Public Comment on Sale of Trillium Health Plan to Centene
June 10, 2015

When Oregon set up the Coordinated Care Organizations (cco's) in 2012 to manage the Oregon Health Plan, it transferred federal funds to the cco's that came with conditions including compliance with a number of federal civil rights obligations.

Among them was responsibility to ensure provision of and access to services for special populations like the seriously mentally. It does not appear, however, that the state included any performance and outcome measures for mentally ill service systems related to the federal obligations in the cco contracts. The state did retain some of the federal funds for special populations as well as its own oversight functions but it did not articulate how the various subcontractors (cco's, counties) receiving some of the federal funds would be held accountable for services designed to benefit the seriously mentally ill.

Instead the performance measures in the state's cco contracts focused on expanded primary care access, a worthy goal consistent with the Affordable Care Act standards but still not the only obligation of receiving federal funds. The absence of written accountability measures in the contracts for the seriously mentally ill, maybe other special populations, reinforced the conditions that led to the federal Department of Justice, Civil Rights Division to open an investigation of Oregon's mental health system in 2012. See the attached November 9, 2012 DOJ agreement.

On the occasion of the sale of Trillium to Centene, the state, through the Oregon Insurance Division and Addictions and Mental Health, has an opportunity to correct the original contract omission. Specifically, it can build in accountability language for Centene to become a partner in addressing the Department of Justice's investigation objectives.

This comment on the sale of Trillium is not whether Trillium should have done more for the mentally ill or whether Centene will do any better given the current contract language. Neither has to do anything unless the state adds language that

requires the cco to help it meet the federal civil rights protections of its seriously mentally ill citizens.

The Insurance Division might consider treating this issue not as one about special populations but about risk to the state. Since the DOJ investigation started in 2012, there have been a number of interim reports on the state's progress none showing much improvement other than the state replacing its data collection system and beginning to create a picture, or baseline, of what the target population looks like. See the attachments of the 2014 and 2015 interim reports. Unless the state makes changes in how it holds cco's accountable, the risk grows that the DOJ will take further action in the form of a consent decree that takes control away from the state for expenditure of federal funds.

It could be said that during the last 3 years while the state improved its data collection performance and Trillium established its cco operations, the insurance company could not do much regarding the DOJ reports. Now that the state is ready to move into phase two (labeled year two in the November 9, 2012 DOJ/Oregon agreement) and Centene with its additional resources will take over Trillium, the state can reinforce forward movement and amend the state/cco contract to bring responsibility for the seriously mentally ill and the accountability of the cco into alignment.

Prepared by Mary Meacham

Addictions and Mental Health Division Report
to the United States Department of Justice

October 15, 2014

This report is in accordance with the 2012 collaborative agreement between the United States Department of Justice (USDOJ) and the State of Oregon. The agreement outlines a four-year process of data collection, analysis and the establishment of performance measures for the behavioral health system. The purpose of this process is to guide Oregon towards improved services and supports for individuals with a serious and persistent mental illness to help them live a full life in the most integrated setting in the community.

This report outlines the data collection methodology and findings to date with discussion and summary. A description of the significant health system improvements is provided. Finally, the report discusses actions the State of Oregon is taking to address the needs of individuals with a serious and persistent mental illness. The narrative report section highlights key elements of the data. The complete comprehensive data tables and other deliverables are in appendices following the narrative.

In the first year of the agreement, Oregon collected data based on an agreed upon data matrix. The data proved challenging to collect and in the January 2014 meeting between USDOJ and the State, both parties agreed that the data matrix was not adequate to reliably identify system gaps and needs. Numerous changes to the data matrix were proposed and discussed and agreement on a final data matrix was reached in July 2014. This report reflects the data collected using the extensively revised data matrix. The information is from the second and third quarters of 2013 and the first quarter of 2014. Therefore, most of the measures include three data points, from these three quarters. Given the small number of data points, it is not yet possible to identify clear trends in the data, although the results from some measures are suggestive.

Data Collection Methodology

Most of the data was collected from the Medicaid Management Information System (MMIS). The other significant data sources are surveys completed by Community Mental Health Programs (CMHP) for services and supports not

captured in MMIS. The Data Dictionary found at "Appendix B" provides the details regarding each data source and how the data points were calculated.

There is a six-month lag between the last quarter reported and the release of this report. This is because providers are allowed three months to submit claims for encounters. Another three months is needed to compile the data, complete the review for data integrity and to incorporate an analysis into the report.

As noted above, this report relies on surveys completed by CMHPs for the non-Medicaid data. The Addictions and Mental Health Division (AMH) worked closely with the CMHPs to craft the survey to improve the validity and reliability of the reporting across the CMHPs. The quality of the data has significantly improved, but there are limitations that are inherent in any survey process. AMH has implemented a new data system called Measures and Outcomes Tracking System (MOTS). This new system requires providers to input encounter-like data and status data. This new system will enable AMH to gather most of the data currently captured in surveys directly from MOTS.

The MOTS application replaces a 30-year old mainframe system and went live late in 2013. Initially the adoption was slow, as final data input processes were developed in the spring of 2014. To date, over 100,000 clients have been entered into MOTS by publicly funded treatment programs across the state. By collecting data at intake and then requiring status updates to occur every 90 days, AMH will be able to track outcomes associated with behavioral health treatment. Since MOTS has both status and services data, AMH will also be able to analyze which services lead to improved outcomes, including the costs associated with those services. Outcomes associated with improvements in employment, education and housing will be monitored.

Health System Changes

Beginning in 2013, there were three significant changes to the health care system in Oregon that have had an impact on the availability and quality of services for individuals with severe and persistent mental illness (SPMI). The three changes are:

- Development of the coordinated care organizations (CCOs)
- Expansion of Medicaid (Oregon Health Plan)
- Legislative investments in new and expanded mental health services

The State implemented a process of health system transformation with the creation of coordinated care organizations (CCO). The sixteen CCOs are responsible for the integrated physical and behavioral healthcare of Medicaid members. The first CCOs were launched in August of 2012 and the sixteenth CCO became operational in the fall of 2013.

The expansion of Medicaid under the Affordable Care Act began in January 2014. To date, the State has added over 380,000 individuals to the Oregon Health Plan, for a total enrollment of just over one million individuals. The data in this report includes the first quarter that followed the addition of these 380,000 persons to Medicaid funding. AMH will continue to monitor the data carefully to identify the impact of the expansion.

The 2013, the Oregon Legislature made unprecedented investments in the community mental health system for children, adolescents and adults. A review of the investments is included in "Appendix G." The investments in mobile crisis, jail diversion, Assertive Community Treatment (ACT), supported employment and supported housing are of particular interest because of the potential positive impact on individuals with SPMI. Implementation of the programs started in the spring of 2014. This report will help provide a baseline to measure the impact of the investments over time.

State Hospital Utilization

The Oregon State Hospital (OSH) is an important part of the continuum of care for people in need of longer term care for psychiatric illness. In this section, the referral, length of stay and admissions to the hospital are examined.
Figure 1 shows the number of individuals referred to OSH over the last two quarters of 2013 and the first quarter of 2014 and the number of persons admitted to OSH during each quarter. When an individual who is civilly committed meets the criteria for admission to OSH, they are put on a waiting list and remain in acute care until a bed at OSH becomes available. The number of people identified as 'referred' in this graph is the number total number who were referred to the waiting list.

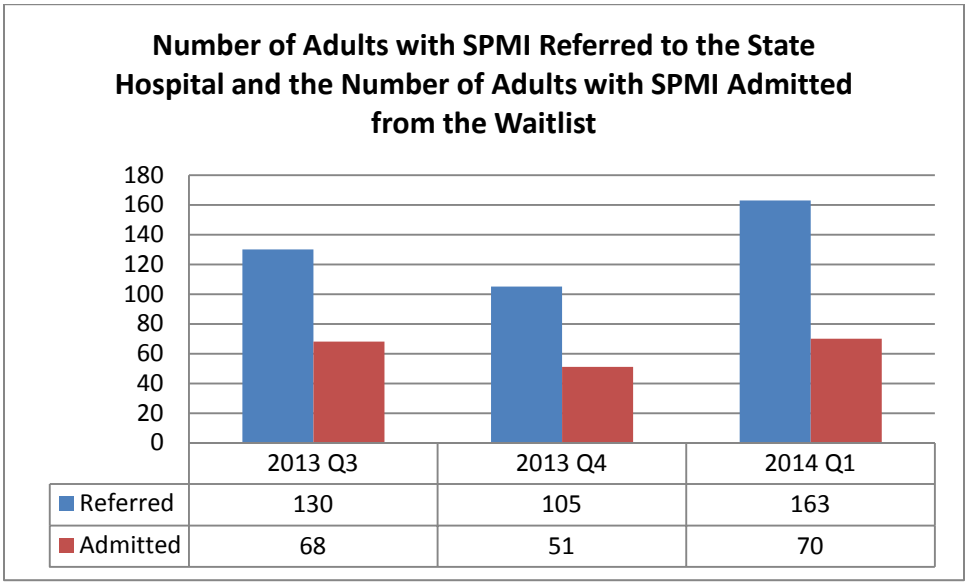


Figure 1

More people are referred to the waiting list than are accepted. The number of people referred to the waiting list increased slightly over three quarters, but the number of people admitted from the waiting list did not increase. There appears to be a slight upward trend in referrals from Q4 2013 to Q1 2014. This trend will be monitored.

Figure 2 shows all admissions to OSH for three quarters by legal status.

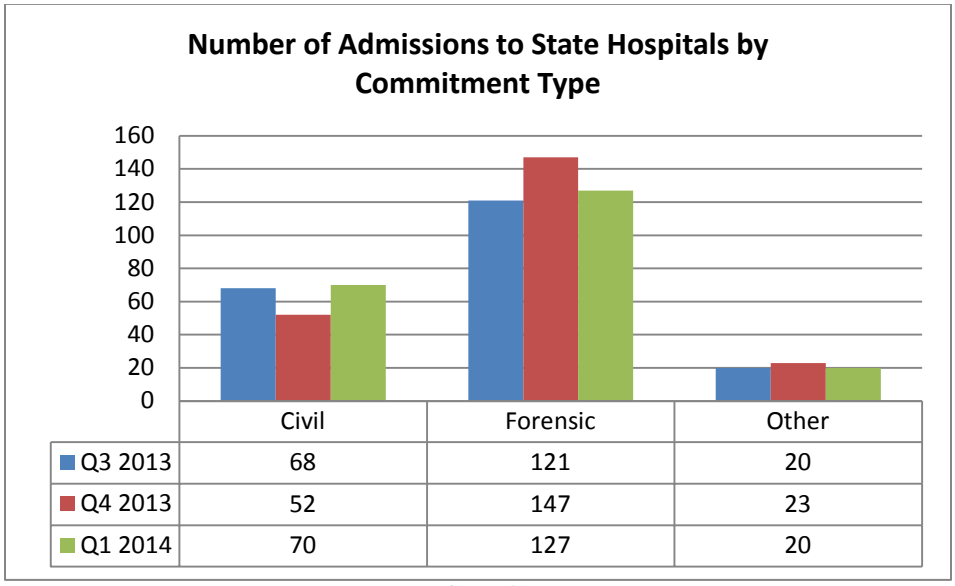


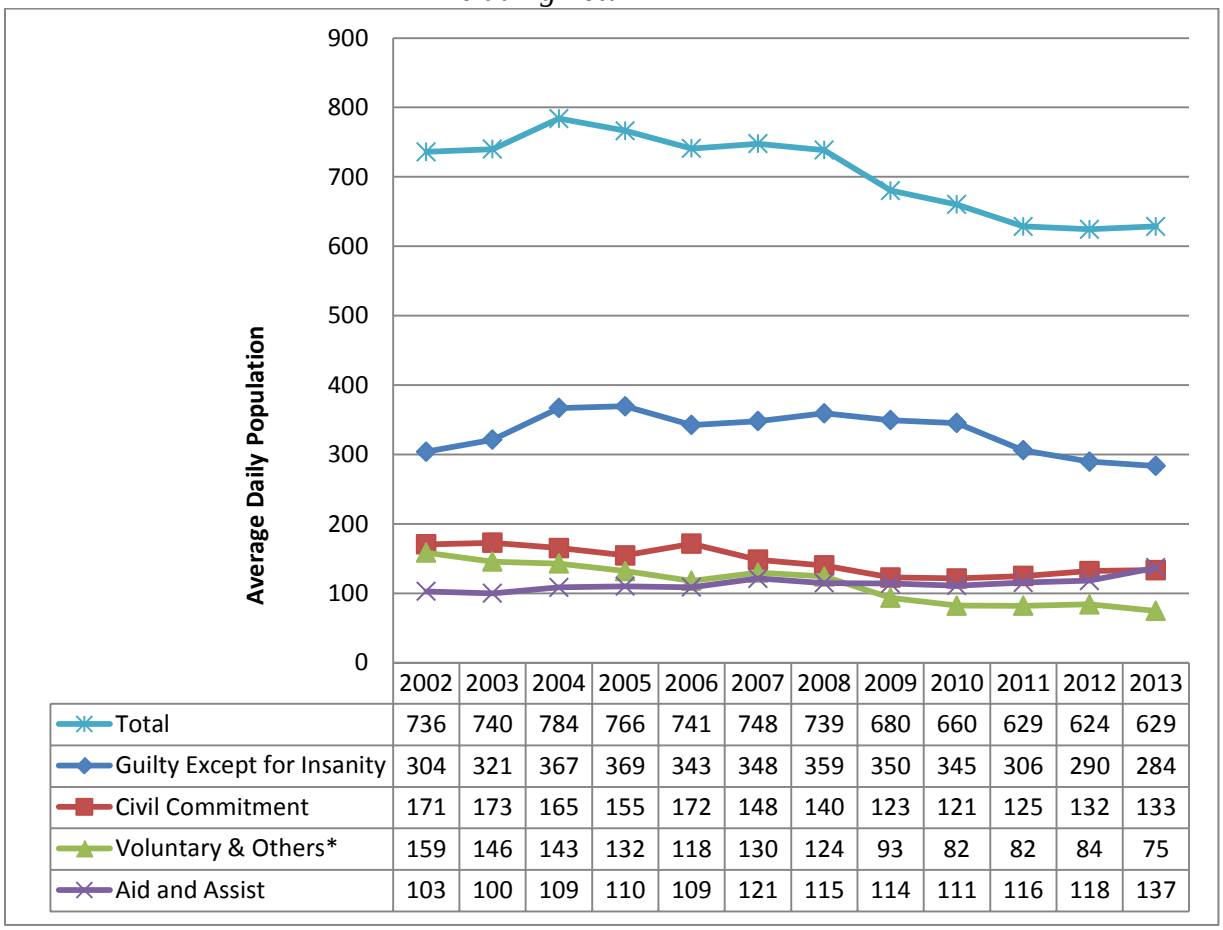
Figure 2

Note: "Other" category primarily consists of neuro-geriatric patients on a guardianship

There is variability in the data across the three quarters without any trends emerging. Within each quarter, the number of civil, forensic and other patients appears to be similar. These data are consistent with the overall percentages of the forensic and civil population at OSH.

Figure 3 shows the average daily population for the past 12 years by legal status.

Annual Average Daily Population at Oregon State Hospitals
By Legal Status
Including Total



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total	736	740	784	766	741	748	739	680	660	629	624	629
Guilty Except for Insanity	304	321	367	369	343	348	359	350	345	306	290	284
Civil Commitment	171	173	165	155	172	148	140	123	121	125	132	133
Voluntary & Others*	159	146	143	132	118	130	124	93	82	82	84	75
Aid and Assist	103	100	109	110	109	121	115	114	111	116	118	137

Figure 3

Note: "Voluntary & Others" category primarily consists of neuro-geriatric psychiatric patients on a guardianship

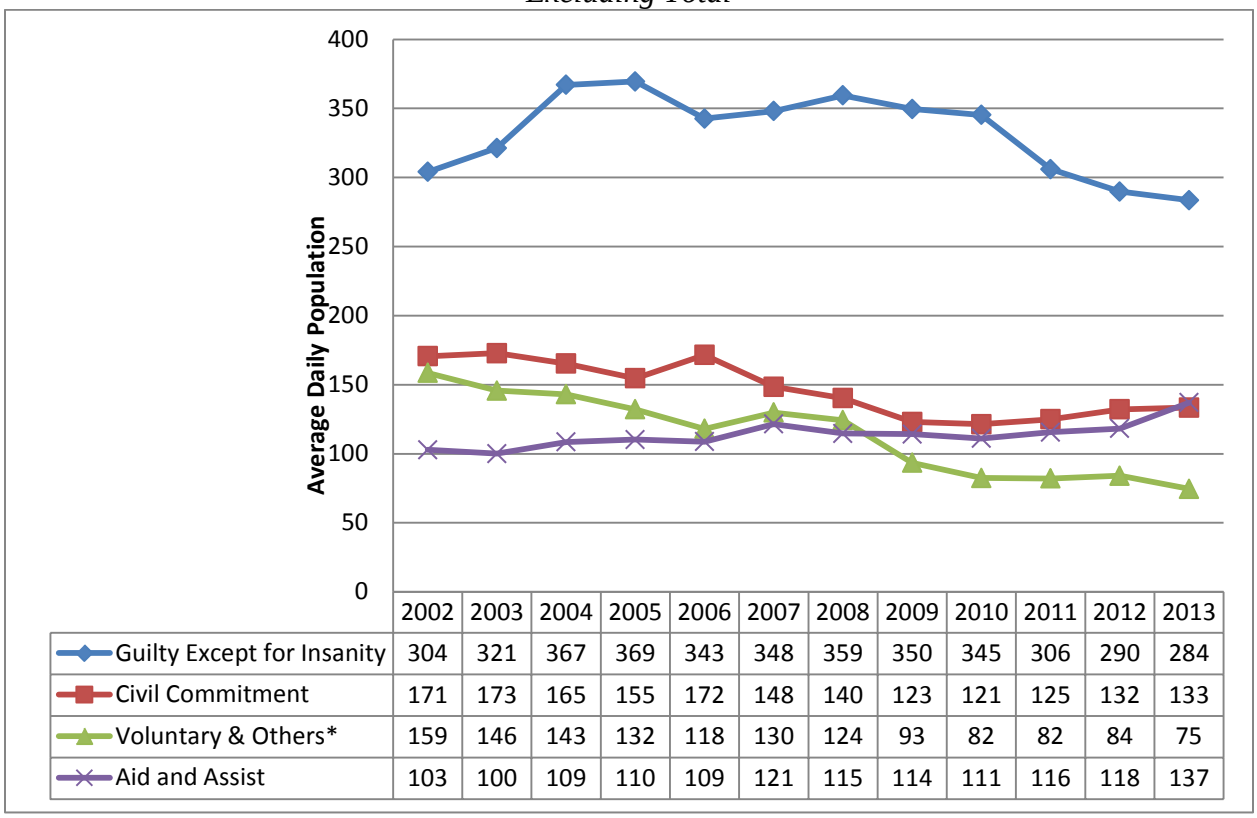
These data show that the total annual average daily population in the state hospitals decreased from a high of 784 in 2004, to 629 in 2013, which is a 19.8% decrease in the total population over a nine year period. The numbers of people in the 'Guilty Except for Insanity' category and people who were civilly committed, voluntary or

in the 'Other' category have also gone down. For example, the average daily population for people civilly committed was 171 in 2002 and 133 in 2013 which is a 22% decrease.

The one category that has shown a steady increase is the number of individuals in the 'aid and assist' category who are remanded to the OSH for competency restoration following arrest.

Figure 4 differs from Figure 3 only in that it does not include the total population across all categories. Because of the change in scale used in Figure 4, it is easier to seethe decrease in persons at the hospitals in the guilty except for insanity, civil and voluntary categories and the increase in people in the aid and assist category.

Annual Average Daily Population
By Legal Status
Excluding Total



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Guilty Except for Insanity	304	321	367	369	343	348	359	350	345	306	290	284
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Aid and Assist	103	100	109	110	109	121	115	114	111	116	118	137

Figure 4

Note: "Voluntary & Others" category primarily consists of neuro-geriatic psychiatric patients on a guardianship

Figure 5 is the median length of stay for individuals on civil commitment at OSH.

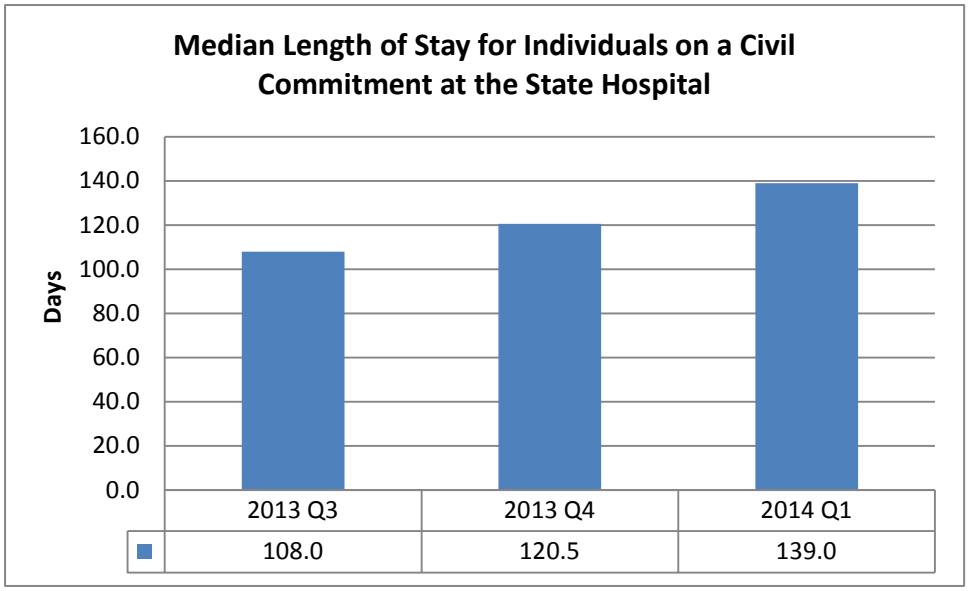


Figure 5

These data show that the median length of stay in OSH for persons civilly committed has increased over the past three quarters. While it is too soon to conclude that this is a trend that will continue, the length of stay at OSH has been identified as an area of concern.

Figure 6 is the percentage of individuals on civil commitment who were readmitted to OSH within 180 days of discharge. (The 30-day readmission rate is not shown because individuals receive acute care in the community and are not readmitted to OSH within 30 days. The rate will always be zero.)

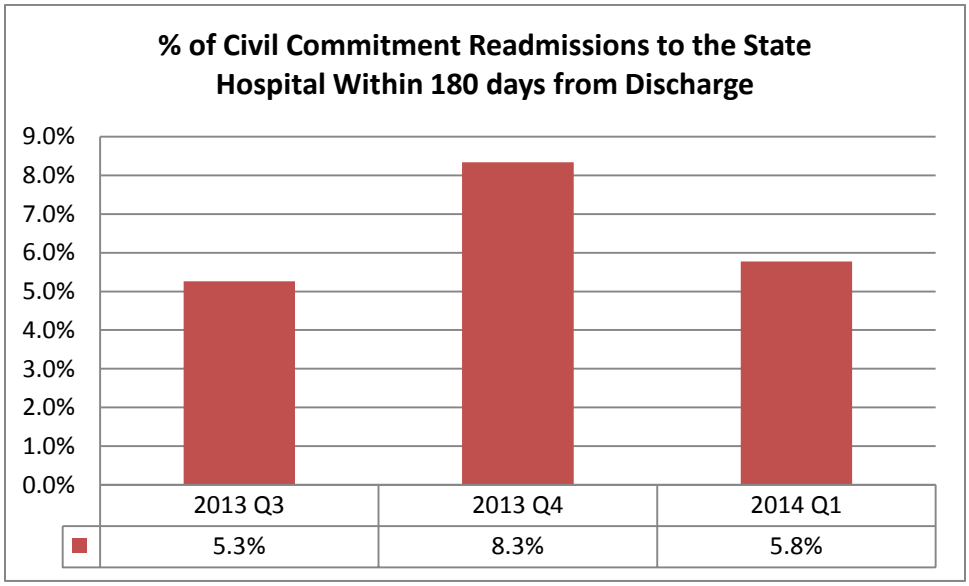


Figure 6

Although the readmission rates for OSH are within the national norms, state hospitals vary greatly in how they are used by communities for treatment. Some state hospitals are used for crisis stabilization and acute care while others are similar to the Oregon State Hospital and focus on longer-term care. Therefore for this measure, it is more useful to establish a baseline for readmission to the Oregon State Hospital and monitor against this baseline rather than relying on national trends.

Discussion:

The number of individuals admitted to OSH from the waiting list has remained stable and the median length of stay has increased for individuals on civil commitment. Based on these data, the OSH has selected the reduction in the length of stay as a performance improvement project. Metrics to reduce the length of stay at OSH and to reduce the length of stay after a patient has been deemed "Ready to Transition' are included in the 2014 AMH Strategic Plan.

AMH is also seeking consultation to improve the transition of state hospital patients to the community. A reduction in the length of stay and the time elapsed between 'Ready to Transition' and discharge should also reduce the number of individuals in acute care waiting to start treatment at OSH.

And, while the annual daily average population at OSH has decreased over the past decade, the number of people going to the hospital for 'aid and assist' evaluations has increased. The Oregon Health Authority (OHA) is developing a Legislative Concept to decrease the number of people coming to the hospital for 'aid and assist' evaluation and restoration. The Legislative Concept will focus only on people charged with misdemeanors or Class C felonies. If implemented, this change might reduce the number of people hospitalized for 'aid and assist' by as much as 20%.

Acute Psychiatric Care in the Community

Acute psychiatric hospital care is a vital service for individuals in need of intensive psychiatric intervention. This section has information about the utilization of the community psychiatric acute care system.

Figure 7 shows OSH capacity and community acute care capacity as of December 31, 2013.

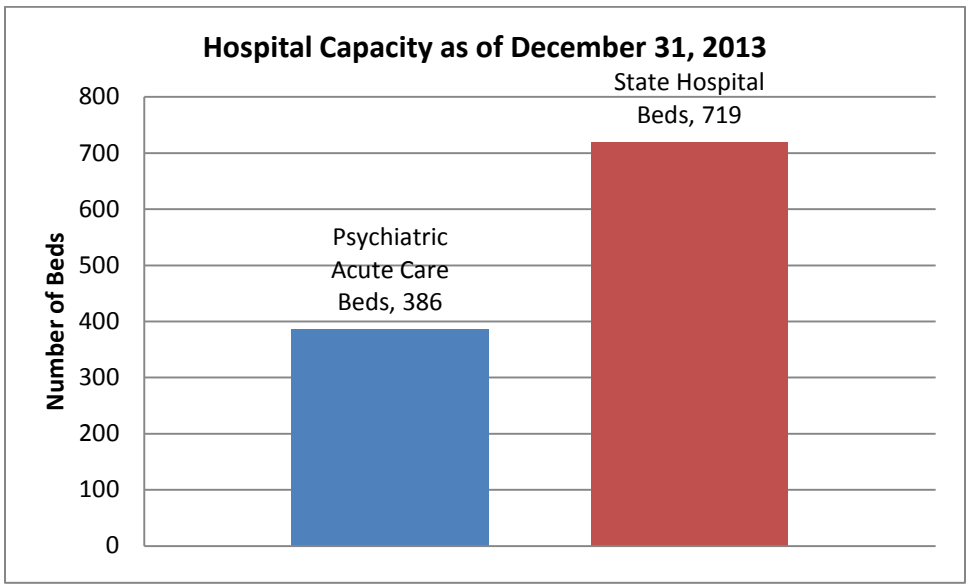


Figure 7

As of December 2013, there were 386 acute psychiatric beds in the community and 719 beds at the two state hospitals. (Note: Since that time, Blue Mountain Recovery Center has closed.) The majority of OSH beds in Oregon were occupied by individuals who are in the 'guilty except for insanity' and 'aid and assist' categories. OSH bed capacity was reduced when the Blue Mountain Recovery Center (BMRC) closed in March 2014. BMRC had a licensed capacity of 60. The current capacity of OSH as of October 2014 is 659.

Figure 8 shows the average length of stay for individuals with a diagnosis of SPMI in community psychiatric acute care hospitals.

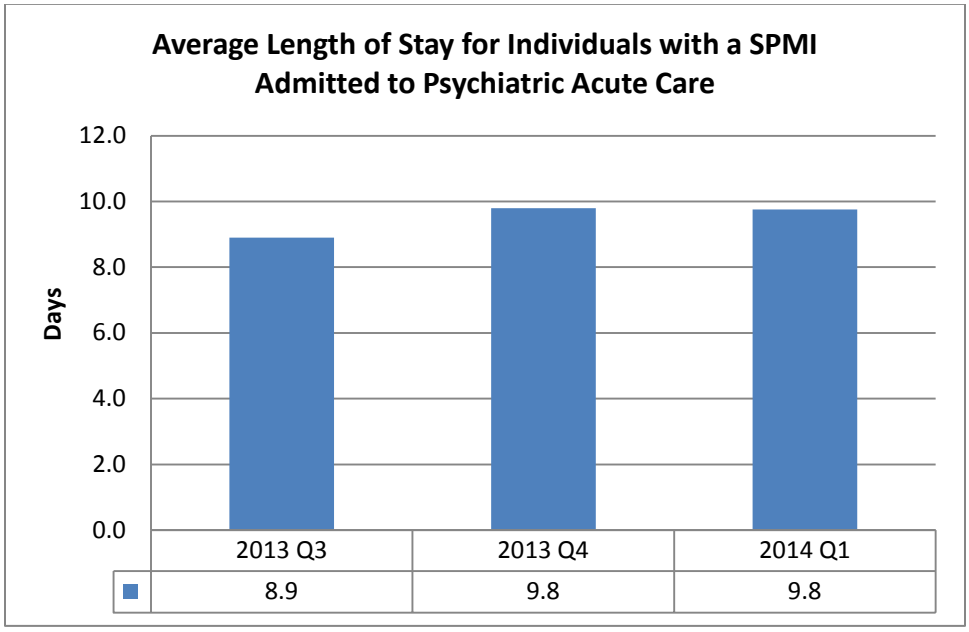


Figure 8

The average and median length of stay continues to remain relatively stable. The average length of stay was between 8.9 and 9.8 days, while the median ranged from 5 to 6 days. These data are very close to the national average of eight days. In this case, comparison to national benchmark is acceptable because psychiatric acute care hospital beds are similar in how they are used in the continuum of care.

Figure 9 shows the total number of acute care admissions for individuals with Medicaid combined with a non-Medicaid group consisting primary of people with no insurance whose care was supported by an indigent fund. These data do not include voluntary commercial insurance patients.

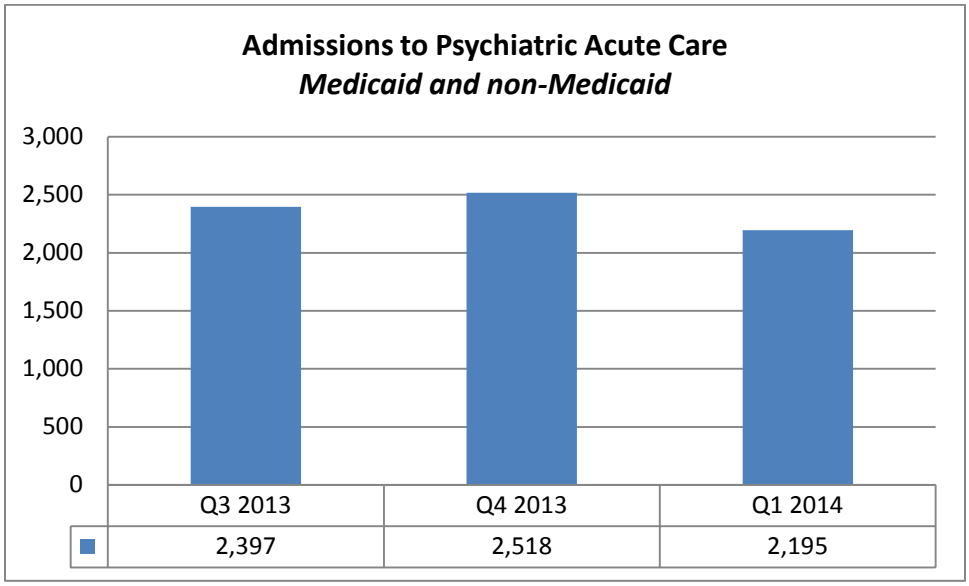


Figure 9

Psychiatric acute care capacity is near 100% much of the time. The variability among the quarters may be related to the change in the patient mix among those with commercial insurance, Medicaid, Medicare or indigent funding.

Figure 10 shows the percentage of readmission for adults with SPMI to psychiatric acute care hospitals within 30 and 180 days from discharge.

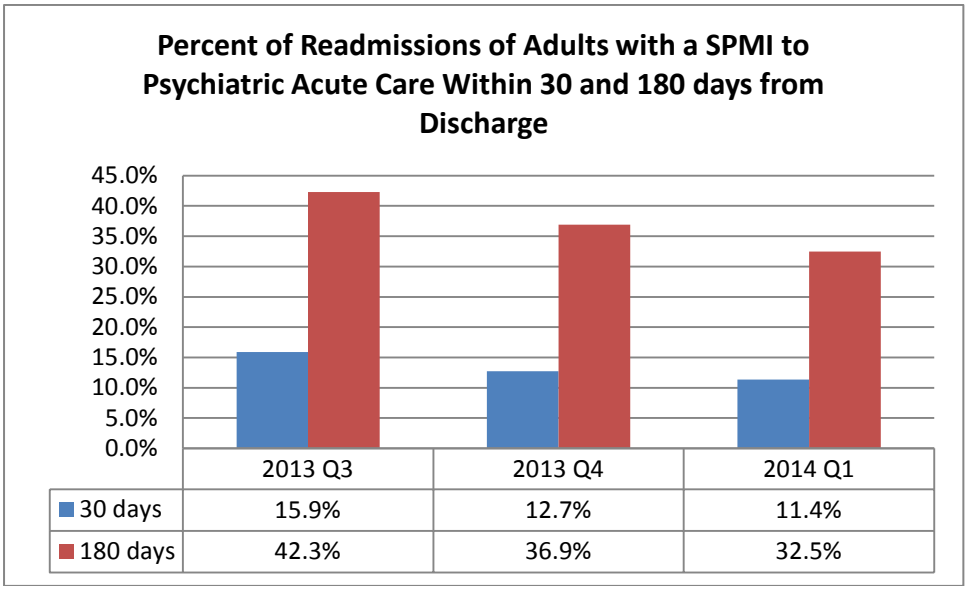


Figure 10

The data regarding acute care readmission rates demonstrates a decline in the rate over the three quarters. However, the lowest readmission rate within 180 days is 32%. This indicates that almost a third of individuals in acute care are readmitted within 6 months.

Figure 11 shows the percentage of adults with SPMI who have a follow-up visit with an outpatient provider following 7 and 30 days of discharge from an acute psychiatric care hospital.

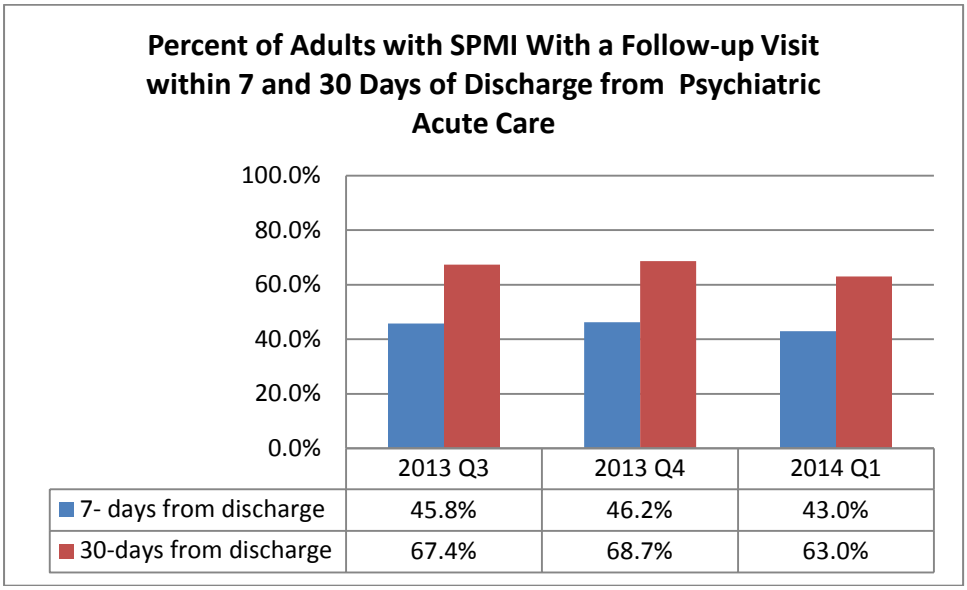


Figure 11

This data indicates that a low percentage of individuals receive follow-up care after a psychiatric hospitalization within 7 and 30 days. Less than half of those discharged from psychiatric acute care have a follow-up visit within 7 days of discharge and over 30% have still not received outpatient follow-up 30 days after discharge.

Figure 12 shows the number of emergency department visits made by adults with mental illness who are enrolled in Medicaid.

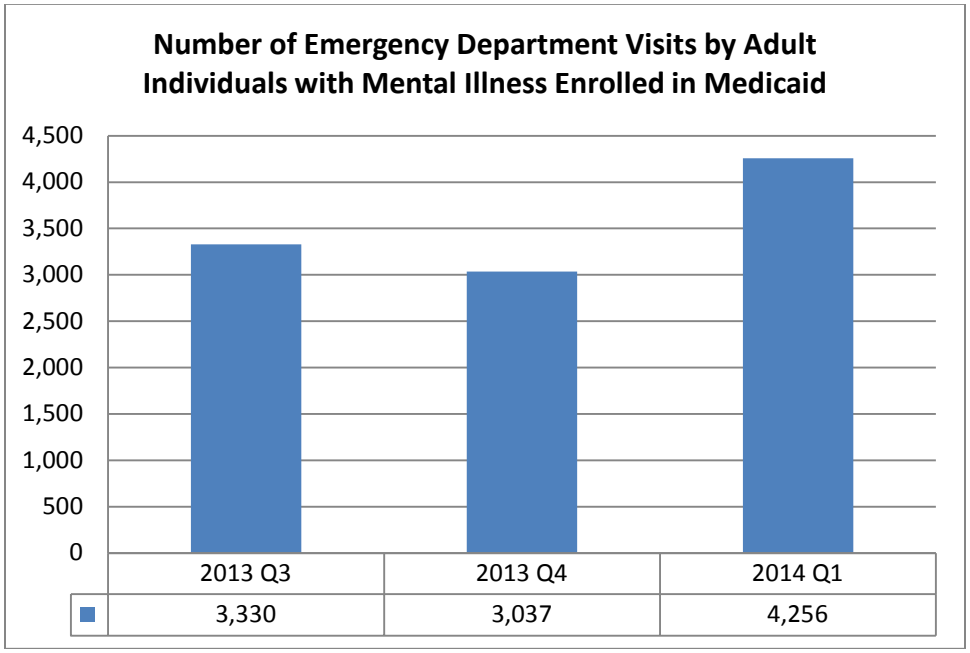


Figure 12

Figure 12 indicated that the number of visits increased in the first quarter of 2014. This time period was the first quarter of the Medicaid expansion, when 380,000 persons became eligible for services through the Oregon Health Plan.

Figure 13 converts the data from Figure 12 to a rate of visits per 1,000 member months to enable a comparison of emergency room use across three quarters.

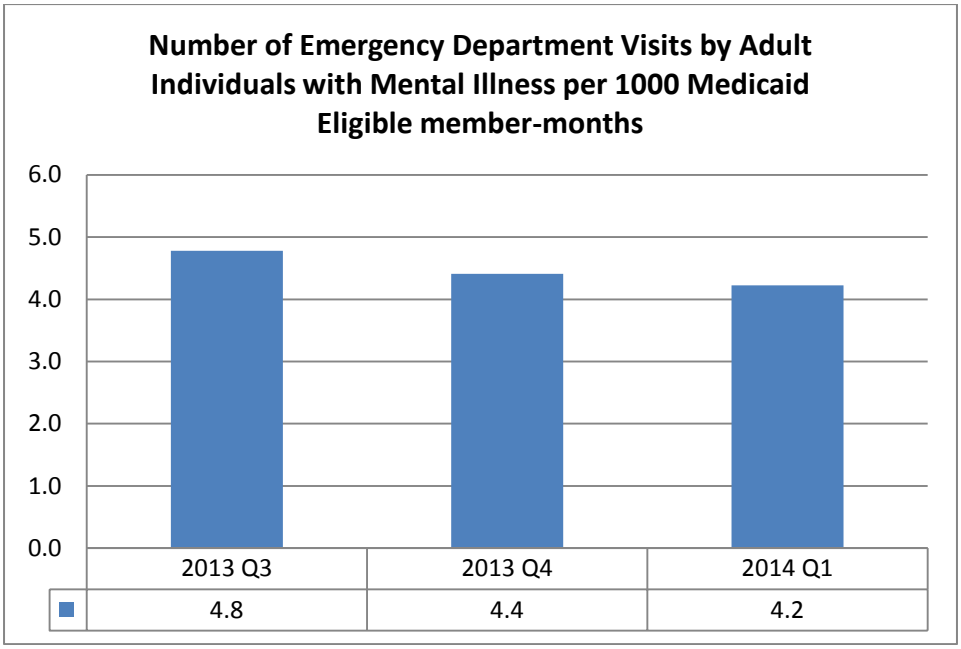


Figure 13

Figure 13 shows that the rate of visits for this population actually declined slightly over the three quarters. Although the total number of people with mental illness seeking care in emergency departments went up, the rate per 1,000 declined.

Discussion:

The readmission rates and the number of individuals receiving follow-up care at 7 and 30 days are of concern. These two issues and the data were presented to the Coordinated Care Organization Quality and Health Outcomes Committee on October 13, 2014, to determine how best to work with CCOs to positively impact these measures.

Crisis Services

A robust crisis system is key to supporting individuals with mental illness in the community and reducing institution-based care. The data collected regarding crisis

services is vital to monitoring the capacity and utilization of community based services.

Figure 14 shows the capacity of beds in the community for individuals experiencing a mental health crisis. There are three types of crisis beds being monitored. 'Community crisis beds' are located in apartments, private residences or unlicensed facilities that provide temporary housing. 'Crisis stabilization beds' are located in licensed, non-secure crisis respite facilities. 'Subacute beds' are located in licensed, secure crisis respite facilities.

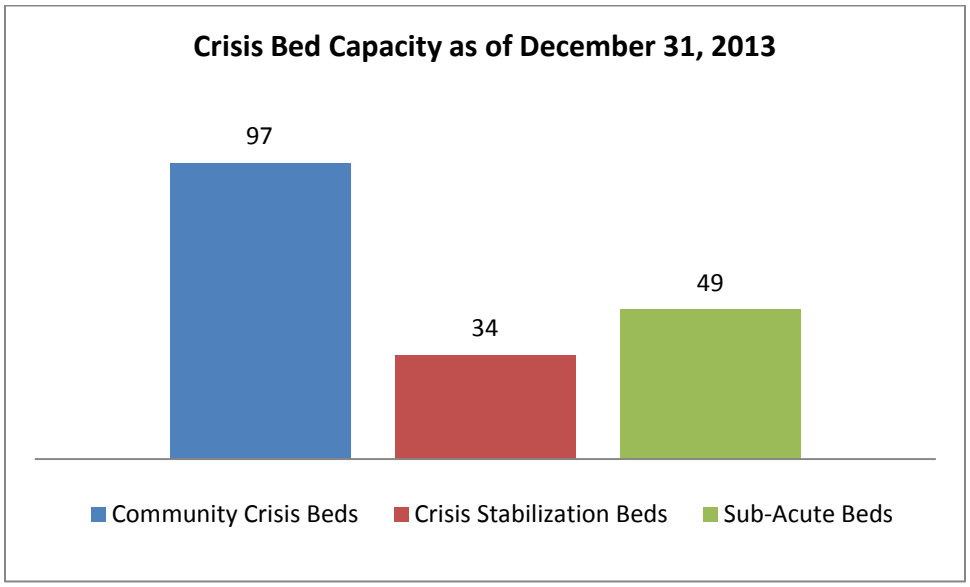


Figure 14

There are a total of 180 crisis beds in Oregon.

Figure 15 shows the number of people who used crisis beds.

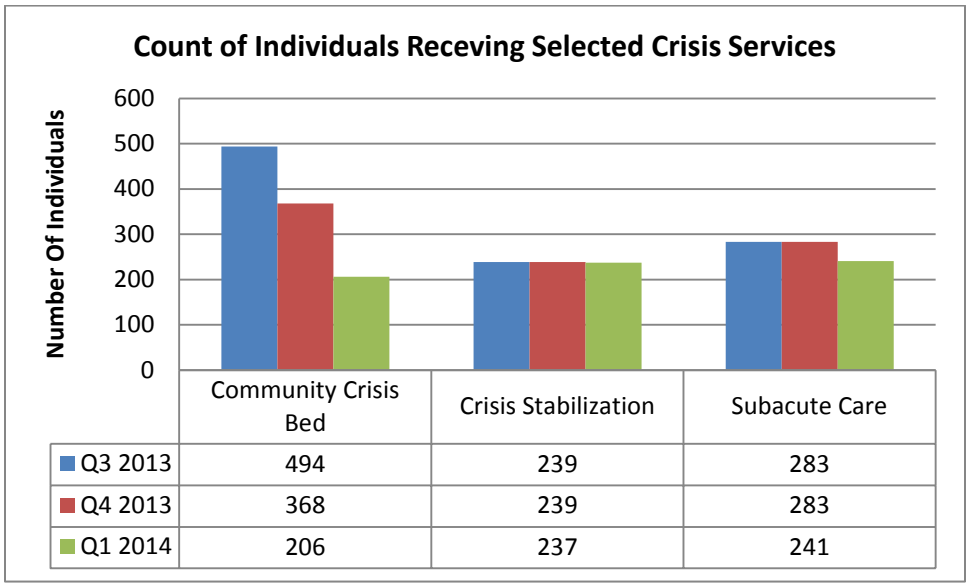


Figure 15

Crisis stabilization bed and subacute care utilization is relatively stable for these three quarters. There is a large decrease in the use of community crisis beds. In reviewing the county level data, there appears to be some inconsistency in the reporting of this service. AMH is evaluating the reliability of the data.

Figure 16 shows the number of mobile crisis services and walk in crisis services.

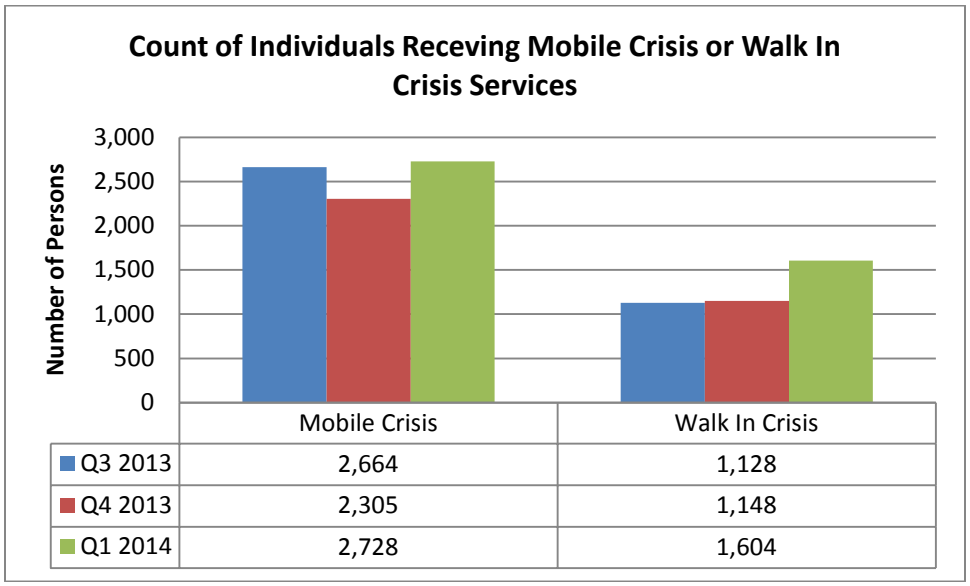


Figure 16

There is an increase in the number of individuals receiving these crisis services in the first quarter of 2014. It is unclear if this related to the increase in persons enrolled in Medicaid. $6.27 million in new funding was awarded to twelve counties to create or expand crisis services. The funding went to those programs in the spring of 2014 so an increase in mobile crisis services should be evident in the next report. For example, in a separate report, Marion County indicated that from April 2014 through June 2014, 155 mobile crisis services were delivered compared to zero mobile crisis services during the last half of 2013.

Figure 17 shows the number of crisis calls to the crisis line services provided by or subcontracted by Community Mental Health Programs.

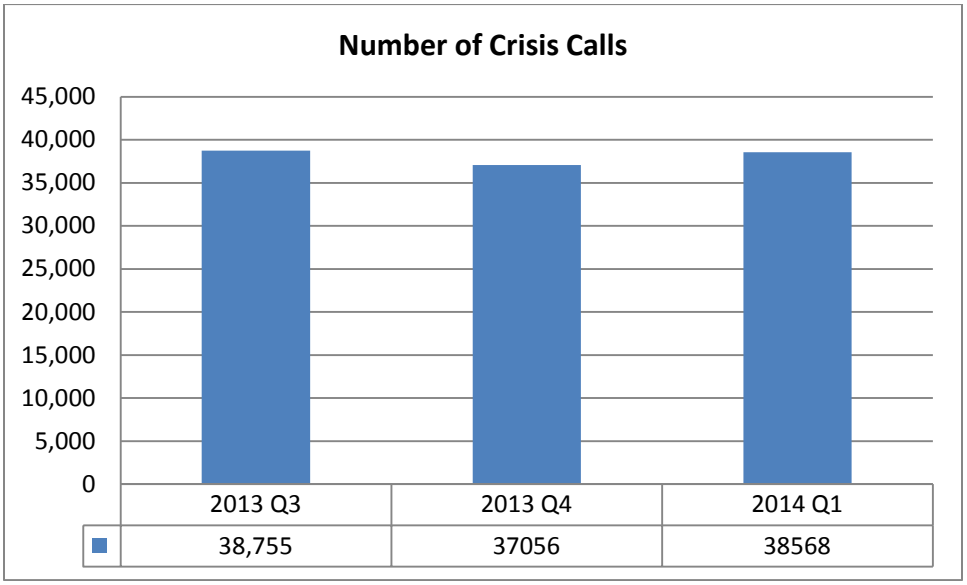


Figure 17

There are other crisis lines in Oregon that are not part of the community mental health system. Information from those services is not included in these data. The calls appear stable over these three quarters.

Discussion

AMH experienced several challenges in collecting data regarding the number of mobile crisis services/teams. Several surveys were conducted to collect the number of mobile crisis teams. However, due to the variety of configurations of how mobile crisis services are delivered, the data collected was inconsistent and unreliable. AMH then requested that the community mental health programs submit a narrative describing their mobile crisis services and specifically address when and how those services are provided.

A qualitative review of the narratives showed that the following 21 counties have Community Mental Health Programs that report having the capacity to respond to crises 24/7 and at any location in the community, with safety precautions:

- Baker
- Benton
- Clackamas
- Columbia
- Crook
- Deschutes
- Gilliam
- Hood River
- Jackson
- Jefferson
- Josephine
- Lane
- Linn
- Marion
- Morrow
- Multnomah
- Polk
- Wasco
- Washington
- Wheeler
- Yamhill

Details regarding the level of availability including the number of staff and geographic coverage are described in the narratives. The following counties, all in Eastern Oregon, indicate that the Community Mental Health Programs provide 24 hour crisis services but are limited to providing services in hospital emergency departments or jails:

- Sherman
- Umatilla
- Union

The following counties, generally in less populated parts of the State, did not provide a response to this survey question or reported that they did not have mobile crisis services:

- Curry
- Douglas
- Harney
- Klamath
- Lincoln
- Malheur
- Tillamook
- Wallowa
- Lake
- Coos
- Clatsop
- Grant

Oregon recognizes the need to bolster mobile crisis services. Two community providers were recently awarded funds to add a total of 24 crisis respite beds to the Portland area. AMH, the state Public Health Division, the City of Portland, Multnomah County and many community partners are working collaboratively to examine the feasibility of developing a psychiatric stabilization facility that would

provide psychiatric specialty care to many who are currently seeking care in general emergency departments.

AMH also has been working with a group of stakeholders to make crisis line services more standardized and available. The group has a goal to complete a plan for crisis line services by the end of 2014, with implementation of the plan to begin in 2015.

Evidence Based Community Practices

Assertive Community Treatment

Assertive Community Treatment (ACT) and Supported Employment are evidence-based practices that help enable many individuals with serious and persistent mental illness to live in integrated settings in the community. Peer Support is another key service rendered by traditional health workers in the community.

Figure 18 indicates the number of persons with a serious and persistent mental illness receiving ACT, Supported Employment and Peer Support services.

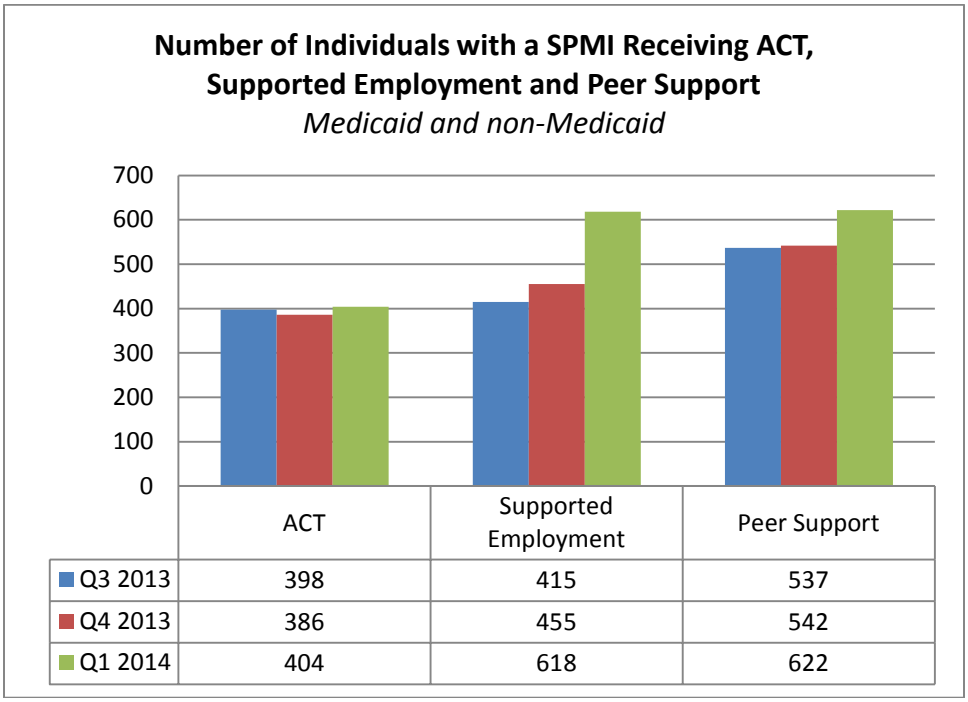


Figure 18

There is an increase for Supported Employment. It is anticipated that the number of individuals receiving these services will increase due to recent investments in these services statewide.

Discussion

ACT

Oregon received a considerable investment by the Legislature in the community mental health system. $5.5 million was invested to expand the availability of ACT across the state. This funding will create 14 new ACT teams and expand capacity of four existing teams. An important aspect of this expansion is that fidelity to the ACT model be assured. In Oregon a provider must be approved by the state before

it can bill Medicaid for ACT services. A new ACT provider may be provisionally approved while it builds itsr program. However, the provider must attain high fidelity within one year. Oregon funds the Oregon Center of Excellence for ACT (OCEACT), which provides technical assistance and conducts the fidelity reviews. This process will ensure that ACT services are provided at a high level of fidelity. With the implementation of the new MOTS data system AMH will be able to monitor the outcomes of ACT providers.

Oregon has large areas of the state that are rural and frontier. Providing high fidelity ACT services in these areas is challenging. The state is working with OCEACT and Dartmouth University on how to apply the fidelity scales to rural programs.

Supported Employment

Oregon has long recognized the value of supported employment services to enable individuals with a SPMI to fully participate in the community. Since 2008, Oregon has contracted with the Oregon Supported Employment Center for Excellence (OSECE) to provide technical assistance and to conduct fidelity reviews. OSECE uses the Dartmouth fidelity tool when conducting reviews. In July of 2013, providers were required to have a high fidelity score for supported employment to be able to bill Medicaid for those services. During the three quarters reported, there is an increase in the number of persons with a serious and persistent illness receiving supported employment services. Also, the Legislature has provided funding to expand supported employment services for the entire state. At the start of this reporting period, 19 counties had the availability of supported employment services. As of July 2014, 28 counties had qualified or provisionally qualified supported employment services. AMH expects supported employment data elements to increase as the new funding is implemented.

Peer Support Services

Peers can provide services and supports that enable individuals to embrace recovery and live in the most integrated setting. Peer support specialists are used to provide a wide variety of services including subacute services, supported housing services, ACT, a warmline and a host of other types of services and supports.

Oregon's Health System Transformation embraces the services of traditional healthcare workers which include behavioral health peers and families. OHA has implemented a registry for traditional health care workers, which will include Peer Support Specialists. OHA has established rules for how an individual is placed on the registry. Once that registry is established, AMH will report the number of Peer Support Specialists registered. AMH will continue to report the number of individuals receiving peer support services. However, this number is only based on encounters for that service. Many peer support services are imbedded in other services and will not be captured by the peer support code.

Early Assessment and Support Alliance (EASA)

For the period from July 1, 2013 through December 3, 2013, 344 young adults received EASA services. EASA is an early intervention with young adults experience symptoms of psychosis. This service enables young adults to experience a life of recovery in the community. The Legislative Community Mental Health Investments include $1.8 million to expand the availability of EASA statewide.

Supported and Supportive Housing

During the first year of the agreement with USDOJ, AMH surveyed providers to determine the number of Supported and Supportive Housing units. There was considerable variability in the data reported from one quarter to the next. Much of that variability was related to confusion about the definitions of Supported and Supportive Housing. AMH provided extensive technical assistance to providers to help them understand the definitions. The data in the current report demonstrate stability in reporting.

Figure 19 shows capacity and occupancy data for Supported and Supportive housing. The occupancy numbers represent the number of individuals with a serious and persistent mental illness in such housing on the last day of the reporting period.

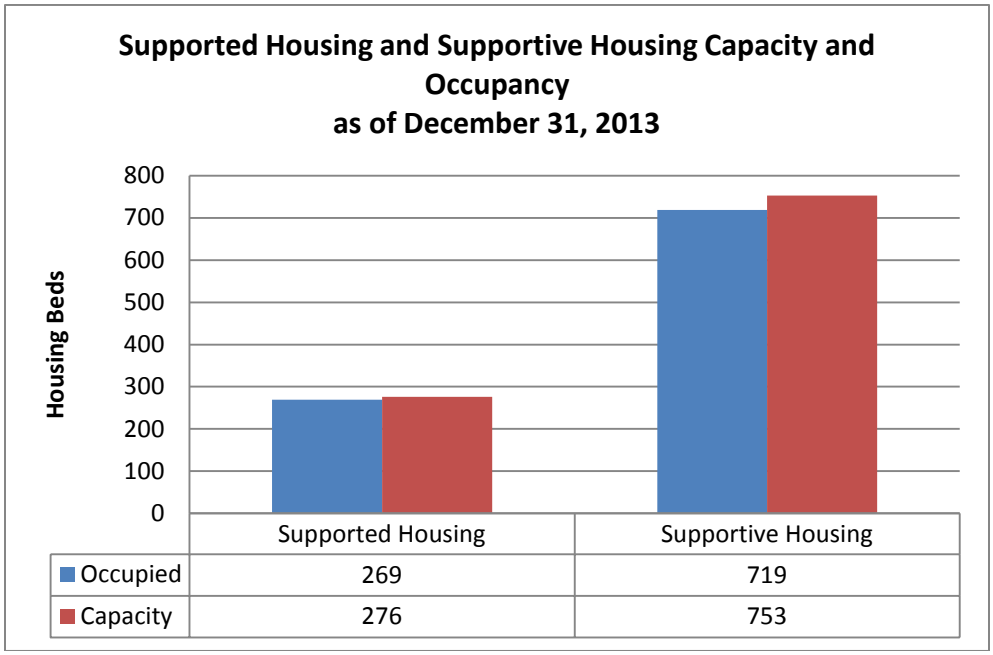


Figure 19

The numbers for supported housing are lower than the numbers for supportive housing. At the point in time when data was collected, the occupancy rate was 97% for supported housing and 95% for supportive housing.

Figure 20 shows the number of adults on civil commitment at OSH who were discharged into supported housing, supportive housing or independent living.

At this time the data system is unable to distinguish between supported housing and supportive housing, so the data is combined.

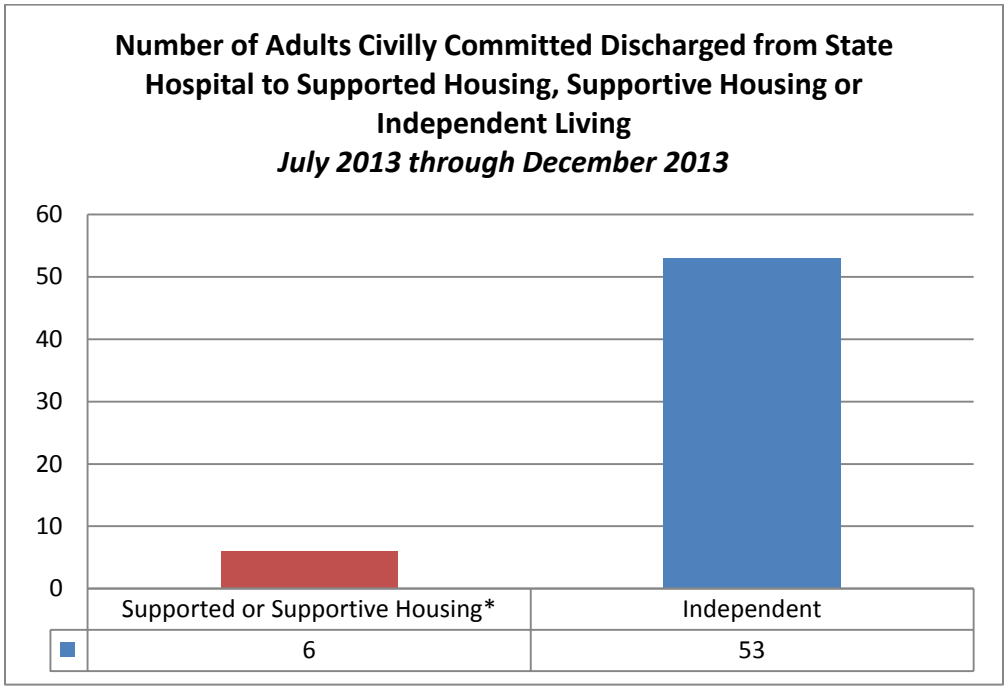


Figure 20

These discharges represent 40% of the civil commit discharges from OSH.

Figure 21 shows a more global picture of the living setting for individuals with SPMI and receiving Medicaid mental health services.

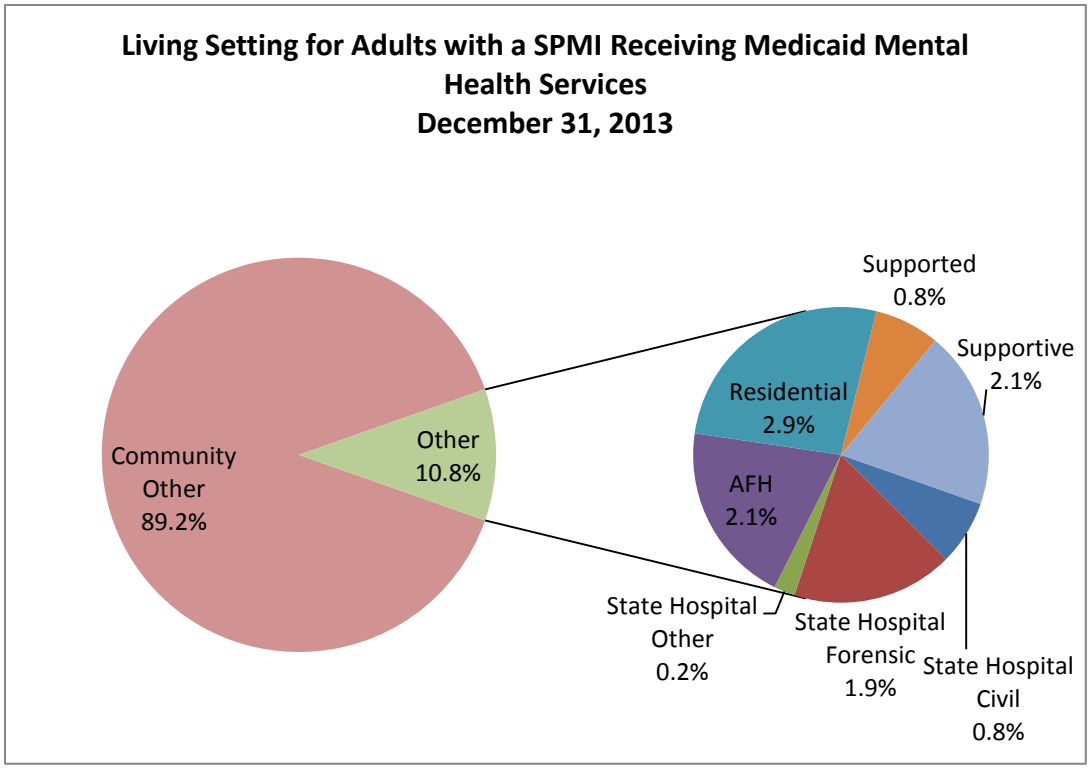


Figure 21

The vast majority of people are living in the 'Community Other' category. The number of individuals in this category was derived by subtracting the total number of individuals residing in the other identified settings from the total number of individuals served. This category does not include individuals who are homeless.

The new MOTS data management system will allow AMH to more accurately report living situations.

Discussion

The capacity for supported housing will increase when the supported housing projects funded by the new investments from the legislature are implemented. The

Legislature invested $14.2 million for housing. $10 million of this funding resulted from a joint effort among NAMI – Oregon, the Oregon Residential Providers Association and AMH to support the development of housing for people with a mental illness. $9.2 million of the investment funds were for a Rental Assistance program providing rent subsidies with support from staff and peers for a total of 576 people services through Supported Housing. Approximately $4.5 million of the $14.2 million will support the development and construction of Supported Housing units for individuals with a serious and persistent mental illness. (Please note that the there is some overlap among the breakdown amounts described in this paragraph. The total of the various parts is $14.2 million.) Through a competitive solicitation process, ten projects were awarded funding for 168 units of affordable housing. No more than 20% of the units will be reserved for individuals with a mental illness.

Case Management

Figure 22 reports the number of individuals with SPMI who received case management, and pychoeducation and living skills training.

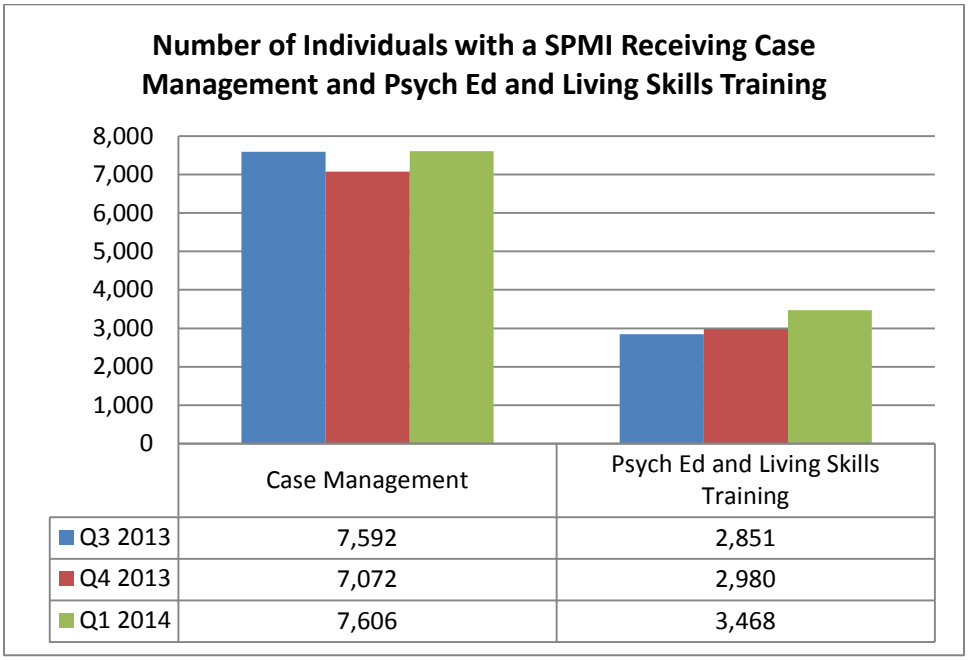


Figure 22

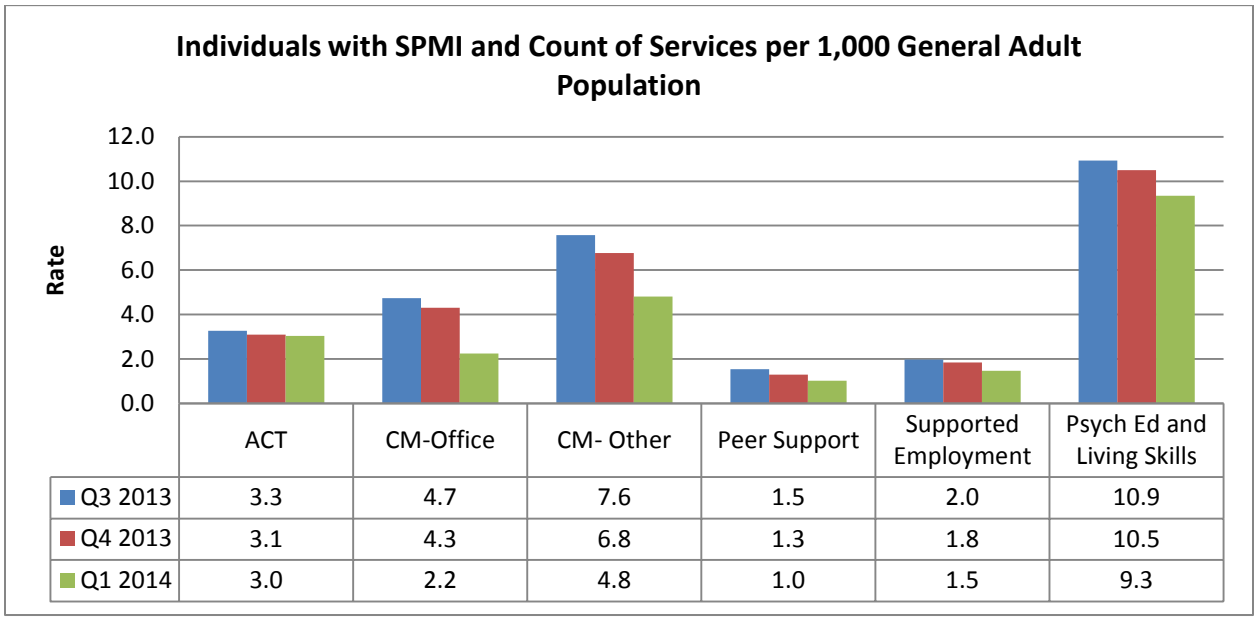
It is difficult to interpret this information since community mental health providers use different codes to bill for services. For example, one CMHP recently reported that at the beginning of this calendar year they directed their providers to move from a case management code to a living skills training code.

Discussion

Collecting and reporting case management data continues to be a challenge. In Oregon, the case management model varies across the state and impacts how caseload sizes are calculated. Most programs have staff who provide case management functions, but also perform other duties; some programs have caseloads of both high need and low need individuals, and still other programs have a master's level Qualified Mental Health Professionals (QMHP) paired with a bachelor's level Qualified Mental Health Associate staff to provide case management services. Two attempts to survey the programs based on agreed upon definitions resulted in wide variability and inconsistent data. AMH is working with the CMHPs to make another attempt to capture staffing capacity by collecting data regarding the total number of QMHPs and QMHAs and divide that into the number of individuals receiving identified services. AMH will provide a report of that information as soon as it is available.

Community Mental Health Service Rates

Figure 23 shows the count of selected community mental health services per 1,000 people.



	ACT	CM-Office	CM- Other	Peer Support	Supported Employment	Psych Ed and Living Skills
Q3 2013	3.3	4.7	7.6	1.5	2.0	10.9
Q4 2013	3.1	4.3	6.8	1.3	1.8	10.5
Q1 2014	3.0	2.2	4.8	1.0	1.5	9.3

Figure 23

The rate of services appears to have declined over the three quarters with a larger decline in the first quarter of 2014.

Figure 24 show the number of assessments and routine service within 14 days after initial assessment for adults with SPMI.

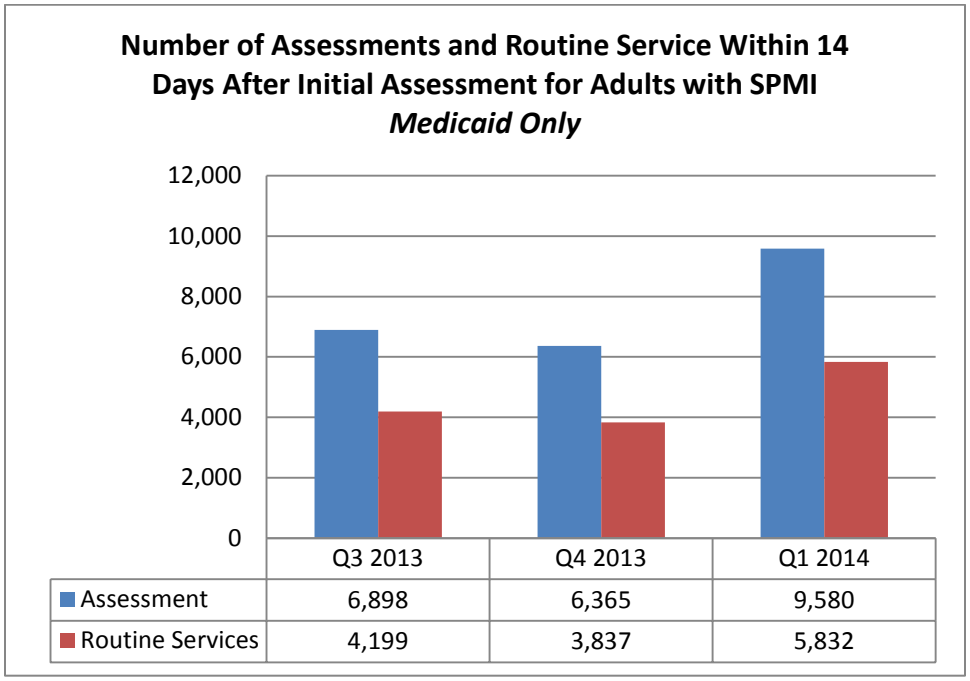


Figure 24

Figure 24 shows that the number of assessments going up significantly in the first quarter of 2014. This indicates that more people are receiving assessment and also receiving services.

Figure 25 looks at the percentage of routine service rendered within 14 days after initial assessment.

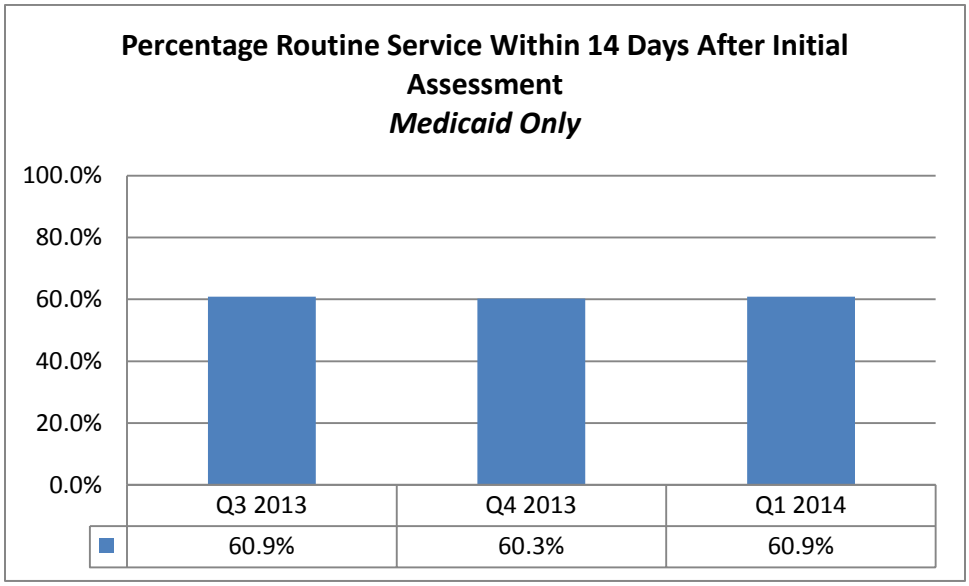


Figure 25

The percentage of individuals with SPMI receiving routine services after the assessment remains consistent across three quarters at approximately 60%.This demonstrates that the rate did not decline with the large numbers of new enrollees.

Discussion

In discussion with some community mental health providers regarding the apparent decline in services, they noted the large influx of new Medicaid members after January 2014. The increase in members may have led providers to concentrate on assessment of new members for services. Providers also cited the need to add people to the workforce to meet the needs of the expanded population. AMH will be watching these numbers closely as the system adjusts to absorb new members.

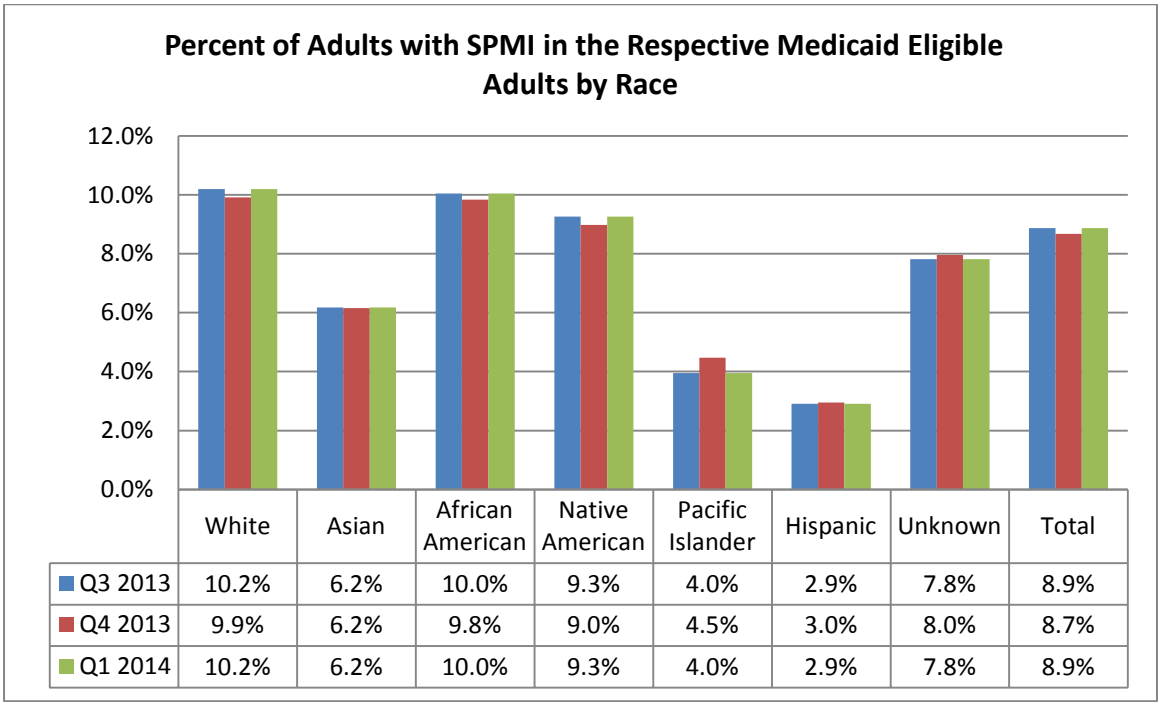
The percentage of individuals with SPMI receiving routine services has increased but the percentage of people getting services within 14 days is consistently around 60%. This presents as an opportunity to improve the access to services after the

initial assessment. AMH presented this data to the CCOs Quality and Health Outcomes Committee on October 13, 2014. AMH will continue to meet with CCO groups monitor this metric.

Access to Mental Health Services for All Races

It is important to examine the access to mental health services for adults with SPMI for all races.

Figure 26 presents data regarding the percentage of adults with SPMI accessing mental health services by race for individuals enrolled in Medicaid.



	White	Asian	African American	Native American	Pacific Islander	Hispanic	Unknown	Total
Q3 2013	10.2%	6.2%	10.0%	9.3%	4.0%	2.9%	7.8%	8.9%
Q4 2013	9.9%	6.2%	9.8%	9.0%	4.5%	3.0%	8.0%	8.7%
Q1 2014	10.2%	6.2%	10.0%	9.3%	4.0%	2.9%	7.8%	8.9%

Figure 26

The percent of adults with SPMI in a race category receiving mental health services remained relatively stable over the three quarters. There is consistent variability across groups.

Discussion

One group that clearly is accessing services at a lower rate is Hispanic adults. This information will be reviewed by AMH's Committee on Health Equity and Policy to consider incorporating this into behavioral health equity planning.

Access to Primary Care

Individuals with SPMI are at significant risk for physical health conditions. A major goal of healthcare transformation is the integration of behavioral, physical and oral healthcare so that people have better access to all their health care needs.

Figure 27 shows the percent of adults with SPMI who had a visit with a primary care physician (PCP) during the previous twelve months.

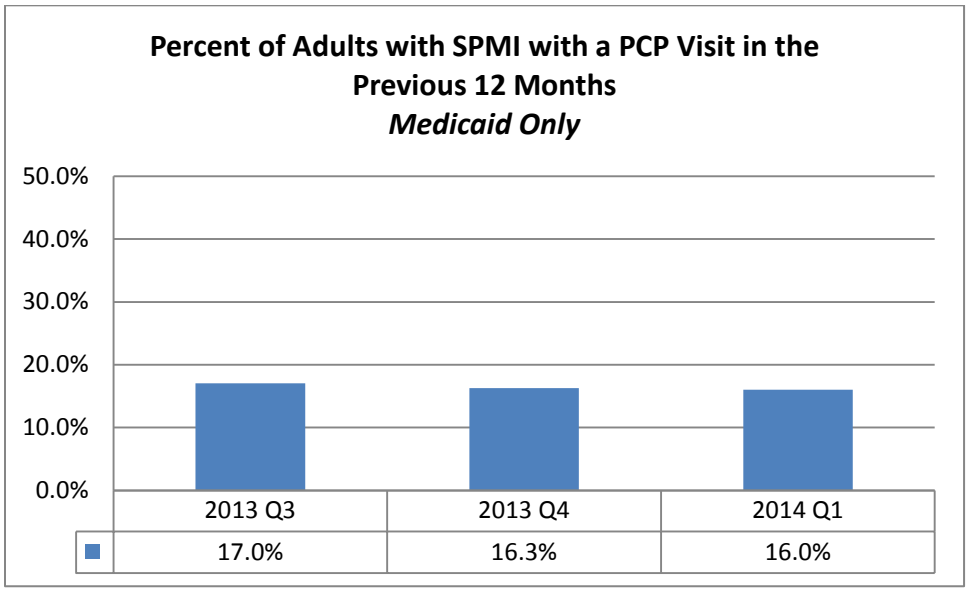


Figure 27

These data shows that about 16% of adults with SPMI saw a primary care physician in the last 12 months.

Discussion

These data were collected using specific primary care codes and it is likely some routine or preventative services are not captured. AMH will continue to collect and

report this data and also look for opportunities to improve data collection that represents all primary care types of services.

OHA has several initiatives to improve the healthcare of adults with SPMI. The CCOs do have a Performance Improvement Project to improve the care of adults with SPMI and diabetes. AMH is working with a group of providers to develop Behavioral Health Homes similar to Person Centered Primary Care Homes. The goal is to develop standards for Behavioral Health Homes and encourage the development of primary health services within behavioral health agencies.

Cost of Medicaid Services

Figure 28 presents Medicaid expenditures for mental health services for adults with SPMI.

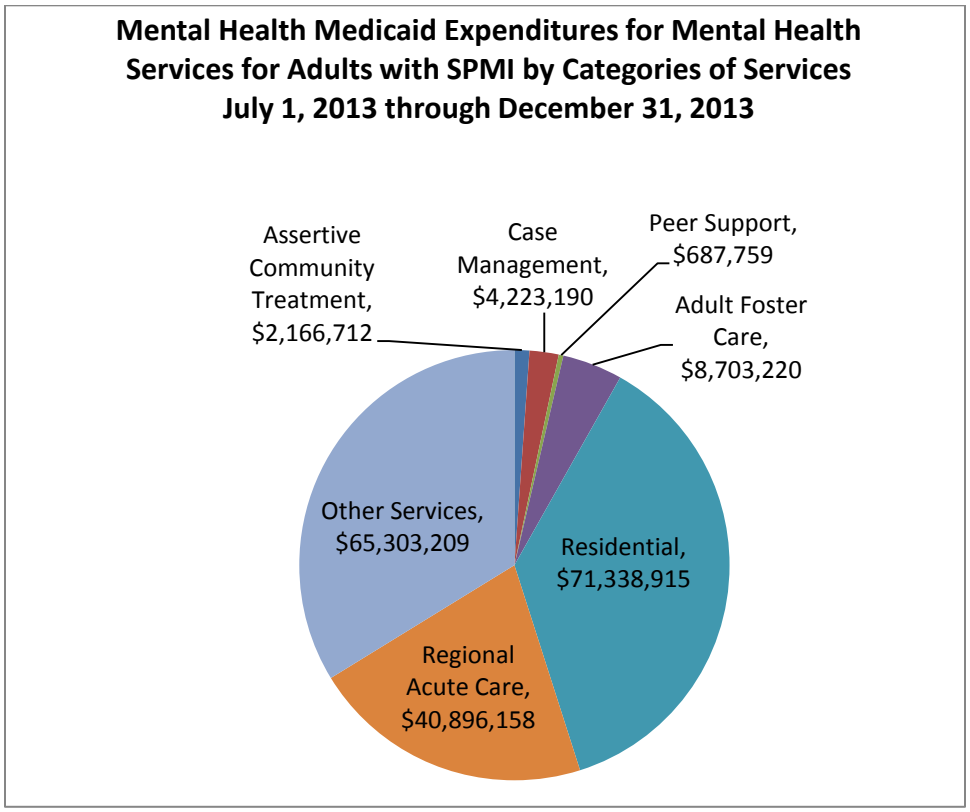


Figure 28

Figure 29 shows the percentages of total mental health Medicaid expenditures for mental health services for adults with SPMI by service category.

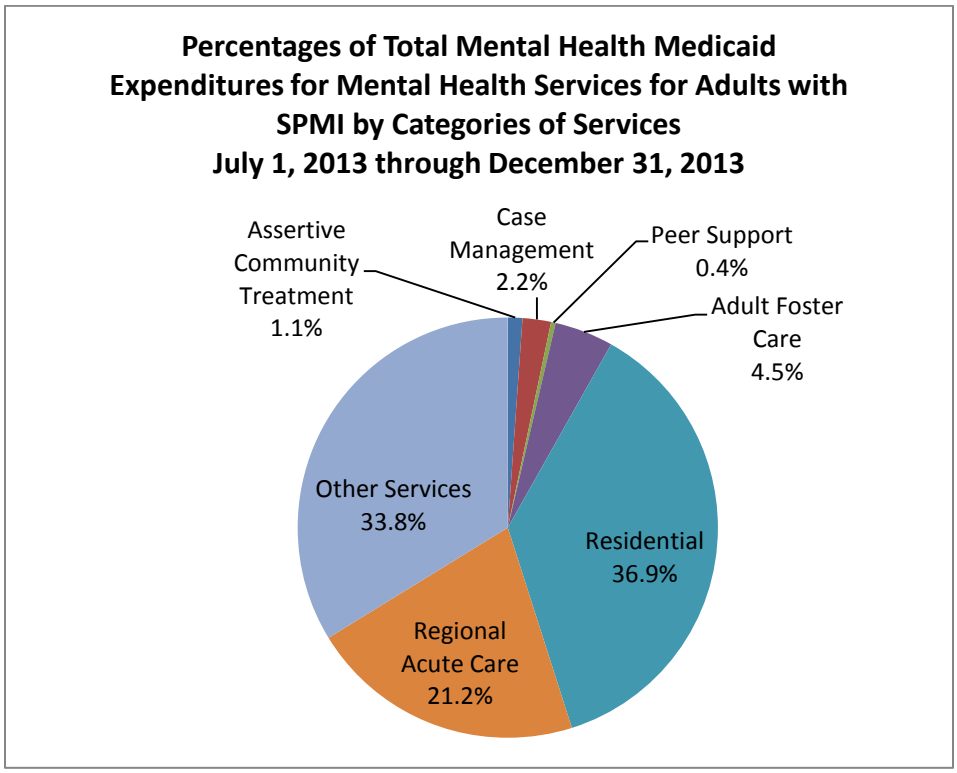


Figure 29

Acute psychiatric care is 21.2 % of the expenditures, and residential and adult foster care together is 41.4%.

Discussion

It is not unexpected that acute care and residential care comprise more than 60% of the Medicaid mental health expenditures since 24 hour care is expensive. AMH will monitor these expenditures looking for shifts to community services expenditures. Our goal in Oregon is to invest more in community services and reduce admission and length of stay in acute care and residential settings.

Addictions and Mental Health Division Report
to the United States Department of Justice

October 15, 2014

Summary

This is the first report based on the revised data matrix. The narrative summarized key data elements with some analysis and discussion. These data provide a baseline to evaluate the impact of initiatives to improve processes and improve access to important community services and supports. Some of the opportunities identified in this report include:

- Reduce the length of stay at OSH for adults civilly committed.
- Improve follow-up after psychiatric acute care.
- Reduce readmission rates to psychiatric acute care.
- Expand access to community crisis services.
- Expand the availability of supported housing.
- Expand ACT and supported employment throughout the state.
- Improve access to primary care for persons with SPMI.
- Reduce behavioral health disparities.

The development of CCOs, expansion of Medicaid and the major Legislative investments support the improvements in services and supports for adults with SPMI. This report and subsequent reports will enable AMH to monitor the impact of these healthcare changes enabling adults with SPMI to be integrated in the community.

U.S. Department of Justice
S. Amanda Marshall
United States Attorney
District of Oregon
1000 SW Third Avenue, Ste. 600 *(503) 727-1000*
Portland, OR 97204-2902 *Fax:(503) 727-1117*

November 9, 2012

John Dunbar
Attorney in Charge, Special Litigation Unit
Oregon Department of Justice
1515 S.W. Fifth Avenue, Suite 400
Portland, OR 97201

Re: Agreement regarding United States' Investigation of Oregon's Mental Health System, DJ#168-61-30

Dear Mr. Dunbar:

This letter will memorialize the agreement between the State of Oregon ("State") and the United States Department of Justice ("Department") to implement a process which upon full implementation as described below, will resolve the Department's investigation of the State's compliance with the integration mandate of Title II of the Americans with Disabilities Act ("ADA") and *Olmstead v. L.C.*, 527 U.S. 581 (1999) for persons with serious and persistent mental illness.

The State is currently in the midst of transforming its health care system. The transformation includes integration of the systems delivering physical and mental health care, expand coverage under the Oregon Health Plan, and ensure improved quality of services through an outcome-driven system. This health transformation process provides a unique opportunity for the State and the Department to work together to address the Department's concerns in this particular investigation by embedding reform in the design of the State's health care system. We have agreed that it is the State's intent to use this health reform process to better provide individuals with serious and persistent mental illness with the critical community services necessary to help them live in the most integrated setting appropriate to their needs and achieve positive outcomes. We agreed that these measures cannot be implemented all at once, but that the process must be staged over the next few years as outlined below.

First, in year one of this agreement, the State will collect statewide system data on the services currently being provided and the people being served as provided in the attached agreed upon matrix. This matrix contains both "System Development Measures" and "Program Outcome Measures" which outlines the information the state will collect throughout this process to identify not only what services are available throughout the state, but also to assess what gaps need to be filled during the State's healthcare transformation. Three of the terms used in the matrix – Serious and Persistent Mental Illness (SPMI), Supported Housing, and Supportive Housing -- are defined in the attachments to the matrix. The State also agreed to include community integration and data collection requirements in provider contracts, regulations

promulgated to implement Oregon's transformation process, and other guidance issued to the Community Care Organizations (CCOs) and Counties. The data collected will be shared with the Department at periodic intervals as the State collects it. More specifically, the State will provide data to the Department as shown in the attached matrix. It is anticipated that it will take about a year to collect data that covers the entire system. Therefore, the State will share final system wide data with the Department no later than October 15, 2013, except as shown in the matrix. During year one of the agreement, the State and the Department will meet periodically to discuss gaps revealed by the data. In conjunction with this investigation, the Department also has conducted an investigation of the Oregon State Hospital, which is not yet complete. The parties are hopeful that the work described in this agreement will aid Oregon in providing treatment in the setting that is most integrated and appropriate.

Second, in year two of this agreement, the State and the Department will resume discussions shortly after the system wide data has been shared with the Department. It is anticipated that these discussions will resume in early November, 2013. These discussions will focus on identifying gaps in the community service system that are impeding serving individuals in the most integrated setting appropriate to their needs. These discussions will also include whether the data collected should be broadened to include crisis services access by those with serious mental illness as well as those with SPMI as defined herein. If gaps in the system are agreed upon, the State has agreed to include further requirements in its plan documents, regulatory materials, and provider contracts with the CCOs and Counties to ensure that an adequate array of community services is available throughout the State to help individuals live successfully in the community and prevent their unnecessary institutionalization. If the State and the Department cannot agree upon gaps in the system, the Department reserves the right to continue its investigation. The State will continue to collect the data listed in the matrix, or other data that may be agreed to at that time, in order to fill the gaps and discern if gaps are being filled throughout the year.

Third, in year three of the agreement, the State and the Department will develop outcome measures that will be included in plan documents, contracts and regulatory materials. It is anticipated that these discussions will occur in early November, 2014. Throughout this year, the State will provide the data it collects on the measures in the matrix, to the Department.

Fourth, in year four of the agreement, the State and the Department will meet to discuss whether positive outcomes are being achieved on the agreed-upon outcome measures. If adjustments need to be made to the outcome measures, the State and the Department agree to engage in discussions about making those adjustments. It is anticipated that these discussions will occur in early November, 2015.

This agreement is without any admission of liability by the State, and it shall not be received or construed as an admission on any issue. Both parties reserve their rights in the event that they fail to reach agreement in the future on issues described in this agreement.

The State and the Department are optimistic that this iterative process will improve the lives of thousands of Oregonians with severe and persistent mental illness. It is contemplated that this process will successfully resolve the Department's investigation once an array of adequate community services is in place and positive outcomes are being achieved on agreed-upon outcome measures.

Enclosure (as noted)

Agreed to by the State:	Agreed to by the United States:
ELLEN F. ROSENBLUM Attorney General of the State of Oregon By: John Dunbar John J. Dunbar Attorney In Charge, Special Litigation Unit Oregon Department of Justice	S. AMANDA MARSHALL United States Attorney District of Oregon Jonathan M. Smith Chief Special Litigation Section Civil Rights Division

Oregon Health Authority – Addictions and Mental Health Division
United States Department of Justice (USDOJ) matrix

System Development Measures	Date Reported
1. # of CCOs that operate a single 24/7 behavioral crisis hotline.	April 1, 2013 October 15, 2013 Biennially thereafter
2. # of subcontractors with each CCO and the number of subcontractors with each County who offer each of the following behavioral health services: • Crisis hotline • Mobile crisis teams • Walk-in/drop-off crisis centers • Crisis apartments/respite • Short-term crisis stabilization units • Inpatient hospitals • Agreed-upon alternatives to above crisis services in frontier • Assertive Community Treatment (ACT) • Intensive case management (out of office) • Peer support • Supported employment • Psych-education and living skills training • Supported housing services, using definition provided by USDOJ for supported housing • Supportive housing services, using SAMSHA definition for supportive housing (or subset of SAMSHA definition such as single site housing) • Assessment (initial and review) • EASA	April 1, 2013 October 15, 2013 Biennially thereafter
3. # of adults with SPMI who utilized/received: • Crisis hotline • Mobile crisis teams • Walk-in/drop-off crisis centers • Crisis apartments/respite • Short-term crisis stabilization units • Inpatient hospitals • State Hospital	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

System Development Measures	Date Reported
• Agreed-upon alternatives to above crisis services in frontier • Assertive Community Treatment (ACT) • Intensive case management (out of office) • Peer support • Supported employment • Psych-education and living skills training • Supported housing services, using definition provided by USDOJ • Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition) • Non Title XIX supported housing services (subject to agreement on definition) Assessment (initial and review)	
4. # of service units per adult with SPMI per month for each of the following behavioral health services: • Case management • Peer support • Supported employment • Psych-ed and living skills training • Supported housing services, using USDOJ definition • Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition)	CCO: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter County: October 15, 2013 Quarterly thereafter
5. Housing: • # of available independent supported housing units for adults with SPMI, using USDOJ supported housing definition. • # of available supportive housing units for adults with SPMI, using SAMSHA supportive housing definition (or subset of SAMSHA definition)	April 1, 2013 October 15, 2013 Biennially thereafter
6. # adults with SPMI who reside in each of the following settings: • Own house • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition)	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

System Development Measures	Date Reported
• Adult foster home (AFH) • Residential treatment homes (RTH) • Residential treatment facilities (RTF) • Secure residential treatment facilities (SRTF) • State hospitals	
7. # of adults with SPMI: Moved from the state hospital, inpatient hospital, or residential care setting into an independent supported housing setting.	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
8. % of funding for community services spent for adults with SPMI living in supported housing for each of the following: • ACT • Intensive case management (out of office) • Peer support • Supported employment • Psych-Ed and living skills training • Assessment (initial and review)	CCO: April 1, 2013 October 15, 2013 Biennially thereafter Counties: October 15, 2013 Biennially thereafter
9. % of all service dollars spent for adults with SPMI that are used for care provided in: • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition) • AFH • RTH • RTF • SRTF • Inpatient hospital • State hospitals	CCO: April 1, 2013 October 15, 2013 Biennially thereafter Counties: October 15, 2013 Biennially thereafter

9.1. Amount of funds spent for EASA	April 1, 2013 October 15, 2013
10. % of adults with an identified SPMI who: • Have had a PCP visit within the past 12 months • Have a current care plan (e.g., has been reviewed and updated within the past XX months) • Have a current bio-psycho-social assessment • Have had a level of care assessment within the past 12 months	First Bullet: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Other Bullets: October 15, 2013 Annually thereafter
11. % of care plans for adults with SPMI that include a current crisis intervention plan.	October 15, 2013 Annually thereafter
12. # of behavioral health screen (e.g., depression, substance abuse) conducted by PCPs during initial health screens for newly enrolled adults (all adults enrolled in a CCO, not just adults with SPMI).	October 15, 2013 Annually thereafter
13. % of adults with SPMI who had a follow-up after hospitalization for mental illness within 7 days and within 30 days.	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
14. Conduct assessment of current Quality Assessment and Performance Improvement (QAPI) program and develop a plan for establishment of a QAPI program that integrates behavioral health and physical health at the state and individual CCO level. For the CCOs this includes development of contractual requirements related to QAPI.	October 15, 2013

15. Establishment of integrated QAPI structure (committee, staff) at state and individual CCO that includes expertise in the delivery of care to adults with SPMI.	April 1, 2013
16. Development and implementation of comprehensive data system (data warehouse) that allows for analysis of encounter/claims and client demographic/clinical data and monitoring of care delivered to adults with SPMI at level of individual client, individual provider, individual CCO and overall system of care.	October 15, 2013
17. Development of management reports and dashboards that monitor system performance for adults with SPMI.	April 1, 2013
18. Identification of Performance Improvement Projects (PIPs) that seek improvement in at least one of the identified areas of poor performance in the behavioral health system for adults with SPMI.	October 15, 2013 Annually thereafter
19. Identification of gaps, barriers, and needs of behavioral health as collected by CCOs and Counties. NOTE: CCOs are required to do a Community Health Assessment that identifies gaps and barriers and the counties are responsible for conducting a behavioral health community assessment. Both require plans to address gaps and needs. AMH has agreed to provide copies of those county plans in April 2013. OHA has taken significant steps in the past to increase outreach for Medicaid enrollment. OHA can provide a report of such actions and the outcomes of those efforts.	April 30, 2013 (copies of County plans)
SYSTEM DEVELOPMENT MEASURE (for third-year contract by OHA)	
1. # of CCOs that have formal agreements with law enforcement agencies or clear policies and procedures for coordination with and/or training of law enforcement.	3rd year of CCO contracts

Program Outcome Measures	Date Reported
1. Ability to effectively manage behavioral health crises in a community setting as measured by: a. # of emergency room visits for adults with SPMI in crisis b. # of inpatient hospital admits for adults with SPMI that are the results of a behavioral health crisis c. # of 30 and 180 day readmission rates for inpatient psychiatric care for adults with SPMI d. # of adults with SPMI who are referred/moved to the state hospitals e. # of adults with SPMI who are referred/moved to a SRTF, RTF, RTH and AFH from a less intensive setting f. Behavioral health crisis hotline call standards, e.g., 24/7 coverage, response rates of 5 rings/30 seconds, abandonment rate g. % of adults with SPMI (and or their family) that report positively about the system response to a behavioral health crisis event h. % of adults with SPMI show have a behavioral health crisis event who also had a crisis intervention plan	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Note: g. will be provided by November 30, 2013, based on current survey results.
2. Ability to provide access to behavioral health services in a community setting as measured by: # of service units per adult with SPMI per month for each of the following behavioral health services: o Case management o Peer support o Supported employment o Psych-ed and living skills training o Supported housing services, using USDOJ definition o Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition)	CCO: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Counties: October 15, 2013 Quarterly thereafter

Program Outcome Measures	Date Reported
3. Ability to provide access to adequate housing as measured by: • % of adults with SPMI living in supported housing, using DOJ definition (90 consecutive days in supported housing) • % of adults with SPMI living in supportive housing, using SAMSHA definition or subset (90 consecutive days in supportive housing) • % of adults with SPMI who are living in a setting that is at the appropriate level of care	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
4. # of adults with identified SPMI who reside in each of the following settings: • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition) • AFH • RTH • RTF • SRTF • State hospital	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
5. The average length of stay, admission rate, and readmission rate for adults with SPMI in each of the following settings: • State hospitals • Inpatient hospital setting • SRTF • RTF • RTH • AFH	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
6. % of adults with an identified SPMI who: • Received their first routine services with XX days of their initial assessment • Have had a PCP visit within the past 12 months • Are employed	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

Program Outcome Measures	Date Reported
• Have abstained from drug/alcohol use • Had a criminal justice event (jail, arrest, other interactions with law enforcement, etc.) • Had a homeless event	
7. % of adults with SPMI reporting positively about: • Their living environment • Their opportunity to improve their housing situation (e.g., supported housing) • Ability to access community-based behavioral health services • Outcomes (i.e., perception of care) • Improved level of functioning • Service quality and appropriateness • Social connectedness	November 15, 2012 (Current survey results) October 15, 2013 (next year's survey) Annually thereafter
8. % of adults receiving mental health services who filed complaints related to: • Quality of care (substantiated and unsubstantiated) • Access and availability to services • Effectiveness/appropriateness of services	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
9. QAPI programs at the state and CCO level: • Are successfully implemented and meet contractual requirements • Are able to demonstrate the operation of an effective system for continuous quality improvement (identification of areas for improvement, implementation of interventions, and improved outcomes)	October 15, 2013
10. The statewide comprehensive data system: • Includes accurate and timely encounter/claims/and client demographic/clinical data for adults with SPMI • Generates key management reports, including dashboards with program outcome scores (statewide and at individual CCO level).	October 15, 2013

Program Outcome Measures	Date Reported
11. The individual CCOs have methods that are able to: • Identify adults with SPMI who are high-risk (high need) and would benefit from intensive services • Generate key QAPI-related management reports, including those that are submitted to the State	October 15, 2013
12. Ability to provide access to behavioral health services in a community setting as measured by: • Time from enrollment to first encounter for adults receiving mental health services • % of primary care providers who report no difficulty obtaining behavioral health services for members	April 1, 2013 (first bullet) Quarterly thereafter October 15, 2013 (second bullet)

Serious and Persistent Mental Illness Definition

Addictions and Mental Health Division

AMH previously submitted a definition of Serious and Persistent Mental Illness (SPMI) based on defining this for the Medicaid population. The definition takes into account both the diagnosis and functioning. To define SPMI beyond the Medicaid population is more challenging due to the limits of CPMS, the current data system. CPMS only collects diagnostic impression which only captures broad diagnostic categories. For example, the data will indicate that someone has a Mood Disorder but will not distinguish between Major Depression and Depressive Disorder, NOS. This distinction is necessary to determine if the person has a SPMI. The new system COMPASS we will capture specific diagnoses that will enable us to select individuals, 18 or older based on the diagnoses listed below:

- Schizophrenia and other psychotic disorder: 295xx; 297.3; 298.8; 298.9
- Major Depression and Bi-Polar Disorder 296xx
- Anxiety Disorders: 300.3; 309.81 (PTSD and OCD)
- Personality Disorders: 301.22; 301.83 (schizotypal and borderline)

OR

Has one or more mental illnesses recognized by the current edition of the Diagnostic and Statistical Manual, excluding substance abuse and addiction disorders, and a GAF score of 40 or less that result from such illnesses.
This definition incorporates diagnosis and functional impairment and the elements in this definition will be captured in Compass.

Therefore, if the decision is to collect information on individuals that are enrolled in Medicaid **and** those that are not enrolled in Medicaid, then AMH will be able to collect data on individuals with SPMI after the implementation of COMPASS.

Supported Housing

United States Department of Justice

Supported housing is 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 supported housing, with no more than 20% of the units in any building to be occupied by individuals with a disability known to the State.

Supported housing has no more than two people in a given apartment or house, with a private bedroom for each person. If two people are living together in an apartment or house, the individuals must be able to select their own roommates.

Supported housing providers cannot reject individuals for placement due to medical needs or substance abuse history.

Supportive Housing Definition

Addictions and Mental *Health Division*

The Addictions and Mental Health Division will collect data for supportive housing based on the Substance Abuse and Mental Health Services Administration definition

Permanent Supportive Housing is the following:

Permanent. Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent;
Supportive. Tenants have access to the support services that they need and want to retain housing; and
Housing. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities [and can be] single-site housing, in which tenants who receive support services live together in a single building or complex of buildings with or without onsite support services; or scattered-site housing in which tenants who receive support services live throughout the community in housing that be agency-owned or privately owned."

"key elements" of supportive housing are:

- *"Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction."*
- *"Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability."*
- *"Participation in services is voluntary and tenants cannot be evicted for rejecting services."*
- *"House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community."*
- *"Housing is not time-limited, and the lease is renewable at the tenants' and owners' option."*
- *"Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market."*

- *"Housing is affordable, with tenants paying no more that 30 percent of their income toward rent and utilities, with the balance available for discretionary spending."*
- *"Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities."*
- *"Tenants have choices in the support services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences."*
- *"As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes."*
- *"Support services promote recovery and are designed to help tenants choose, get, and keep housing."*
- *"The provision of housing and the provision of support services are distinct."*

Source: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Evidence Based Practices Kit

U.S. Department of Justice

Civil Rights Division

JMS: JP: JP: LL
DJ 168-61-30

Special Litigation Section - PHB
950 Pennsylvania Ave, NW
Washington DC 20530

March 11, 2015

VIA FIRST CLASS MAIL AND ELECTRONIC MAIL

John Dunbar
Markowitz Herbold PC
1211 SW Fifth Avenue, Suite 3000
Portland, OR 97204-3730

Re: Oregon's Status Resolving the U.S. Department of Justice's Investigation into Oregon's Mental Healthcare System

Dear Mr. Dunbar:

We write in connection with our ongoing negotiations with state officials regarding the U.S. Department of Justice's investigation of Oregon's compliance with the integration mandate of Title II of the Americans with Disabilities Act ("ADA") and *Olmstead v. L.C.*, 527 U.S. 581 (1999), as it applies to adults with mental illness. As anticipated in our November 9, 2012 letter, the Department and the State continue to work cooperatively to resolve our investigation. The United States agreed to this collaborative effort because of Oregon's stated commitment to develop the infrastructure and services which will allow individuals with serious and persistent mental illness to live integrated lives in the community, maintain safe and stable housing and employment, and avoid outcomes such as homelessness, jail, and unnecessary hospitalizations and institutionalization. As provided in our 2012 letter, we are currently working to develop outcome measures which the State must meet in order to resolve the Department's investigation. These outcome measures will be crucial in demonstrating whether Oregon is in compliance with the ADA's integration mandate.

Since Oregon and the Department began our work together, the State has begun to lay the foundations to improve its mental health system. We commend the State's progress in a number of areas. First, Oregon has significantly increased the number of individuals who have healthcare coverage under the Oregon Health Plan. We applaud the State's work to provide healthcare coverage for vulnerable individuals. Second, the Addictions and Mental Health Division ("AMH") has rolled out the Measures and Outcomes Tracking System (MOTS), an electronic data system for behavioral health providers. There are now more than 127,000 individuals enrolled in MOTS. This system has the capacity to address one of the Department's key concerns about Oregon's historic failure to collect statewide data about the mental health services it funds and the individuals receiving those services. We look forward to MOTS being fully developed for utility with providers. We are similarly encouraged by the new Emergency

Department Information Exchange system AMH is unveiling, which will provide hospital emergency departments with key information for the treatment of individuals with mental illness. We also appreciate AMH's efforts to develop a strategic plan under the leadership of Pam Martin, the Director for Addictions and Mental Health.

There are several key areas that we continue to watch closely as we embark on an agreement regarding outcome measures: development of reliable baseline data; the population of the State Hospitals; fidelity and outcomes of Assertive Community Treatment teams; supported housing; crisis services and jail diversion; supported employment; peer services; and delivery of care in frontier regions.

Development of Baseline Data

We are pleased that the State has begun to collect and report data on the areas agreed upon in our data matrix. This data is providing us with critical information regarding Oregon's use of institutions and community-based mental health services, and once the State achieves consistency in its reporting, such data will provide us with baseline data that we can use to track outcome measures. However, it is concerning that there were significant discrepancies in certain data points between the October 2014 and January 2015 reports – purportedly reporting on the exact same time periods. For example, in the October 2014 report, AMH reported that in the first quarter of 2014 there were 4,256 emergency room visits by Medicaid-enrolled adults with mental illness. In the January 2015 report, AMH revised that number for the same quarter to 3,447 – a decrease of more than 800. In another example, in the October 2014 report, AMH reported that in the third and fourth quarters of 2013, 415 and 455 individuals with SPMI received supported employment services, respectively. Yet, in the January 2015 report, AMH reported that for the exact same time periods – the third and fourth quarters of 2013 – more than 1,000 individuals with SPMI received those services during each of those quarters. These shifts in data that are supposed to be reporting on the exact same periods of time illustrate that we still do not have true baseline data. Our November 2012 letter contemplated that we would have this baseline data by October 2013, but as of March 2015, we do not yet have reliable baseline data for important measures. By necessity, because we are more than a year past a key agreement deadline, the timelines in our November 2012 resolution must be extended. As we move forward with an agreement to track outcome measures, it will be critical to have data upon which we can all rely in order to determine whether Oregon is meeting the agreed-upon outcome measures.

State Hospital Population

The population at the Oregon State Hospital has decreased since the start of our investigation. We are pleased with the State's current success in this key area. However, as previously stated, we have serious concerns about the State's development of another state hospital institution at Junction City, when the resources necessary to resolve this investigation must be focused on increased community-based services.

Assertive Community Treatment

We are cautiously optimistic of the State's expansion of critical community-based services under the 2013 Investments in Community Mental Health. These investments included expanded Assertive Community Treatment (ACT) services, mobile crisis services, supported housing, and jail diversion programs. While it is too early to see results of these investments in the data that we have been provided, we are encouraged that the State is investing in these critical areas. If the State continues to expand these services and provides that they have the intended outcomes, it will address many of the concerns raised in our investigation. We encourage the State to utilize these cost effective, evidence-based practices for solving the vicious cycle of institutionalization of vulnerable populations in the jails and hospitals.

As noted above, the State has expanded its ACT services, and it is committed to increasing the provision of ACT services across Oregon. The developments around ACT are encouraging, including the creation of the Oregon Center of Excellence for Assertive Community Treatment, the expansion of the number of ACT teams statewide, the use of fidelity reviews, and the creation of an ACT team for a forensic population. However, the State's data shows that many ACT teams are still not meeting fidelity, and that caseloads for most ACT teams are well below that of full-fidelity ACT services. Further, there still are not nearly enough ACT services across the State. Indeed, according to the most recent data we have been provided, just 460 individuals across the State received ACT services during the second quarter of 2014. Moreover, as we have emphasized in meetings and in our August 8, 2014 letter, the State must confirm that ACT achieves the desired outcomes for the individuals receiving those services. We encourage you to begin assessing outcomes for ACT services. In addition, we urge you to ensure that appropriate high-intensity services are available for individuals with mental illness in the State's frontier regions.

Supported Housing

It is also critical that the State continue to increase its investments in integrated, community-based supported housing for individuals with serious mental illness. The 2013 Mental Health investments provide for rental assistance and for the development of 32 units of housing for individuals with serious mental illness. However, there is still a dearth of supported housing, as is evidenced by the fact that of the 115 individuals who were discharged from the Oregon State Hospital in the first half of 2014, just 3 or 4 were discharged to supported housing. Disturbingly, more than half of those individuals leaving the state hospital were moved to another institutional setting, and two individuals were discharged to homelessness.

Crisis Services and Jail Diversion

It is vital that the State work collaboratively with local agencies to develop strategies to address services for individuals experiencing mental health crises and to prevent their unnecessary hospitalization and incarceration. For example, the State must make efforts to provide that individuals with mental illness do not end up arrested or incarcerated due to their mental illness. As memorialized in our May 12, 2014 letter, AMH had committed to partnering with local law enforcement agencies statewide to develop its crisis system and was evaluating

how partnerships might occur through the Local Public Safety Coordinating Councils. AMH had further committed to drafting a comprehensive plan to establish agreements between providers and law enforcement agencies by July 2014 and to implementing that plan by January 2015. To our disappointment, these steps have not occurred. We are concerned with AMH's lack of progress in working with local law enforcement and other community partners, beyond providing some grant funding.

While AMH has not taken the lead in this area, we are aware of some promising models in Oregon. For example, the Marion County mental health system, sheriff's office, police department, and court system are working together to provide services to individuals in mental health crisis and to avoid their unnecessary arrests. These services respond directly to our concerns. We encourage AMH to explore these and other models further, to help bring these models to scale and to provide that these services are available statewide. We appreciate that AMH has committed to meet with sheriffs and other local law enforcement as it continues to explore these areas, and we look forward to further work and investments in this area.

Supported Employment

The State has increased its investment in supported employment services, and it is providing data by county and conducting fidelity reviews. However, we still are not receiving information which the State committed to provide in May 2014 regarding the number of individuals with serious and persistent mental illness who are competitively employed. This data is necessary in order to evaluate the success of any of these programs. Additionally, there are significant swaths of the State where there are no providers of supported employment services.

Peer Delivered Services

We applaud the State's increased focus on peer-delivered services, including the creation of an Office of Consumer Affairs and the development of a peer certification process. We have seen the effectiveness of peer-delivered services in other jurisdictions, and we urge the State to further incorporate these services throughout its mental health programs, such as in walk-in centers for crisis stabilization, and through warm-lines utilized for telecare.

Frontier Services

Finally, there are still significant gaps in the provision of services in the frontier areas. This is especially problematic with regard to crisis services, ACT, jail diversion, and supported employment services. In order to resolve the Department's investigation, the State must ensure that appropriate services are available to all individuals with serious and persistent mental illness, and we look forward to discussions with you concerning services in the frontier.

Conclusion

This is a critical time for the reform effort. While we are encouraged by some of the State's efforts, there are key areas of community-based services where the State needs to increase its efforts to achieve compliance with the ADA's integration mandate. Those investments are both evidence-based and provide the public health system a significant cost savings to institutional care. We urge the State to be ambitious in developing the high-intensity community services and supports that are necessary so that Oregonians with serious and persistent mental illness can live in the most integrated setting appropriate to their needs.

Sincerely,

BILLY J. WILLIAMS
Acting United States Attorney
District of Oregon

JONATHAN SMITH
Section Chief
Special Litigation Section
Civil Rights Division