, a Residential Treatment Facility, an Adult Family Home, and Independent Living settings, with one individual discharged to APD. OHA is ***in compliance*** with the commitment to report the number of individuals who are discharged (albeit not from the beginning of the OPP as implied in Subsection D.49.c.), and ***in compliance*** with the commitment to report the number of civilly committed individuals in SRTFs, their lengths of stay, and the dispositions of those discharged.

Qualitative Commitments re SRTF Discharge Plans and Timing

Subsection D.49. and D.50. indicated "civilly committed individuals in [SRTFs] whose clinical needs no longer necessitate placement in a secure facility shall be moved *expeditiously* [emphasis added] to a community placement in the most integrated setting appropriate for that individual, to "housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice."

The results from chart reviews conducted in 2018 of individuals discharged from SRTFs are described at length in IC Report #5 and indicated the vast majority being discharged to settings consistent with their clinical and treatment needs, although less consistent with their documented choices. Some of the choices individuals expressed during discharge planning were not possible to fulfill, e.g., those who expressed a desire to return to a family home where the individual was not welcomed back by the family, move to a setting without adequate support and assistance for safety and self-care, move to a location or to pursue an interest requiring more transition to accomplish, or choices inconsistent with clinical and treatment needs at the time of discharge with additional time needed for treatment and support services before pursuing those initially stated personal choices and goals. Reviews of charts from later treatment settings after SRTF discharge was not possible. This may be something OHA wants to pursue going forward to determine how and whether individuals' personal choices and longer-term goals are being incorporated into on-going treatment planning across various community service settings over time.

Disposition data across the last few OHA data reports show individuals being discharged to a variety of settings depending on their clinical and treatment needs rather than individuals being routinely "stepped down" to any specific type of residential treatment facility. Most individuals are discharged to residential treatment facilities of various sorts. Few are discharged directly to supportive or supported housing from the

[101] NOTE: The numbers for June 15, 2018 have been corrected from those previously reported in IC Report #5.

locked environment of an SRTF. Several have been discharged to Independent Living, some characterized by the same scattered site, integrated, and choice components of supported housing. These data are summarized in **TABLE 6** below. From this and earlier chart reviews described in IC Report #5, I conclude the State to be ***in compliance*** with the commitment regarding appropriateness of placement upon discharge and the expeditious nature of discharge planning and transitions and ***in partial compliance*** with the commitment regarding placements upon discharge being consistent with individuals' informed choices and preferences. Improvements in capturing and considering individuals' preferences and choices are needed. These choices may be appropriate to work on with the individual beyond the immediate discharge from a locked and highly structured environment of an SRTF or state hospital. OHA may want to work further regarding how to assist individuals to develop choices and work on them over time and across various treatment or living settings. In the meantime, the documentation of work with an individual on their choices and life plans is critical for those in and leaving SRTFs and other settings.

TABLE 6: Dispositions Upon Discharge from SRTFs

DISPOSITION[102]	Q1 – Q3 CY 2018[103]	Q4 CY 2018	Q1 CY 2019	Q2 CY 2019	**TOTAL**
Residential Treatment Facility (RTF)	12 (Q avg 4.0)	6	3	2	**23**
Residential Treatment Home (RTH)	7 (Q avg 2.3)	2	1	0	**10**
Adult Foster Home (AFH)	4 (Q avg 1.3)	2	3	2	**11**
Independent Living	9 (Q avg 3)	3	1	2	**15**
Supportive Housing	2 (Q avg 0.7)	0	0	0	**2**
Supported Housing (SH)	0	0	0	0	**0**
Acute Psychiatric Hospital (ACPF)	1 (Q avg 0.3)	0	1	2	**4**
Aging & People w/ Disabilities (APD)	0	0	0	1	**1**
Against Medical Advice (AMA)	1 (Q avg = 0.3)	1	0	0	**2**
TOTALS	**36 (Q avg = 12)**	**14**	**9**	**9**	**68**

As discussed in IC Report #5, the IQA's role, process, and criteria by which admission and discharge determinations are made have been under reconsideration, with OHA making changes about expectations and contract requirements for the future. This process has now concluded with the selection of Comagine[104] as the IQA beginning July 1, 2020. The transition from KEPRO to Comagine has been underway. This change bears watching to determine how it improves or causes difficulties for individuals with SPMI in SRTFs as does the admission and discharge planning processes for those providing SRTF care and services over the next couple of years.

IC Report #5 included a number of recommendations and suggestions from stakeholders and from the chart reviewers regarding SRTFs and the discharge planning process. These should continue to be considered as OHA works to improve its efforts for the OPP population in these settings. In addition to selecting a new IQA with revised contract expectations, OHA has undertaken two efforts regarding CCOs' responsibilities for individuals in SRTFs that will be helpful in improving the use of these facilities and discharges from them. One is inclusion in the CCO 2.0 contract language from the OPP Subsections regarding SRTF discharges

[102] A description of Oregon's residential treatment settings can be found on the OHA website at https://www.oregon.gov/oha/HSD/AMH-LC/Pages/RT.aspx.
[103] Since the numbers in this column are for three quarters rather than one, the calculated avg is simply for reference to the other quarterly data and do not represent any actual numbers discharged in these disposition categories.
[104] Comagine was formerly known as HealthInsight Assure and is the entity that has reviewed ACPF charts for OHA for the last few years to determine performance and documentation of warm handoffs and other elements of the OPP subsections regarding acute psychiatric care.

being expeditious, appropriate, to integrated settings, and to housing consistent with individuals' treatment goals, clinical needs and informed choice.[105] OHA also indicates such individuals are likely to be in need of Intensive Care Coordination (ICC) with specific requirements about assistance and supports.[106] While this is an excellent start, the compliance process for the CCO 2.0 contract is still in process so bears watching to assure CCOs are held accountable for this responsibility.

OHA has also concluded its rate standardization process in which it created tiered rates for SRTFs to incentivize and pay more for facilities providing services for individuals with more intensive needs.[107] This process paves the way for residential treatment facilities to become the responsibility of CCOs after CY 2021 (FY 2021 or FY 2022), on a timeline to be determined by OHA.[108] Significant work will be needed for CCOs to be ready to take on the payment and risk for individuals needing care in such facilities. However, this process, along with the CCOs beginning to share risk for OSH services in the same timeframe (described earlier in this Report) will help to create common accountability for individuals' care across multiple treatment and service settings. OHA's commitment to move this risk to a single entity for each Member is critical for improvements in care for individuals with SPMI when they need higher intensity service settings. It will also help to assure CCOs as payers are committed to utilizing the least restrictive settings appropriate for such individuals and is also likely to increase creativity in the development of needed additional community service options for individuals with SPMI throughout Oregon.

Finally, prior to the COVID-19 pandemic response, OHA was clarifying requirements regarding ACT services for those in, referred to, or being discharged from residential treatment, up to and including SRTFs. In the past, system partners understood ACT services to be unavailable for persons in residential treatment settings, including SRTFs. Clarity about what activity an ACT provider is responsible for while an individual is in such a setting is critical. OHA is expecting the lengths of stay of adults with SPMI in such facilities to continue to decline and is actively encouraging discharge to a lower level of care whenever possible, with ACT support for those persons with SPMI who could likely be successful outside an SRTF. OHA is also setting the expectation for ACT and SRTF providers regarding ACT's responsibility for discharge transitions and connections to other services needed without disrupting the SRTFs' responsibility to provide rehabilitation and supports for the individual while in an SRTF. Hence, OHA plans to finalize a guidance document as part of its revised BHQPIP activities regarding ACT in which it will clarify when an individual can and should be referred to ACT and SRTF at the same time; when and how an ACT provider should continue while an individual is in an SRTF; and when and how they should engage when an individual in an SRTF is ready to be discharged. This clarification will be critical in helping to clear up confusion about roles as well as to assure individuals in SRTFs continue to have access to ACT services just as individuals in hospitals continue to have ACT services during those short stays so their ACT provider is ready to assist when the individual is ready to leave.

SUBSECTIONS D.51. – 53. CRIMINAL JUSTICE DIVERSION [See Also IC Report #4]

Jail diversion services are defined in Subsection B.6.i. of the OPP as:

> . . . community-based services that are designed to keep individuals with behavioral health issues out of the criminal justice system and, instead, supported by other community-based services, such as mental health services, substance abuse services, employment services, and housing. Jail diversion services are intended to minimize contact with law enforcement, avoid jail time, and/or reduce jail time. These services are intended to result in the reduction of the number of individuals with mental illness in the criminal justice system or Oregon State Hospital.

Subsections D.51. – 53. state the "intent" of these Subsections was to reduce the contacts between individuals with SPMI and law enforcement due to mental health reasons. Specifically, Subsection D.51.

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[105] CCO 2.0 Contract, Exhibit M, 17.f.
[106] See OAR 410-141-3160, 3165, and 3170 as well as CCO 2.0 Contract, Exhibit B, Parts 2 and 4.
[107] See https://www.oregon.gov/oha/HSD/OHP/Pages/MH-Rates.aspx, and https://www.oregon.gov/oha/HSD/OHP/Announcements/Final%20standardized%20adult%20mental%20health%20residential%20rates%20effective%20July%201%202019.pdf for information regarding the residential rate standardization process.
[108] See CCO 2.0 Contract, Exhibit M, 16.a.

indicated OHA "hopes" to reduce arrests, jail admissions, lengths of stay in jail, and recidivism for individuals with SPMI who are involved with law enforcement due to a mental health reason. These sections indicate OHA would "work to" decrease the number of individuals with SPMI who are arrested or admitted to jail based on a mental health reason, by engaging in identified strategies, namely:

- continue to report the number of individuals with SPMI receiving jail diversion services and the number of reported diversions; and require, under new contracts with entities providing jail diversion services, that contract providers report the number of diversion pre- and post-arrest,[109] as well as including this requirement in all RFPs for any new jail diversion programs (Subsection D.52.a.);
- by July 2016, begin to work collaboratively with the Oregon Sheriffs' Association and the Association of CMHPs to determine strategies to collect data on individuals with SPMI entering jails (Subsection D.52.b.);
- by July 2016, contract with the GAINS Center[110] to consult on the expansion of the use of the Sequential Intercept Model (SIM) by local jurisdictions throughout the State and encourage local jurisdictions to adopt and implement interventions in accordance with the SIM, and require Counties receiving new jail diversion services funding to adopt SIM (Subsection D.52.c.);
- as of July 2016, track arrests of individuals with SPMI who are enrolled in services and provide data by quarter thereafter (Subsection D.52.d.);
- provide USDOJ with data quarterly from the jail diversion programs it funds [and seek contract amendments requiring quarterly reporting, per Subsection F.6.] (Subsection D.52.e.);
- collect data regarding individuals with SPMI enrolled in mental health services who are arrested, the County where these individuals encountered law enforcement, existing jail diversion services, the impacts of those services, and obstacles to the success of those services; provide the results of any mapping and any additional relevant data to USDOJ and allocate existing funding as necessary to support additional or enhanced jail diversion programs based on results; prioritize pre-charge (i.e., pre-booking) diversion activities.

The State also committed OHA to "work with local jurisdictions to develop strategies to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of individuals with SPMI who are incarcerated." (Subsection D.53.)

OHA efforts on these OPP commitments are described below.

Efforts to Reduce Contact with Law Enforcement, Arrests, Jail Admissions, Lengths of Stay in Jail, and Recidivism

Unlike the mobile crisis services subsections of the OPP, the OPP language in Subsection D.51. is specifically about individuals with SPMI and is written as a statement of intent rather than a plan to achieve specific quantitative or qualitative actions. As described in IC Report #4, most county programs have worked to increase collaborations and interactions with law enforcement entities and personnel who often encounter or identify individuals with SPMI and others who are in crisis or soon could be. The focus of CMHP activities is to be responsive to and with law enforcement in the community and to work with jails, courts, and probation and parole entities to divert individuals in crisis or individuals with behavioral health issues from arrest and/or to shorten their time spent in a detention setting. However, statewide data about arrests and reductions or increases of time in a detention setting for the population of adults with SPMI have only recently become available and have now been provided to USDOJ and to me. My preliminary review of these data indicates a fairly consistent approximately three percent arrest rate (ranging from 2.82 – 3.21%) among adults with SPMI enrolled in mental health services during each quarter of the OPP three-year period from July 2016 through June 2019. The data do not indicate any clear pattern of increase or decrease arrest rates during this time period. However, the data currently available are in aggregate without any breakdown

[109] In consultation with the GAINS Center, the terms "pre-arrest" and "post-arrest" are considered to be synonymous with "pre-charge" used in Subsection D.52.f. and with the terms "pre-booking" and "post-booking" utilized by the GAINS Center and by the IC in this report.
[110] The GAINS Center is the SAMHSA supported Center for Behavioral Health and Justice Transformation. The acronym stands for Gather, Assess, Integrate, Network, and Stimulate. See https://www.samhsa.gov/gains-center.

by diagnosis, type of arrest, number of arrests per person, or disposition, although the OPP did not specify this level of detail for these data.

While the State's and local programs' efforts are appropriate and to be commended, not all services funded through OHA jail diversion grants or CFAA dollars are specifically about diverting individuals with SPMI from arrest, jail time, or recidivism. Many are focused on providing assessments for criminal justice partners and/or treatment or support services for individuals under the jurisdiction of criminal justice partners rather than actually diverting them from these interactions. At this point in time, it appears local mobile crisis programs may be doing as much or more of the diversion from jail/law enforcement interactions as the actual (and somewhat limited) jail diversion grant programs referenced in Subsection D.52.a.

Similarly, the efforts of local programs funded by OHA are disproportionately post-booking. Some indications of the relatively few pre-booking diversion situations are actually diversion from returning to jail due to probation or parole violation, or are efforts to prevent an individual from further penetration into the criminal justice system. These activities include efforts to assist an individual or another system avoid a criminal finding with diversion to community services or avoid being tried on a criminal charge by a determination of incompetence to proceed to trial. The latter may include admission to an inpatient program – often OSH – for treatment and competency restoration. In some counties, community-based programs for this "aid and assist" population are helping to prevent such admissions to OSH.[111] These efforts collectively are largely SIM Intercepts 2 through 5 rather than 0 or 1, the latter being work prior to law enforcement involvement or specifically prior to booking in jail.[112] Again, none of this activity is inappropriate and is a commendable set of activities within communities' behavioral health and criminal justice systems.

While ***compliance with the -hope*** expressed in OPP Subsection D.51. is evident at State and local levels, the actions to implement this intent appear to be occurring in areas other than just criminal justice diversion grant activities, making the actual results in this OPP area difficult to track. For example, mobile crisis services appear to be doing significantly more to reduce or help avoid criminal justice interaction or at least formal arrests of persons receiving mobile crisis services than just the jail diversion programs receiving funding by OHA for that purpose. (See also IC Report #4 for further description of these services and results.)

Efforts to Decrease, Track, and Report the Number Arrested or Admitted to Jail

Subsection D.52. of the OPP committed OHA to a number of action steps "to work to decrease the number of individuals with SPMI who are arrested or admitted to jail based on a mental health reason," with specific strategies described below. The success of these strategies in actually decreasing those numbers is unclear at this point as arrest data just recently became available and in the aggregate for the state as a whole. These data do not show any trend or analysis. However, it is clear OHA is working on most of these action steps as described below.

Reported Numbers Receiving Jail Diversion Services and the Number of Reported Diversions: OHA does collect and report the number of individuals receiving jail diversion services through OHA grants for this specific purpose, and asks the local program to identify whether the service provided was pre- or post-arrest (i.e., pre- or post-booking). However, programs are not required to report a distinction between a jail diversion service and a jail diversion itself. As indicated above, most programs report post-booking services, and almost exclusively provide jail diversion services for individuals who are already involved in the criminal justice system. Services to actually divert individuals from arrest and booking are generally provided through mobile crisis teams, ACT teams, intensive case management, peer-delivered services, or other community behavioral health services (SIM Intercepts 0 and 1). In some limited cases, peer support services are part of a community program's jail diversion services.

OHA reported 1,644 individuals with SPMI receiving jail diversion services from county programs in the last quarter of year three of the OPP (ending June 30, 2019). This does not count those diverted through other

[111] While such situations are critical for aid and assist individuals whether SPMI or not, it should be noted that the aid and assist population per se is not part of the group that is the focus of the OPP.
[112] See https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf for a description of the various SIM intercepts.

programs noted above in which actual diversions are more likely to be happening in greater numbers. The number is higher than the previous quarter, but lower than the eight quarters before that. However, it is still above 2015 baseline, reported by OHA as 1,409. Whether this decline reflects grants ending or other loss of resources for such efforts is unclear. Nevertheless, since this was a commitment to report without a goal and to report about a specific and limited set of grant programs, OHA is ***in compliance*** with this commitment.

Of those receiving jail division program services, OHA reported 337 were pre-booking and 1,307 were post-booking, only 20.5 percent being the preferred pre-booking services. This compares to 499 receiving pre-booking services of the 2015 baseline 1,409 or 35.4 percent. While the baseline number served is lower, the proportion receiving pre-booking services was higher. However, as discussed in IC Report #4, the guidance regarding what is to be counted as which type of service has not been clear and programs reviewed for that IC Report did not appear to be counting and reporting consistently. As of this time, I have seen no further effort to clarify for programs how to count and report pre- and post-booking. Therefore, OHA is still ***not in compliance*** with this part of the Subsection. OHA needs to do more to clarify reporting requirements and expectations regarding how to prioritize actual pre-booking diversions.

OHA also committed in Subsection D.52.a. to include this requirement regarding reporting the number of diversions pre- and post-arrest (i.e., pre- and post-booking) in any new jail diversion grant programs. OHA has not yet provided any additional funding for new jail diversion programs since CY 2016, and therefore has not had an opportunity to implement this commitment. However, a bill passed during the 2019 legislative session (SB 24) will assure probation or parole violators can no longer be admitted to OSH for competency restoration and misdemeanants can only be referred and admitted to OSH if a certified forensic evaluator or a CMHP finds the individual to need hospital level of care due to the defendant's dangerousness or acuity of symptoms. The bill also requires a court determining a defendant lacks fitness to proceed to consider a CMHP recommendation whether the services and supervision necessary to safely allow the defendant to gain fitness (i.e., be restored to competency to go to trial) are available in the community rather than in an inpatient setting. This bill allows more options for this population than just admission to OSH. Along with OHA's commitment to create more community restoration options for such defendants, this bill was intended to help decrease pressure on OSH admissions and serve individuals in more community-based settings when possible.

In addition, a new program was funded by the Oregon Legislature in 2019. SB 973[113] is intended to help address the issue of increasing numbers of individuals found to be in need of competency restoration before being able to stand trial for criminal charges (referred to as the aid and assist population). This program is called IMPACTS (Improving People's Access to Community-based Treatment, Supports, and Services). It is designed to address the shortage of comprehensive community supports and services for individuals with mental and/or substance use disorders, leading to their involvement with the criminal justice system, hospitalizations, and institutional placements. This bill resulted in $10 M in competitive grant funds to be administered by the Oregon Criminal Justice Commission (OCJC), in collaboration with OHA. The first request for Grant Applications was released in May with applications due June 12, 2020.Grant funds were expected to be awarded this spring for use beginning July 1, 2020 (FY 2021).[114] Grantees will be required to utilize the local county's SIM mapping outcome/report if it exists or work with the Oregon Center on Behavioral Health and Justice Integration (OCBHJI) to conduct a SIM mapping process in the county they will be serving.

While the IMPACTS grant program is not limited to serving those with SPMI, it is very likely to have an impact on those among this population who end up in the criminal justice system – as aid and assist individuals or otherwise – due to inadequate community-based services and living arrangements. By increasing the capacity for such services to prevent and divert from criminal justice system involvement those individuals with behavioral health needs and histories of multiple entries into the criminal justice system and/or restore aid and assist individuals to competency without an institutional admission, adults with SPMI are likely to benefit. This program is also expected to help build infrastructure to "better provide . . . community services that will assist [individuals] to live in the most integrated setting appropriate to their

[113] See https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB973/Enrolled.
[114] See https://www.oregon.gov/cjc/impacts/SiteAssets/Pages/default/2020_IMPACTS%20RFGP_Final.pdf for the grant application.

needs, achieve positive outcomes, and prevent their unnecessary institutionalization" as committed in Subsection A.1. of the OPP.

In addition, the current FY 2019 – 2021 CFAA language for the Jail Diversion Services element (MHS 09) includes required quarterly reporting as follows:

- Individual's name, gender, date of birth, Medicaid identification number (if applicable); race; ethnicity; whether the Individual has an SPMI diagnosis; identify whether the Individual received pre or post booking services; number of times individual was arrested during the reporting period; charges individual was arrested for during the reporting period; and description of service provided;
- Number of incidences where charges were dismissed or dropped as a result of CJD Services;
- Report the number of crisis consultations provided by mental health staff in pre-booking diversions;
- Detailed description of any MHS 09 Service created prior to the current reporting period; and
- Information regarding any activities related to MHS 09 Services that involved law enforcement agencies, jails, circuit and municipal courts, community corrections, and local mental health providers.

This set of reporting specifications is significantly different and arguably less helpful for OPP purposes than reporting requirements for pre- and post-booking[115] jail diversion services in the prior 2017 – 2019 CFAA CJD service element. These were as follows:

- individuals who received services designated as pre-booking diversion, and the number of times the individual was arrested during the reporting period;
- individuals arrested who received services designated as post-booking diversion, and the number of times the individual was arrested in the reporting period;
- the number of incidences where charges were dismissed or dropped as a result of jail diversion services;
- number of individuals diverted from OSH for determination of fitness for aid and assist services;
- number of crisis consultations provided by mental health staff in pre-booking diversions;
- charges for which individuals who received jail diversion services were arrested;
- number of individuals arrested during the reporting period who received jail diversion services;
- description of jail diversion services individuals received in the reporting period;
- detailed description of any jail diversion service created prior to the reporting period; and
- information regarding any activities related to jail diversion services that involved law enforcement agencies, jails, circuit and municipal courts, community corrections, and local mental health providers.

Arguably, these new reporting requirements are backtracking from the previous specificity and focus. However, the current language does still require providers to adopt the GAINS Center SIM to identify and intervene at various "points of interception" or opportunities for intervention to prevent individuals with SPMI from entering or penetrating deeper into the criminal justice system. It also allows counties/CMHPs to utilize jail diversion funds to create partnerships and diversion agreements with criminal justice entities, as well as to create opportunities for individuals to access housing in addition to vocational and educational services; to provide support services to prevent or curtail relapses and other crises; to assist individuals to negotiate and minimize continuing criminal sanctions as they make progress; and to promote peer support and social inclusion of individuals with or in recovery from mental and substance use disorders. These are all activities consistent with the definition of jail diversion in the OPP. However, the current CFAA language does not define pre- or post-booking for reporting purposes and does not indicate pre-booking diversion as a priority or preference as committed in the OPP.

It should be noted as indicated earlier in this report, revisions to the CFAA language were being considered with minor changes expected during 2020 for 2021 and further revisions to be considered during 2021 for 2022 and beyond. This process bears watching as it may offer an opportunity to improve the language regarding criminal justice diversion expectations. Similarly, regulatory revisions which could have clarified

[115] NOTE: Neither the current nor the former language nor any current regulatory language includes a definition of pre- and post-booking to assure consistency of reporting and tracking of the pre-booking preference in the OPP.

this requirement and approach to counting and reporting (although was not drafted to do so) have been suspended for the time being. All these processes along with the IMPACTS grant program bear watching to assure criminal justice diversion services increase and reporting is consistent and meaningful with positive outcomes for adults with SPMI in Oregon.

Work with Sheriffs/CMHPs (and Local Jurisdictions) to Determine Strategies to Collect/Share Data: Subsection D.52.b. committed OHA to begin collaborative work by July 2016 with the Oregon Sheriffs Association and the Association of CMHPs to determine strategies to collect data on individuals with SPMI entering jails. Subsection D.53. committed OHA to work with local jurisdictions to develop strategies to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of individuals with SPMI who are incarcerated. OHA leaders have attended and spoken to the Oregon Sheriffs' Association and to the Association of CMHPs about individuals with SPMI entering criminal justice systems. Pursuant to an OHA contract, Eastern Oregon Human Services Consortium (EOHSC), the parent company of GOBHI, has had discussions with law enforcement about strategies to facilitate data sharing about persons with SPMI who are in jail. Work on both of these issues is described in detail in IC Report #4.

In addition, CCOs are now required to "engage with local law enforcement, jail staff and courts to improve outcomes and mitigate health and safety impacts for Members who have criminal justice involvement related to their Behavioral Health conditions. Key outcomes include reductions in Member arrests, jail admissions, lengths of jail stay and recidivism along with improvements in stability of employment and housing."[116] As indicated elsewhere in this Report, how OHA will hold CCOs accountable for such requirements is yet to be determined although the compliance oversight effort is in development.

These efforts are certainly evidence of OHA working on data-sharing issues. However, I believe Subsection D.52.b. and certainly Subsection D.53. is about more than just working on these issues. Rather, I believe the intent was to actually develop strategies to share information. OHA is still working on these issues so is ***in compliance*** with Subsection D.52.b. and is ***working toward compliance*** with Subsection D.53. of the OPP.

Work with the GAINS Center and Expansion of the Use of the Sequential Intercept Model (SIM): OHA's efforts to achieve the commitments in Subsection 52.c. regarding contracting with the GAINS Center and encouraging use of SIM mapping and implementation were described in detail in IC Report #4. This requirement to use SIM was included in the 2019-2021 CFAA for CMHPs as described above.

The Oregon Center on Behavioral Health and Justice Integration (OCBHJI) website displays 26 counties' completed SIM maps,[117] up from 11 at the time of IC Report #14. Additional counties may have engaged SIM mapping through another avenue so this website may undercount counties with SIM maps in place or underway. As indicated in IC Report #4, while the State might be able to do more in this area, OHA is ***in compliance*** with the OPP commitments to engage the GAINS Center, encourage local jurisdictions to adopt and implement interventions in accordance with SIM, and require counties to adopt SIM with any new jail diversion funding (as in the new IMPACTS grant program). The OCBHJI website also helps fulfill Subsection D.52.f. commitment to make data available about the results of mapping.

Tracking and Reporting Arrests of Individuals with SPMI Who Are Enrolled in Services: Subsection D.52.d. committed OHA to tracking arrests of individuals with SPMI who are enrolled in services as of July 2016 and to providing data by quarter thereafter. Subsection D.52.f. committed OHA to collecting additional data for those arrested including the county where individuals encountered law enforcement, existing jail diversion services, the impact of those services, and obstacles to the success of those services. OHA also committed in this Subsection to providing the results of mapping and "additional relevant data" to USDOJ and to allocating existing funding as necessary to support additional or enhanced jail diversion programs based on the results.

OHA experienced challenges regarding work with system partners to obtain these data even though arrest data should be publicly available and could be matched confidentially to OHA's data regarding those enrolled in services. While OHA continued to work on these issues, the efforts were not consistent or substantial enough to make a difference or to obtain these data until recently. After almost two years of work with OCJC

[116] CCO 2.0 Contract, Exhibit M, 3.f.
[117] See http://www.ocbhji.org/resources/completed-sim-maps/.

which has arrest data provided to them by the Oregon State Police (OSP), OCJC and OHA determined they could not find a way for OCJC to provide these data to a third party, namely OHA. OHA began discussions with Oregon State Police (OSP) to attempt to obtain these data directly. OSP and OHA reached agreement for OSP to provide data by quarter by county about the number of individuals enrolled in services (as provided by OHA) who were arrested. These data only recently became available and were shared with the IC and USDOJ in aggregate statewide rather than by county but by quarter for all three years of the OPP (July 1, 2016 through June 30, 2019). It is my understanding OHA will be able to receive these data for time periods going forward. These data indicate only a small percentage of individuals enrolled in mental health services were arrested each quarter (i.e., just under three percent, ranging from 2.82% to 3.21%, with no apparent trend up or down over this 12-quarter timeframe). As a consequence, OHA is now ***in compliance*** with this OPP commitment.

However, while the OPP does not include any specific data elements to be tracked, these data will likely be of limited usefulness if OHA cannot identify who was arrested, how many times, for what kinds of charges, etc. so information can be provided to CCOs or other providers to help mitigate these situations. OHA may want to consider requiring CCOs to work with local jurisdictions to identify which of their Members with SPMI have been arrested, for what, when, and with what outcomes.

OPP Subsection D.52.f. committed OHA to collect other data regarding individuals with SPMI enrolled in mental health services and to make the results of any mapping and any additional data to USDOJ and allocate funding as necessary to support additional or enhanced jail diversion programs based on the results. Some work in this area has been done or is underway as part of the recent enhanced attention to the aid and assist population. Likewise, SIM mapping information is available via website (see descriptions of these efforts earlier in this Report and in IC Report #4). Hence, OHA is ***in partial compliance*** with these provisions,

Prioritizing Pre-Booking Diversion Activities: Subsection D.52.f. committed OHA to prioritize pre-charge [pre-booking] diversion activities in its jail diversion grant programs. As discussed above, OHA does require reporting regarding pre-booking services, but does not require these types of services to be prioritized and does not provide a specific definition of pre- or post-booking for reporting purposes. As also indicated above, the OPP may be incorrect in trying to prioritize these services and this outcome in the criminal justice diversion performance outcome section. Rather, the State's future plans may need adjustment to reflect pre-booking services (SIM Intercepts 0 and 1) to be prioritized or at least documented in mobile crisis services and other community-based services performance outcomes reporting. OHA is only ***in partial compliance*** with the commitment to prioritize pre-booking diversion activities through its jail diversion grants, but may actually be prioritizing pre-booking diversion activities through other community-based services such as mobile crisis and ACT.

While significant work is going on in Oregon regarding the interaction of individuals with SPMI and criminal justice systems, comprehensive jail diversion is not yet happening to truly prevent interactions with law enforcement and other parts of the criminal justice system. OHA has included some of these -goals in its revised BHQPIP to continue work in this area. In the meantime, many recommendations emerged from the previous review of Oregon's criminal justice diversion programs. These recommendations are in IC Report #4 and should be considered as Oregon's efforts in this area continue.

SECTION E. QUALITY AND PERFORMANCE IMPROVEMENT

Subsections E.1. – 7. committed OHA to numerous provisions regarding quality and performance improvement going forward, beyond the initial timeline of the OPP. Specifically, OHA committed to:

- continue to develop and implement a quality and performance improvement system specific to the performance outcomes described in Section D., focused on ensuring compliance with those outcome measures; and seek to ensure the mental health and other services and supports for individuals with SPMI addressed in Section D. and funded by the State are of good quality and are sufficient to help achieve good outcomes and avoid negative ones (Subsection E.1.);
- maintain a system of accountability for the performance outcomes specified in Section D., specifically to comprise an OPP Stakeholder Advisory Team and an Olmstead Plan Stakeholder

Team with specified membership from named organizations; both teams to include persons with lived experience and both to review and comment on OHA's progress on OPP commitments and provide advice to OHA regarding strategies being employed (Subsection E.2.);

- provide minutes, formal correspondence and reports from these groups' meetings to USDOJ and the IC; and modify these groups and process if desired after consultation with the IC (Subsection E.3.);
- maintain a quality improvement system for behavioral health services incorporating data collection and analysis to identify trends, patterns, strengths, successes, and problems at the individual, service-delivery, and systemic levels and develop preventative, corrective, and improvement measures to address identified problems and build on successes; and track the efficacy of such measures and revise as appropriate (Subsection E.4.a.);
- issue regulations or enter into performance-based contracts with CMHPs and other providers, either directly or through CCOs that describe expectations with regard to the outcomes in Section D and services and supports to be provided to individuals with SPMI consistent with the OPP (Subsection E.4.b.);
- continue to review SE and ACT programs for fidelity to evidence-based model standards; and require annual fidelity reviews, including interviews with program participants and their families, in order for these programs to bill Medicaid or use General Funds; continue having OSECE and OCEACT provide technical assistance or other support to help providers remedy any deficiencies as well as monitor corrective measures (Subsection E.4.c.);
- assure CMHPs and CCOs develop a corrective action plan with timelines for implementation, oversight and monitoring by OHA if any of these entities are acting in a way OHA believes will frustrate substantial performance of the OPP (Subsection E.4.d);
- post semi-annual reports regarding its quality improvement efforts under this Section E. along with reports regarding performance of mental health outcomes found in other quality improvement initiatives, specifically Medicaid Demonstration(s), metrics established by the Oregon Metrics and Scoring Committee, and external quality reviews of behavioral health services by CCOs (Subsection E.5.);
- use the quality and performance activities in Section E. to direct and measure the implementation of the provisions of Section D., measured by whether it substantially complies and whether OHA establishes or maintains the quality improvement measures required by Section E. and not used to establish additional performance metrics (Subsection E.6.); and
- limit review of OHA's performance of Section E. (for OPP purposes) to the extent it serves individuals with SPMI (Subsection E.7.).

Activities associated with these commitments are described below.

<u>SUBSECTIONS E.1., 4.a., and 6. – 7. QUALITY AND PERFORMANCE IMPROVEMENT SYSTEM FOR OPP PERFORMANCE OUTCOME AREAS</u>

OHA maintains an extensive quality oversight and improvement system, much of which is described and updated on its website[118] and hence is available to the public. The Health Systems Division (HSD) Director and quality improvement staff lead efforts across OHA about health systems improvements desired, with specific goals, timelines, and accountability structures. HSD's Director, along with the Behavioral Health Director who reports to her, have been personally engaged and help to oversee quality performance and improvement of behavioral health services as part of this overall quality improvement system. This system and the activities associated with it have improved significantly over the time period since the beginning of the OPP. While improving quality of services and outcomes for individuals needing those services is never finished, more definitely can be and needs to be accomplished. However, OHA has made great strides in this area and is committed to doing more going forward. As a consequence, it is ***in compliance*** with OPP provisions regarding an overall quality and performance improvement system.

As part of this overall effort and in keeping with the commitment to address quality and improvement on the specific measures in Section D. of the OPP, OHA has undertaken development of a Behavioral Health Quality and Performance Improvement Plan (BHQPIP) that will guide its efforts beyond the timeline of the OPP in those critical areas of the OPP for which the State is not yet where it committed to be by June 30,

[118] See https://www.oregon.gov/oha/HPA/DSI/pages/quality-improvement.aspx.

2019. This BHQPIP was initially developed and shared with USDOJ in early 2020. However, due to the COVID-19 pandemic response and subsequent budget challenges, work on this initial BHQPIP and the development of draft work plans to implement it was suspended for a while. Recently, a revision to the BHQPIP was completed to extend the time period by one year (a total of three years) and to acknowledge the goal in FY 2020 has been to simply preserve gains and not lose ground in any of the BHQPIP goal areas. Goals originally set for FY 2020 and FY 2021 are now goals for FY 2021 (beginning July 1, 2020) and FY 2022 (ending June 30, 2022). The goals now in the revised BHQPIP are not attempts to reduce the State's commitment to try to reach the original metrics in the OPP these goal areas, but rather are an effort to be realistic about what can be accomplished in what time frames to continuing moving toward those ultimate goal outcomes. This BHQPIP process is important for OHA and Oregon stakeholders to hold themselves accountable for continued systemic improvements in the future.

As discussed throughout this Report, OHA has developed the revised BHQPIP for the first three-year period following the OPP timeline (i.e., FY 2020 through FY 2022) and has committed to posting it on the OHA website at a webpage to be constructed for this purpose. OHA has also committed to posting an initial annual report covering FY 2020 in January 2021 (to allow for the six-month data lag) then to develop and post semi-annual reports with data and information on its progress on the issues included in the revised BHQPIP just as it has OPP reports during the OPP timeframe. This BHQPIP focuses specifically on the following ten goal areas in which compliance with the OPP performance expectations have not yet been achieved for adults with SPMI:

1. Increasing the number receiving ACT services;
2. Increasing the number residing in supported housing;
3.1 Increasing the percentage discharged from OSH within 30 days of RTT determination;
3.2 Increasing the percentage of discharges from OSH within 120 days of admission;
4.1 Increasing the percentage of warm handoffs for those discharging from ACPFs;
4.2 Decreasing the percentage of 30-day and 180-day readmissions to ACPFs;
5.1 Decreasing the rate of ED visits for mental health reasons;
5.2 Collecting data regarding psychiatric boarding in EDs for longer than 23 hours; developing, implementing and evaluating strategies to impact services for those experiencing such boarding;
6. Decreasing the average length of stay in SRTFs; and
7. Decreasing the number of arrests for those enrolled in behavioral health services

OHA had also developed working draft workplans for their own use for each goal area to assure they stay on track and continue moving toward achieving these goals. These workplans will evolve and change as action steps are completed or more is learned regarding what additional action steps are needed to achieve the goals. While OHA has not included all OPP performance measures in the BHQPIP, its current focus on those areas where goals and commitments have not yet been achieved makes sense. The BHQPIP is in accordance with Subsection A.8. described earlier in this Report which allows a change to goal outcomes and/or timelines after consultation with the IC and if modifications are in writing. In accordance with Subsection 4.a. to identify trends and patterns and develop additional measures and/or action steps, this BHQPIP is a good place to focus and prioritize and from which to evolve. OHA has indicated plans to expand this BHQPIP to other behavioral health service areas after this first three-year period or to change and perhaps increase the outcome goals so that the original commitments in the OPP may eventually be met or further along. Hence, this is a dynamic process as anticipated in Subsection E.1. and 4., and therefore OHA is ***in compliance*** with these commitments at this time. However, OHA and its stakeholders will still need to be vigilant to assure continued progress is being made and efforts to do so evolve and grow over time.

SUBSECTIONS E.2. – 3. SYSTEM OF ACCOUNTABILITY INVOLVING STAKEHOLDERS

OHA has been meeting regularly with what has been called the OPP Stakeholder Advisory Team throughout the three years of the OPP timeframe and even after that time.[119] The most recent meeting of this group was in February 2020. As IC, I have participated in almost all of these meetings either in person or by telephone. In all its meetings, this Team has discussed a variety of issues, been provided significant information, and

[119] See https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx for minutes of this Team's meetings***, in compliance*** with Subsection E.3.a. This website is being reviewed and updated to assure all meeting minutes are posted.

asked and provided their thoughts and advice to OHA leadership and/or staff on everything from workplans, data, draft guidance documents, proposed regulations, and other materials, as well as service system issues.

The Team does include a variety of stakeholders and representatives of groups ranging from advocacy, family, and consumer groups to providers, CCOs, CMHPs, OSH, and other groups delivering services. People with lived experience of being given a SPMI diagnosis and/or receiving services from system providers (including but not limited to OSH) are included on this group. After consultation with me as IC and ***in compliance*** with Subsection E.3.b., OHA has indicated to the group it wants to modify the process and change this group to be the Olmstead Stakeholder Advisory Team to continue to provide input and advice as OHA continues its work on the BHQPIP goal areas. As a consequence, OHA is considering whether others or different representatives need to be included in this group going forward and has asked the current members about their interest in continuing on the group as its role evolves. Meeting dates for this group are set a few months in advance although the COVID-19 pandemic response necessitated cancellation of the planned March and May meetings of this group. The next meeting is scheduled for July, 2020 and bi-monthly thereafter throughout CY 2020 on the third Tuesday of the month.

In addition, the Olmstead Plan Stakeholder Team[120] called for in Subsection E.2.b. was the Olmstead/Housing Subcommittee of the OHA Addictions and Mental Health Planning and Advisory Council (AMHPAC). Because the larger Council was considering a change in its structure and because of the COVID-19 pandemic response, subcommittees have not been meeting recently although this subcommittee was still meeting during 2019. The subcommittee was composed largely of the stakeholder entities listed in Subsection E.2.b. However, this subcommittee may be reconstituted or changed as the AMHPAC considers its needs in the future. In any case, OHA is ***in compliance*** with Subsection E.2. and 3. regarding stakeholder involvement during the OPP timeframe.

SUBSECTION E.4.b. REGULATIONS AND PERFORMANCE-BASED CONTRACTS

As described throughout this Report, with the selection of CCOs for the 2020 – 2024 period and the new CCO 2.0 contract language now complete, implementation of CCO 2.0 has begun. OHA has included much language in Exhibit M of the CCO 2.0 contract[121] that is consistent with or is specific language from the OPP for key areas such as ACT, Peer-Delivered Services, Crisis Management, Care Coordination/Intensive Care Coordination, CMHP collaboration, OSH, ED Utilization, Involuntary and Long Term Psychiatric Care, ACPFs, and other service and process expectations. While this is all good progress, in the procurement process OHA made significant changes to what was originally the Sample Contract,[122] resulting in less detail about expectations in some cases and elimination of some key concepts such as reporting data elements. However, as OHA reviewed proposals, they identified areas of strength and weakness of CCOs' proposals and have made summaries of these reviews or Evaluation Reports available on their website.[123]

Prior to the COVID-19 pandemic response and recently announced budget challenges, OHA was working to increase its staff and capacity to oversee CCOs' performance during this five-year period and working with CCO Behavioral Health Directors to clarify performance expectations for the OPP and other behavioral health populations. Many of these efforts are described elsewhere in this IC Report. This process is a work in progress so exactly how CCOs will be held accountable regarding OPP areas and to assure BHQPIP goals are met is not yet clear. However, as an example, in late 2019 and early 2020, OHA's Quality Assurance team conducted deliverable evaluations of the CCO behavioral health (BH) policies and procedures to determine if they were in compliance with the behavioral health components in the contract and with state and federal regulatory requirements. If a CCO was out of compliance with a particular requirement, they were expected to revise their policies and procedures and submit documentation to resolve any non-

[120] See https://www.oregon.gov/oha/HSD/AMHPAC/Pages/Subcommittee-Housing.aspx for minutes of this subcommittee's meetings, ***in compliance*** with Subsection E.3.a.
[121] See https://www.oregon.gov/oha/OHPB/CCODocuments/Updated-draft-CCO-contract-terms.pdf.
[122] See https://www.oregon.gov/oha/OHPB/CCODocuments/Updated-draft-CCO-contract-terms-comparison-previous-version.pdf for a comparison of the updated draft contract which became the final contract and the original Sample Contract.
[123] See https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-Contract-Selection.aspx.

compliant item. This is just one example of how OHA is making systematic efforts to assure compliance with requirements and expectations of CCOs.

In addition, OHA undertook a complete review and revision of its OAR chapter 410 regulations covering behavioral health and Medicaid services to be in line with OPP commitments and CCO 2.0 requirements and new statutory obligations. However, the effort to review and revise its OAR chapter 309 regulations covering behavioral health services to be in line with CCO 2.0 was not completed but was suspended. Significant public input caused OHA to decide to step back to reconsider what needed to change and how. This is concerning as many issues affecting the OPP population and community-based services for this population are impacted by these regulations, some of which are not yet in line with OPP commitments.

The CCO 2.0 contract includes the possibility of corrective action plans in areas in which OHA determines such a plan is needed,[124] as does the most recent CFAA language for CMHPs.[125] However, as of this time, neither a CCO nor a county CMHP has been required to develop and adhere to such a corrective action plan, at least not for OPP-related purposes. In some cases, Choice providers have been asked to do corrective action plans related to OPP commitments regarding discharges from OSH. Because it is so early in the five-year time period of CCO 2.0, OHA is working hard to identify and charter cross-divisional workgroups, create processes needed, prioritize tasks, and identify needed data and resources to hold CCOs accountable over the CCO 2.0 five-year time period. They are also working on a remediation matrix so they and CCOs can understand what will be required of non-performing CCOs, including when and how corrective action plans will be utilized. They were also doing significant technical assistance with CCOs on OPP requirements and expectations specifically, including developing a list of reporting elements CCOs will need to include in its BH Reports and data elements OHA will add to those to create a picture of the CCOs performance for this population. While much more needs to be done regarding CCO and CMHP compliance overall, OHA is currently ***in compliance*** with this commitment in Subsection E.4.d. since the corrective action capacity is in the contract language for these and other entities.

As indicated earlier in this report, the CFAA language for CMHPs was also under review and was expected to result in considerable changes once completed. Given the COVID-19 pandemic response, these changes are now expected to be minor for 2021 with further revisions for 2022 and beyond. It will be critical to line up the CFAA timelines with those of the CCOs' contracts[126] and to assure CMHPs understand their roles and expectations as well. All these efforts are laudable and will help to align Oregon's system to be better able to meet the high intensity needs of the most vulnerable Oregonians. However, the work is not yet complete. As a consequence, OHA is ***working toward compliance*** in this area.

SUBSECTION E.4.c. SUPPORTED EMPLOYMENT AND ACT FIDELITY ASSESSMENTS

As described earlier in this IC Report, OHA maintains contracts with OSECE and OCEACT to conduct fidelity reviews of SE and ACT programs, provide technical assistance, training, and other resources for these programs and assure they are operating and providing services in keeping with national evidence-based fidelity standards. OHA is ***in compliance*** with these commitments in Subsection E.4.c.

SUBSECTION E.5. TRANSPARENCY: POSTING MINUTES AND REPORTS ON OHA WEBSITE

OHA committed to transparency of its quality improvement efforts by posting semi-annual reports on its website. It has committed to do so going forward re the BHQPIP effort with the first report being an annual one covering FY 2020 and produced in January 2021. OHA is also working on a dashboard of key performance elements by county, region, or CCO, depending on which makes most sense for the specific performance measure. Once this is completed, OHA indicates it will make this dashboard part of its semi-annual reporting process and post it on the OHA website.

OHA uses quality health metrics to show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care. Some of these metrics are pay-for-

[124] See CCO 2.0 Contract, Exhibit B., Part 9, 6.
[125] County CFAA FY 2019 – 2021, Exhibit D.9.
[126] Currently, CFAAs are on a two-year fiscal year timeline while CCOs are on a five-year calendar year timeline.

performance for which CCOs are eligible to receive payments based on their performance.[127] Others are state quality measures which OHA has agreed to report to the Centers for Medicare and Medicaid Services (CMS) as part of Oregon's 1115 Medicaid waiver. Information about these metrics are on OHA's website. However, as indicated earlier in this Report, none of these current measures are specific to the OPP commitments, and no incentive measures are specific to the OPP population or services. However, as indicated earlier, OHA is developing a list of Behavioral Health Metrics it plans to collect and report and/or require CCOs to report, beginning in early 2021 for 2020 performance, many of which are OPP specific.

During the OPP timeframe, OHA has also posted all OHA data and narrative reports regarding OPP performance over the last several years along with all my IC Reports.[128] In addition, it posts information about quality improvement efforts generally[129] and the Oregon Metrics and Scoring Committee specifically.[130] However, metrics about behavioral health outcomes for adults with SPMI and specifically about OPP performance outcomes are not well represented in this Committee's efforts as described earlier in this Report. OHA also has a significant website for its Oregon Health Plan (OHP) efforts and its current Medicaid waiver.[131] OHA also supports a Transformation Center to address quality improvement across all its programs.[132] It has also posted evaluation reviews of the CCO applicants for CCO 2.0.[133] Hence, OHA is ***in compliance*** with the commitment to further system transparency. The implementation of the BHQPIP and the CCO 2.0 contract and compliance efforts, along with efforts underway to increase community-based services and outcomes for this population, will be the test of whether Oregon continues and expands its quality improvement capacity and therefore its results.

SECTION F. COMPLIANCE AND REPORTING

This Section of the OPP included commitments to:

- contract with an Independent Consultant (IC);
- utilize the IC for consultation as desired;
- provide the IC with the information and assistance to produce regular reports to assess compliance and make those final reports public;
- provide the IC with access to documents, staff, and information to make those assessments;
- provide data quarterly with semi-annual narrative reports regarding efforts to meet OPP commitments; and
- amend appropriate contracts as necessary to require data reporting quarterly on OPP issues.

This Section also specifies a process for replacement of the IC if needed. This action has not been necessary during the timeframe of the OPP.

The OHA is ***in compliance*** with all aspects of this Section of the OPP. The contract with me as IC was in place by July 2016 and has been extended beyond the three-year timeframe of the OPP to provide me with the opportunity to review data and reports from OHA after the OPP timeframe due to data lag issues and give me time to produce this last of the six initially anticipated IC reports. Each of these final IC Reports has been posted to the OHA website along with OHA's own quarterly and semi-annual reports about OPP commitments, data, and activities.

OHA has requested my assistance and input on a number of issues with which they were or are grappling and has provided me an opportunity to weigh in on contract language, regulations, funding and programmatic issues, as well as quality improvement processes. OHA has also requested my continued assistance after the timeframe of the OPP and indicates plans are underway to make this possible. OHA has

[127] See https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-CCO-incentive-measures.pdf.
[128] See https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx.
[129] See https://www.oregon.gov/oha/HPA/DSI/pages/quality-improvement.aspx.
[130] See https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.
[131] See https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx regarding the Oregon Health Plan and https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Waiver-Renewal.aspx regarding the Medicaid 1115 waiver.
[132] See https://www.oregon.gov/oha/HPA/dsi-tc/Pages/index.aspx.
[133] See https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-Contract-Selection.aspx.

given me significant and unfettered access to documents, staff, and information, including providing me an opportunity to talk with stakeholders alone and participate in public meetings of the OPP Stakeholder Advisory Committee and other important groups and processes. OHA has also facilitated my and my team's access to review programs and charts of service recipients at OSH and for other programs throughout the state.

As indicated in the Acknowledgements Section of this Report, OHA has been open and transparent, and in my view clearly committed to succeeding in meeting the commitments the State of Oregon made in the OPP, including continuing those efforts in those areas where the goals have not yet been met, as evidenced by the BHQPIP described earlier in this Report.

CONCLUSION

The initial OPP timeline was technically completed as of June 30, 2019. However, due to a six-month data lag, OHA's performance on its commitments through the end of year three was not available until early 2020. The most recently available data and narrative reports from OHA at the time this IC Report #6 were dated January 2020 and released in early February 2020, with revisions submitted in early March 2020. USDOJ and OHA were set to hold their third annual OPP meeting in March 2020 to discuss these reports and the status of Oregon's performance on all its OPP commitments. That meeting was postponed by OHA in early March as the COVID-19 pandemic advanced, but has now been rescheduled for this summer. This IC Report utilizes the data from OHA's January 2020 report (as revised) as well as my work with OHA over the last several months to assess compliance and describe the State of Oregon's efforts regarding the OPP commitments.

Overall, OHA's performance on the OPP quantitative measures continued to be mixed during this period, albeit with improvements in some areas as described in the OHA report and in this IC Report #6. OHA's efforts to date continue to show its commitment to addressing the OPP provisions and indicate a willingness to tackle big issues in consultation with stakeholders and with USDOJ's and the IC's input. The OPP represents an ambitious undertaking of systems and services changes for just one critical population for which OHA shares responsibilities with other State and local systems. It contains dozens of commitments, and many have been achieved. However, additional work will be needed over time and beyond the timeframe of the OPP to meet the intent in many OPP areas. OHA and other State and local partners have laid considerable groundwork for these additional efforts. It also remains clear OHA and USDOJ are both acting in good faith and are equally committed to improvements in Oregon's behavioral health care delivery system.

Appendix B of this IC Report #6 summarizes the status of activity in the various OPP Sections as of the end of the original OPP time period. Further work on those items identified in the BHQPIP will continue with the assistance of all involved and interested in continuing the improvements made and underway for adults with serious and persistent mental illness in Oregon.

APPENDIX A

ACRONYMS USED IN OREGON INDEPENDENT CONSULTANT REPORTS

- ACPF – Acute Care Psychiatric Facilities
- ACT – Assertive Community Treatment
- ADA – Americans with Disabilities Act
- ADP – Average Daily Population
- AFH – Adult Foster Home
- A&IPS – Acute and Intermediate Psychiatric Services
- ALOS – Average Length of Stay (or mean)
- AMHI – Adult Mental Health Initiative
- APAC – All Payer All Claims
- AOCMHP – Association or Oregon Community Mental Health Programs
- BH – Behavioral Health
- BHQPIP – Behavioral Health Quality and Performance Improvement Plan
- CCBHC – Certified Community Behavioral Health Clinic
- CCO – Coordinated Care Organizations
- CFAA – County Financial Assistance Award
- CFR – Code of Federal Regulations
- CIE – Competitive Integrated Employment
- CIT – Crisis Intervention Team (or Training)
- CITCOE – Crisis Intervention Team Center of Excellence
- CMHP – Community Mental Health Program
- CMI – Chronic Mental Illness
- CMS – Centers for Medicare and Medicaid Services
- CSG – Council of State Governments
- CY – Calendar Year (from January 1 through December 31)
- DACTS – Dartmouth Assertive Community Treatment Scale
- DPSST – Department of Public Safety Standards and Training
- DSM – Diagnostic and Statistical Manual
- ECIT – Enhanced Crisis Intervention Training
- ED – Emergency Department
- EDIE – Emergency Department Information Exchange
- EHR – Electronic Health Record
- e.g. – For Example
- ENCC – Exceptional Needs Care Coordinator
- EOHSC – Eastern Oregon Human Services Consortium
- FEP – First Episode Psychosis
- FFP – Federal Financial Participation
- FFS – Fee for Service
- FMR – Fair Market Rent
- FPL – Federal Poverty Level
- FY – Fiscal Year (July 1 through June 30)
- GAF – Global Assessment of Functioning
- GOBHI – Greater Oregon Behavioral Health, Inc.
- HEDIS – Healthcare Effectiveness Data and Information Set
- HIPAA – Health Insurance Portability and Accountability Act
- HPB – Health Policy Board
- HUD – Housing and Urban Development
- IC – Independent Consultant
- ICC – Intensive Care Coordination
- ICD – International Classification of Diseases
- ICM – Intensive Case Management
- i.e. – that is
- IMD – Institution for Mental Diseases
- IMPACTS – Improving People's Access to Community-based Treatment, Supports, and Services
- IPS – Individual Placement and Support
- IQA – Independent and Qualified Agent
- JC – Junction City
- LEDS – Law Enforcement Data System
- LMHA – Local Mental Health Authority
- LPSCC – Local Public Safety Coordinating Council
- LOC – Level of Care
- LOS – Length of Stay
- LTPC – Long Term Psychiatric Care
- M – Million
- MHAO – Mental Health Association of Oregon MHBG – Mental Health Block Grant
- MHHF – Mental Health Housing Fund (OHCS)
- MHS – Mental Health Services
- MMIS – Medicaid Management Information System
- MOTS – Measures and Outcomes Tracking System
- MOU – Memorandum of Understanding
- N/A – Not Available or Not Applicable
- NCQA – National Committee for Quality Assurance
- NOABD – Notice of Adverse Benefit Determination
- NOFA – Notice of Funds Availability
- OACP – Oregon Association of Chiefs of Police
- OAHHS – Oregon Association of Hospital and Health Systems
- OAR – Oregon Administrative Rule
- OCA – Office of Consumer Activities
- OCAC – Oregon Consumer Advisory Council
- OCBHJI – Oregon Center on Behavioral Health and Justice Integration
- OCEACT – Oregon Center of Excellence for Assertive Community Treatment
- OCJC – Oregon Criminal Justice Commission
- OEI – Office of Equity and Inclusion
- OHA – Oregon Health Authority
- OHCS – Oregon Human and Community Services Department
- 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
- OSP – Department of Oregon State Police
- OSU – Oregon State University

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

APPENDIX B
SUMMARY OF OHA COMPLIANCE WITH OPP PROVISIONS

Blue Shading Indicates Compliance as of Report Date **Reflecting Timelines Noted in Report**
Yellow Shading Indicates Efforts at Compliance Underway but Not Yet Fully Completed, Timeline Not Yet Reached, or Unknown
Pink Shading Indicates Non-Compliance as of Report Date

OPP PROVISION NUMBER & TOPIC	GOALS & ACTIONS COMMITTED TO IN OPP	BASELINE CY 2015	OHA DATA THROUGH 6/30/19 & ACTIVITIES THROUGH 12/31/19
SECTION B: GENERAL TERMS & CONDITIONS			
2. Commitment to Advocate	w/ Oregon Health Policy Board & OHP Quality Metrics Committee	N/A	***IN PARTIAL COMPLIANCE*** Significant work with Health Policy Board, esp. re CCO 2.0 (on website); work with OHP Metrics & Scoring Committee less evident; data reporting metrics for CCOs re BH in development
3. Collect & maintain data & records on provisions of the OPP & make records reasonably available to USDOJ & IC	Keep records re OPP; make available	N/A	***IN COMPLIANCE*** OPP related records posted on OHA website or provided on request
SECTION C: FUNDING LIMITATIONS			
Make diligent efforts to obtain funding & authority necessary to implement OPP; specific request for funding for housing	Diligent efforts	Significant efforts & funding were sought & received from 2012 to 2015	***IN COMPLIANCE*** Additional General Funds requested and secured over last four biennium; Medicaid and total behavioral health spending expanded; CMHP formula revisions underway to prevent reduction in community funding and increase incentives for earlier interventions; Governor's BH Council created to recommend needed actions; IMPACTS grant program underway. [However, note impending budget challenges described in Report]

SECTION D: PERFORMANCE OUTCOMES			
Assertive Community Treatment ("ACT")			
1.a. – b. # SPMI individuals served by ACT Teams	By 6/30/17 – 1,050 By 6/30/18 – 2,000	815	***NOT IN COMPLIANCE*** 1,325 as of 6/30/19
1.c. Reduction of waitlist for ACT	After 6/30/18 – if 10 individuals on waitlist >30 days, increase team capacity or add teams	10 ACT teams meeting fidelity; others in development; # on waitlist N/A	***NOT IN COMPLIANCE*** As of 11/26/19, 33 ACT teams (1 provisional); Funding identified for additional services & for non-Medicaid eligible individuals to be up & running by FY 2021 currently in jeopardy; Waitlist requirements in CCO 2.0 contract; Guidance document in process but stalled due to COVID-19 response
1.d. Waiver of ACT fidelity requirements (rural teams)	Report w/o goals	N/A	***IN COMPLIANCE*** No waivers needed as regs allow smaller teams w/ staffing adjustments
1.e. – f. Criteria for admission to ACT incorporated into administrative rules	By 7/1/16 – Develop criteria consistent w/ OPP definition & national standards; incorporate into regs	N/A	***IN PARTIAL COMPLIANCE*** Criteria developed & in regs; reg revisions pending; guidance documents being developed
2. Individuals who need ACT will be admitted to ACT	Develop process to assure admission to ACT	N/A	***NOT IN COMPLIANCE*** Significant efforts w/ CCOs and Choice providers to reach new goals described in BHQPIP draft workplans; however, future efforts uncertain given State budget challenges
3.Track denials to ACT teams; corrective action if improperly rejected	Tracking process; corrective action capacity	N/A	***IN PARTIAL COMPLIANCE*** Denials being tracked; rate seems high; corrective action provisions in contracts; none taken to date; guidance documents being developed & efforts w/ CCOs underway
4.a. – i. Report data re ACT clients (w/in a quarter) & use for quality improvement purposes	Report following data & use for QI purposes 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	a. 815 Other data elements N/A	***IN COMPLIANCE*** Data elements have been reported to USDOJ & IC separately from quarterly reports; are being considered for reg revisions; OCEACT uses data for TA w/ ACT programs

Crisis Services			
6. Expand mobile crisis services statewide	By 6/30/18 – statewide	N/A	***IN COMPLIANCE*** Statewide as of Fall 2018
7.a. – b. # served/contacts by mobile crisis	FY2017 – 3,500 FY 2018 – 3,700	3,150	***IN COMPLIANCE*** 8,905 as of 6/30/19
8.Track & report # receiving mobile crisis contact & dispositions	By 6/30/17 – Methodology No later than 1/1/18 – # admitted to acute care By 6/30/18 – # stabilized in community setting rather than arrest, ED, or ACPF admission	N/A	***IN COMPLIANCE*** As of 6/30/19 – 2,667 stabilized in community; 472 presented to ED; 63 admitted to acute care
9., 10.a. – b., 11., & 12.a. Mobile crisis response times	By 6/30/17 – Other than Rural & Frontier – w/in 1 hr Rural – w/in 2 hrs Frontier – w/in 3 hrs Rural/Frontier – person trained in crisis management calls w/in 1 hr During FY2018 – Review and adjust if needed	N/A	***IN COMPLIANCE*** Response times being met or exceeded in significantly high percentage of cases; national considerations suggest Oregon is meeting best timelines most of the time; response times incorporated into regs and contracts[134]
13. Uniform standards for hotline services & county crisis lines	Develop standards & enforce	N/A	***IN COMPLIANCE*** Standards developed & in reg; audit process and documents revised to determine whether requirements being met
Supported Housing			
14.a. – c. # in supported housing (SH)	FY2017 – 835 FY2018 – 1,355 FY2019 – 2,000	442	***WORKING TOWARD COMPLIANCE*** 1,903 as of 6/30/19; new ACT teams/services to be functional in 2021 will likely increase #s in supported housing unless budget reduction scenarios include reducing RAP and/or ACT funding; included in BHQPIP
14. Best efforts to match individual w/ housing needs & choice	Best efforts	N/A	***IN COMPLIANCE*** Rental Assistance Program review showed significant best efforts
15. Data re housing stock or inventory available for individuals w/ SPMI; track # in supported housing	Make inventory available w/o numeric goals; track & report # in SH (see #14. above)	N/A	***IN COMPLIANCE*** 53,323 Affordable Housing Units available as of Jan 2017; 57,495 as of July 2019
15. Use housing data for budget requests in 2017-2019 budget	Advocate for budget increases for housing	N/A	***IN COMPLIANCE*** Budget request for 2017-2019 was broader than SH; $4.5 M received for 2019 – 2021 set aside for support services for those in new OHCS units likely to be largely for SH for individuals with SPMI

[134] However, current regulations and contracts use the term "urban" without clearly defining this as "other than rural and frontier." Regulations and contracts also do not yet clarify a county can have multiple types of areas, therefore multiple response time requirements within a single county/CMHP. However, in the vast majority of cases, response times for all areas are well within or under what is required.

Peer-Delivered Services			
16.a. – b. # receiving peer-delivered services (PDS)	FY2017 – ↑ 20% (2,587) FY2018 – ↑ 20% again (3,456)	2,156	***IN COMPLIANCE*** 4,038 as of 6/30/19
17. Explore better ways to track PDS	Process for improvement w/o goals	In process	***IN COMPLIANCE*** Office of Consumer Activities is exploring & collaborates re additional data possibilities
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 # 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*** 45.8% w/in 20 days as of 6/30/19 (down from previous Q); 3 extended to business day following weekend or holiday
20.e. CCO members discharged consistent with OAR; OHA helping CCOs meet their obligations	Regs & process; Work w/ CCOs	Regs in process; work w/ CCOs in process	***IN COMPLIANCE*** Regs revised; requirements in CCO 2.0 contract
21. Preference for discharge w/in 72 hrs of RTT	Preference only; Track w/o reporting	Tracking	***IN COMPLIANCE*** w/ tracking; few discharged w/in 72 hrs of RTT
22. Performance-based contracts w/ CMHPs, CCOs, etc., to pursue #s 20 – 21	Contracting	Revised Contracts w/ CMHPs by 7/1/17 & w/ CCOs by 1/1/19	***IN COMPLIANCE*** Contracts w/ CMHPs, Choice providers, & CCO 2.0 significantly revised with performance goals and expectations; regs being considered for revision; however, CFAA language is still under review
23.a. i. – ii. Everyone appropriate for ACT receives ACT or evidence-based alternative (EBA)	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	N/A No data re referrals, denials, or refusers available for CY 2015	***WORKING TOWARD COMPLIANCE*** Universal tracking form in use & being included in Avatar; data tracker being revised; not everyone appropriate yet receives ACT referral or EBA although a significant percentage of sample reviewed showed engagement about ACT; regs being considered for revision; extensive work with CCOs re obligations; guidance document in development
23.b. OSH individuals who meet ACT LOC discharged w/ services appropriate to needs	Services post discharge for individuals with ACT LOC	N/A	***IN COMPLIANCE*** Service settings upon discharge are consistent with documented clinical and treatment needs
24. % OSH individuals discharged w/in 120 days	By 6/30/17 – 90% w/in 120 days	37.8% (89 of 235)	***NOT IN COMPLIANCE*** But improving – 61.4% as of 6/30/19
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	N/A	***IN COMPLIANCE*** External review organization (IQA) contracted as of April 2018; new contractor begins July 1, 2020; OSH meets w/ IQA weekly

25. Discharges to most integrated setting appropriate, consistent with goals, needs, & informed choice	Appropriateness of discharges documented	N/A	***IN COMPLIANCE*** Discharge form in use; Documentation in OSH data &/or in IQA system
25. No discharge to SRTF unless clinically necessary & w/o express approval of Dir of OHA or designee	Discharges to SRTF only if clinically necessary & w/ Dir or designee approval	N/A	***IN COMPLIANCE*** Contract w/ IQA as designee to assure appropriate discharge setting; working on documentation; chart reviews show documentation in OSH or IQA files
26.a. – 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	N/A	***IN COMPLIANCE*** No discharges from OSH or SRTFs to interim housing
Acute Psychiatric Care			
27. Discharges from acute care psychiatric facilities (ACPF) have documented linkages to behavioral health care	All except transfers to OSH have documented linkages to timely, appropriate behavioral health care in community prior to discharge	N/A	***IN COMPLIANCE*** Charts reviewed showed connection to BH most of the time; CCO 2.0 contract language includes expectation; regs being considered for revision; significant work with hospitals re data collection underway
27. Discharges from acute care psychiatric facilities (ACPF) have documented linkages to primary health care	All except transfers to OSH have documented linkages to timely, appropriate primary health care in community prior to discharge	N/A	***IN PARTIAL COMPLIANCE*** Only some charts reviewed showed connection to primary health care; CCO 2.0 contract language includes expectation; regs being considered for revision; significant work with hospitals re data collection underway; 3 CCBHCs are developing primary care capacity
28. Continue enrolling substantially all indigent in Medicaid prior to discharge from ACPFs or EDs	Aggressive enrollment efforts & incentives	OHA incentives to enroll in place	***IN COMPLIANCE*** Hospitals have incentives to help enroll in order to bill & be paid; all ACPF discharges had CCO assigned
29.a. – c. % receiving a "warm handoff" from ACPFs	Receiving "warm handoff" By 6/30/17 – 60% By 6/30/18 – 75% By 6/30/19 – 85%	N/A	***NOT IN COMPLIANCE*** But improving; 43.3% as of 6/3019 (436 out of 1,007 discharges); Guidance document released Aug 2019 & under revision; regs not yet clear re requirement
29. Track & report % of individuals refusing a "warm handoff" from an ACPF	Aggregate data by ACPF, quarterly beginning with 2nd Q FY 2017 (Oct 1 to Dec 31, 2016)	N/A	***IN COMPLIANCE*** Only 81 refused out of 1,007 discharges as of Q4 FY2019 (OPP Year 3)

30. # discharged from ACPFs receiving a follow-up visit w/ CMH provider w/in 7 days	Report w/o goals	2,011 (of 2,534 or 79.4%)	***IN COMPLIANCE*** 74.3% as of 6/30/19 Percentage has declined somewhat, but is still significantly better than much of the rest of the country (w/in 95th percentile in 2018)
31. Reduce recidivism to ACPFs of individuals w/ SPMI	Reduce recidivism	30 days – 6.5% to 13.5% (avg 9.2%) 180 days – 15.3% to 26.9% (avg 21.3%)	***NOT IN COMPLIANCE*** As of 6/30/19: 30 days – 8.5% to 12.9% (avg 10.7%) 180 days – 17.2% to 26.1% (avg 22.5%)
31.a. Monitor & report 30- & 180-day rates of readmission, by ACPF; track and r	Report w/o goals	30 days – 6.5% to 13.5% (avg 9.2%) 180 days – 15.3% to 26.9% (avg 21.3%)	***IN COMPLIANCE*** w/ reporting; 6/30/19: 30 days – 8.5% to 12.9% (avg 10.7%) 180 days – 17.2% to 26.1% (avg 22.5%)
31.b. Management plan for contacting & offering services to individuals w/ ≥2 readmissions in a 6-mo period; track & report # with 2+ readmissions in a 6 mo period	Management plans designed to assist specific individuals avoid unnecessary readmission in ACPFs	N/A	***IN COMPLIANCE*** Specific management plan requirement included in CCO 2.0 contract; 277 w/ 2+ readmissions in a six-month period as of 6/30/19, down from 346 as of Dec 2016
32. Assess housing needs of individuals w/ SPMI who are homeless & have had ≥ 2 readmissions in 6-mo period in ACPF & refer to housing agency/services	Identify & connect to housing agency or MH agency w/ access to housing for homeless SPMI w/ repeat admissions	OAR requiring connection of all individuals discharged to such agencies	***IN COMPLIANCE*** Over 99% of such individuals had housing plans upon discharge
33. May use interim housing for individuals in #32	(See #26)	N/A (see #26)	***IN COMPLIANCE*** No discharges to interim housing for individuals described
34. Assess housing needs of SPMI individuals in ACPFs	Require ACPFs to consult w/ CCOs in developing assessment & notify individual's community provider re plan for housing	N/A	***IN COMPLIANCE*** IQA contract, CCO 2.0 contract, CMHPs CFAA, & Choice providers facilitate these efforts; regs being considered for revision
35. Avg length of stay of SPMI individuals in ACPFs; # w/ LOS >20 days	Report w/o goals	ALOS – 4.98 – 12.43 days (8.9 days avg); # >20 days – 385 (not reported by facility)	***IN COMPLIANCE*** w/ reporting; 8.3 – 13.3 (10.86 days avg) as of 6/30/19; # >20 days – 8 to 131 per facility (435 total)

Emergency Departments			
37. Boarding data analysis conducted & presented to legislature	Boarding study showing #s in EDs	N/A	***IN COMPLIANCE*** 2016 report of "psychiatric boarding in EDs" by Oregon State University (OSU) released to legislature Jan 2017 w/ potential solutions
37. & 43. Boarding data (> 23 hrs) collected & use of data to initiate community strategies re individuals w/ SPMI using EDs for MH reasons	Analyze data to identify reasons for boarding > 23 hrs provide to legislature & USDOJ along with proposals for solutions; Initiate community-based strategies by fall 2016; Work w/ hospitals on data collection strategy; By July 2017 – begin reporting by Q, by region (or by hospital if possible)	N/A	***WORKING TOWARD COMPLIANCE*** Law changed effective July 2019; data now being collected by OAHHS; OHA efforts to report & begin to develop strategies to increase connections described in BHQPIP; regs being considered for revision
38. SPMI individuals connected to services at time of leaving EDs	Data analysis used to assess needs of individuals w/ SPMI leaving EDs & strategies for linking them to services; initiate strategies to increase # connected to services at discharge; collect data to measure effectiveness	OAR in process; data methodology under discussion w/ hospitals	***IN PARTIAL COMPLIANCE*** Law changed; regular data being collected by OAHHS; OHA working on reporting & developing strategies to increase connections
39. Continue enrolling substantially all indigent in Medicaid prior to discharge from EDs	Aggressive enrollment efforts & incentives (See # 28)	OHP incentive to enroll in place (see #28)	***IN COMPLIANCE*** Hospitals have incentives to help enroll in order to bill & be paid
40.a. # SPMI individuals w/ ≥2 readmissions to emergency departments (EDs) in a 6-mo period	Report w/o goals	810	***IN COMPLIANCE*** 838 reported as of 6/30/19, higher than previous Q and above baseline; will continue to monitor as part of goal to reduce recidivism to EDs; individualized management plans required of CCOs for such individuals
40.b. Address needs of SPMI individuals w/ ≥2 readmissions to EDs in 6-mo period	Collaborative efforts w/ CMHPs/CCOs to implement plans & contract amendments w/ CCOs to require ACPFs to develop & implement plans	N/A	***IN COMPLIANCE*** CMHP contract revisions in process by 6/30/17; CCO contracts revised in 2018 & again in 2019 for CCO 2.0 include these provisions
41.a. – b. Rate of visits by SPMI individuals to general EDs for MH reasons	FY2017 – ↓ 10% (1.45/1,000) FY2018 – ↓ 20% (1.29/1,000)	1.54/1,000	***NOT IN COMPLIANCE*** 1.88/1,000 as of 6/3019, higher than baseline; in BHQPIP for FY 2020 and FY 2021
42. Use of EDs by individuals w/ SPMI	Meet w/ Independent Consultant (IC) to discuss	N/A	***IN COMPLIANCE***

Supported Employment			
45.a. # receiving supported employment (SE) services & employed in competitive integrated employment (CIE)	Report w/o goals	N/A	***IN COMPLIANCE*** Data reported quarterly; 769 receiving SE & in CIE (up from prior 11 Qs)
45.b. # in CIE w/o receiving SE	Report w/o goals	N/A	***IN COMPLIANCE*** 139 in CIE & no longer receiving SE (up from most prior Qs)
46. Monitor data to improve SE services	Monitor 45.a. – b. data to improve SE services	N/A	***IN COMPLIANCE*** Reg revision completed; data requirements clarified; OSECE uses data for TA w/ SE programs
Secure Residential Treatment Facilities			
49.a. & 50. Move civilly committed individuals w/ SPMI who are in SRTFs to more appropriate community setting expeditiously when clinical needs no longer necessitate a secure facility	Move individuals no longer needing a secure setting expeditiously to a community placement in most integrated appropriate setting	N/A	***IN COMPLIANCE*** Review of discharge records shows significant efforts re appropriateness & timing of placements; contract w/ new IQA completed, to begin July 1, 2020
49.a. & 50. Move civilly committed individuals w/ SPMI to community settings consistent with informed consent & housing preferences	Community setting post discharge is consistent with individual's informed consent & preferences	N/A	***IN PARTIAL COMPLIANCE*** Not all charts show informed consent or housing preferences noted; sometimes preferences are not consistent w/ setting determined appropriate for clinical needs & treatment goals; regs do not clearly require documentation of individual's preferences & consent
49.b. i. – ii. Seek to reduce LOS of civilly committed individuals in SRTFs	FY2017 – ↓ 10% (574.2 days) FY2018 – ↓ 20% (510.4 days)	638.0 days	***NOT IN COMPLIANCE*** 656.1 as of 6/30/19, significantly higher than baseline but lower than previous 5 Qs; data specification will be revised for tracking in BHQPIP
49.c – 50. Report # in SRTFs, LOS, # discharged, & dispositions	Report w/o goals; Beginning 7/1/17 – collect data identifying type of placement at discharge	36 discharged Dispositions N/A (See #49b for LOS)	***IN COMPLIANCE*** 33 in SRTFs as of 6/15/17 29 in SRTFs as of 6/15/18 47 in SRTFs as of 6/15/19 9 discharged in Q ending 6/3019; Dispositions & LOS reported

Criminal Justice Diversion			
51. – 52. Intent to reduce arrests, jail admissions, LOS in jail, & recidivism of SPMI individuals involved w/ law enforcement due to MH	Develop strategies	N/A	***IN PARTIAL COMPLIANCE*** Relationship building & strategy development underway; new BH Director has significant experience in this area w/ law enforcement
52.a. # Individuals receiving jail diversion services; # diversions (pre- & post-arrest/booking)	Report w/o goals; Include in RFP & contracts requirement to track pre- & post-arrest [booking] diversions	N/A	***IN PARTIAL COMPLIANCE*** 1,644 receiving services as of 6/3019 (down from most prior Qs); however, many services provided are w/in jail or court systems rather than working to divert individuals from jail
52.a. # of diversions (pre- & post-arrest [booking])	Report w/o goals	N/A	***IN PARTIAL COMPLIANCE*** As of 6/30/19: 337 reported pre-booking; 1,307 reported post-booking; Proportion post-booking is higher than at baseline;
52.a. Prioritize pre-arrest [pre-booking] services	Include in RFP & contracts requirement to track pre- & post-arrest [booking] diversions	N/A	***NOT IN COMPLIANCE*** Pre-/post-booking preference not included in most recent CMHP contract or proposed reg revisions; definitions for reporting not identified clearly and not consistently applied statewide
52.b. Work w/ OR Sheriffs Association & Association of CMHPs to determine data collection strategies for individuals w/ SPMI entering jails	By July 2016 – Begin work on data collection strategies	N/A	***IN COMPLIANCE*** Some work with groups has occurred; new BH Director has significant experience in this area working w/ law enforcement
52.c. Expand use of sequential intercept model (SIM)	By July 2016 – Contract with GAINS Center; New funding for jail diversion services will require adoption of SIM	2015 GAINS Center contract	***IN COMPLIANCE*** SIM Training Jan 20-21, 2016; SIM Train the Trainers Feb 16-17, 2016; New jail diversion & CMHP contracts require SIM use although regs do not; CCO 2.0 contract identifies reduction in jail and law enforcement interaction as a goal; OCBHJI provides CIT training/SIM assessments w/ 26 county mappings completed
52.c. Encourage local jurisdictions to adopt interventions in accordance w/ SIM	Encouragement of interventions in accordance w/ SIM	N/A	***IN COMPLIANCE*** Program review indicated most use SIM; now required in CMHP regs & contracts
52.d. # Arrests of individuals w/ SPMI enrolled in services	As of July 2016 – track arrests; Report w/o goals	N/A	***IN COMPLIANCE***
52.e. Jail diversion program data provided quarterly	Report w/o goals	N/A	***IN COMPLIANCE***

52.f. Collect data re arrests, impacts of & obstacles to success of CJD services; provide results re mapping & allocate funding accordingly; prioritize pre-charge [booking] diversion activities	Report specified data & allocate funding to support addition or enhanced jail diversion programs based on results of mapping; Prioritize pre-charge [booking] diversion activities	N/A	***IN PARTIAL COMPLIANCE*** Data being reported; nature of program does not actually support prioritization of pre-booking diversion; program review suggests inconsistent reporting of what constitutes pre-booking diversion & regs/contracts are not clear on the requirement
53. Strategies for sharing information w/ jails re MH diagnosis, status, medication regime, & services of incarcerated individuals w/ SPMI	Work w/ local jurisdictions to develop strategies	N/A	***WORKING TOWARD COMPLIANCE*** Information & training being developed for programs re how to share information consistent w/ state & federal laws & regulations
SECTION E: QUALITY & PERFORMANCE IMPROVEMENT			
1. Develop & implement Q&PI system to ensure compliance w/ OPP	Ensure services in Section D. are of good quality & sufficient	N/A	***IN COMPLIANCE*** BHQPIP completed w/ action steps & three-year goals & is being implemented to reach OPP goals not yet met
2. System of accountability for performance outcomes in Section D	Governance structure includes OPP Stakeholder Advisory Team, including ≥20% individuals w/ lived experience, to review/comment on progress & advise; Olmstead Plan Stakeholder Team w/ specified membership to review/comment on progress/advise	N/A	***IN COMPLIANCE*** OPP Stakeholder Advisory Team meeting regularly; being reconstituted & transitioned into Olmstead Stakeholder Advisory Team in 2020 to advise/provide input re BHQPIP and beyond
3. Documentation of groups' (#2) efforts	Minutes, correspondence, reports to USDOJ & IC	Posted on OHA website	***IN COMPLIANCE***
4.a. QI system includes data collection & analysis; regulations & performance-based contracts; SE & ACT fidelity reviews annually; & corrective action plans	Data used to i. identify trends, patterns, strengths, successes, & problems at multiple levels, e.g., service quality, gaps, accessibility, success & obstacles; ii - iii. develop & track efficacy of preventative, corrective, improvement measures; SE/ACT fidelity reviews & TA will continue	N/A	***IN COMPLIANCE*** Data collection & analysis included in BHQPIP working draft workplans with timelines; commitments to post semi-annual reports; BHQPIP developed
4.c. SE and ACT providers reviewed annually for fidelity to evidence-based model standards	Annual fidelity reviews; provision of technical assistance to improve performance; use of corrective measures to remedy deficiencies	OSECE and OCEACT contracts in place	***IN COMPLIANCE*** Fidelity reviews & TA continue by OCEACT & OSECE; CCO 2.0 compliance process in active development
4.b. & d. QI system includes regulations and performance-based contracts including use of corrective action plans	Regs & contracts include expectations of CMHPs/CCOs consistent with OPP; contracts are performance-based; OHA will develop corrective action plans for CMHPs or CCOs w/ timelines & oversight	N/A	***WORKING TOWARD COMPLIANCE*** Reg revisions completed or under consideration; contracts include expectations and possibility for corrective action plans although none yet required for OPP-related issues except some Choice providers re OSH discharge process; CCO 2.0 compliance process actively in development
5. Make public reports re BH QI efforts (See also B.3)	Post on website: semi-annual reports re OPP QI efforts; MH outcomes from other QI efforts (Medicaid demo special terms & conditions, OR Metrics &	N/A	***IN COMPLIANCE*** BHQPIP has been completed & will be posted on a website being developed for this purpose; includes commitments to post semi-annual reports beginning

	Scoring Committee, CCO external quality reviews)		January 2021; BH Dashboard being developed for public reporting by region or CCO
6. Compliance w/ Section D performance outcomes	Substantial compliance w/ Section D & establishment of Section E QI measures	N/A	***IN COMPLIANCE*** BHQPIP incorporates QI measures
SECTION F: COMPLIANCE & REPORTING			
1. Contract w/ Independent Consultant (IC)	Contract w/ IC	N/A	***IN COMPLIANCE*** Contract in place as of July 2016 & extended to June 2020 to allow time for final report
2. Utilization of IC for consultation	At written request, use IC to assist in implementing, including training & TA	N/A	***IN COMPLIANCE*** OHA has requested & received consultation re a variety of topics
3. Semi-annual reports assessing compliance	IC semi-annual reports assessing compliance provided in draft w/ 30-day review by USDOJ & OHA; final reports made public	N/A	***IN COMPLIANCE*** 6 IC Reports completed & posted on OHA website[135]
4. IC access to documents, staff, information	Facilitate IC access; designate contact person	N/A	***IN COMPLIANCE*** Access to documents, staff, information facilitated through OPP Project Director
5. Process for replacement of IC if needed	Specified process for replacement IC if needed	N/A	***IN COMPLIANCE*** N/A to date
6. Data & reports (See also Section B.3)	OHA to provide data quarterly w/ semi-annual narrative report; contract amendments after 7/1/16 require data reporting quarterly to OHA	N/A	***IN COMPLIANCE*** All quarterly data & semi-annual narrative reports completed, provided to USDOJ & IC, & posted on OHA website

[135] This IC Report #6 will be posted shortly after receipt by OHA.

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