Oregon Performance Plan
Semi-Annual Narrative Report
July 2018

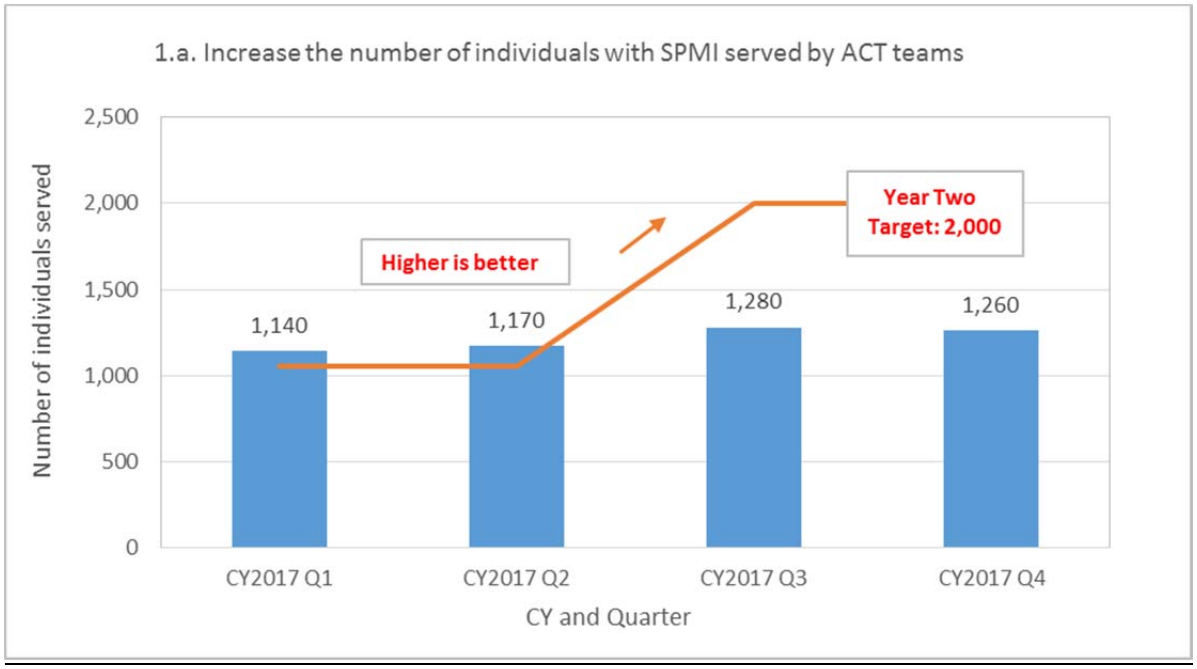
The Oregon Performance Plan (OPP) requires that Oregon Health Authority (OHA) provide data to USDOJ on a quarterly basis and a narrative report about the data every six months. This is the second semi-annual report about data.

For each of the data metrics, this report will describe the calendar year 2015 Baseline Data (if applicable and available), the target for the time period reported (if applicable) the methodology for collecting the data, and the progress of each metric for the quarter ending 12/31/2017. At the end of each section, this report will describe the activities associated with the metric(s) in that section. This report does not review or discuss requirements related to OHA's implementation of various processes. However, those processes may be referenced if related to the data metrics. Some of the metrics in the OPP require baselines to be established since there are percentage improvement targets. The other metrics have baselines to inform the review of progress, and numeric annual targets are provided for a number of the metrics. While OHA has detailed implementation plans associated with the OPP, only some of the implementation activities are highlighted in this report.

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

Assertive Community Treatment (ACT)

#1 (a-b) Number Served with ACT



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

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

Comment on Progress

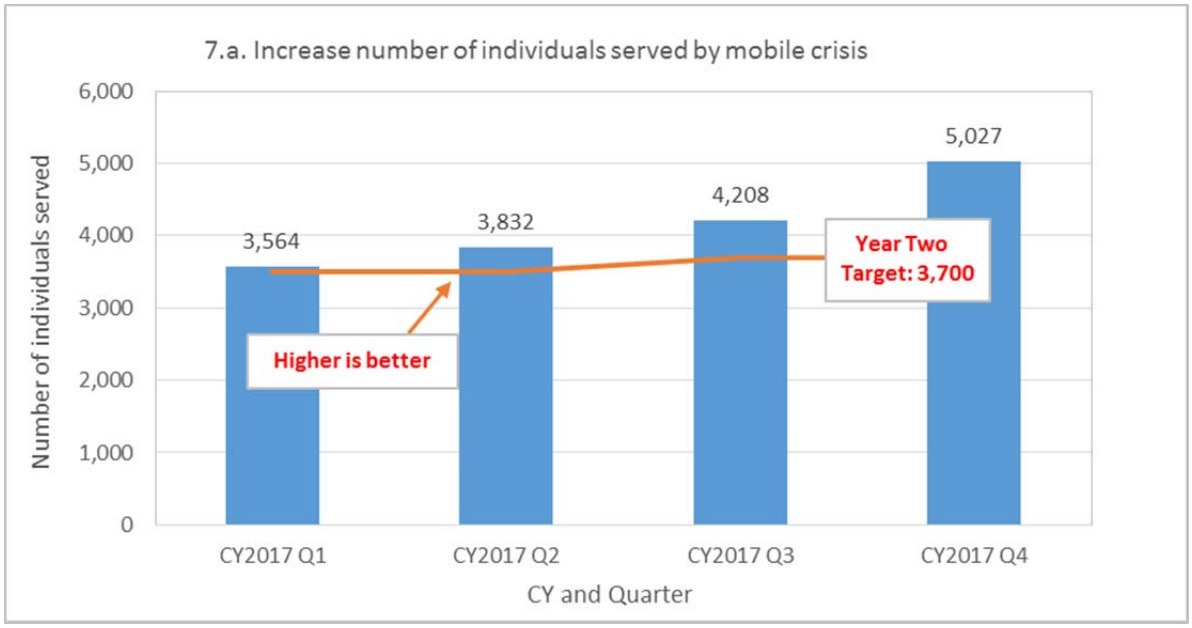
Pursuant to the OPP, OHA will increase the number of individuals with SPMI served by ACT teams. OHA will provide ACT services to everyone who is referred to and eligible for ACT, and will meet a metric so that 2,000 individuals will be served by the end of fiscal year two (June 30, 2018). As of the quarter ending 12/31/17, 1,260 individuals were served by ACT. OHA appears behind pace on this this metric, but is taking steps to address this. Those steps are described in the section below.

Activities Associated with Metric

OHA continues to partner with the Oregon Center of Excellence for ACT (OCEACT) to ensure individuals eligible for ACT services receive ACT services. OCEACT and OHA are working individually with metro area counties to increase access and capacity of ACT services. OHA is also working on improving the language in the CCO 2019 Contract to better align with the provisions of the OPP.

Crisis Services

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



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

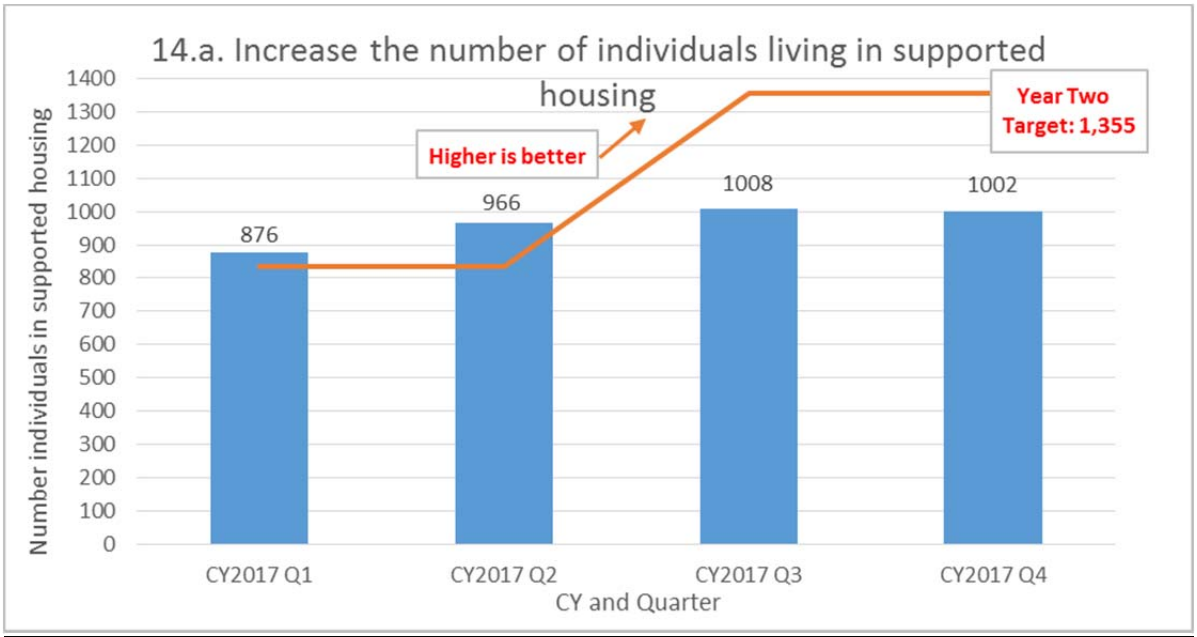
Comments on Methodology
Up through this report, OHA is capturing mobile crisis services utilizing the Measures and Outcomes Tracking System (MOTS). The number of individuals receiving these services is unduplicated. For instance, if the same individual received mobile crisis services multiple times through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

Comment on Progress
Pursuant to the OPP, OHA will increase the number of individuals served with mobile crisis services, so that during fiscal year two (July l, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis. There were 5,027 individuals who received mobile crisis services during the quarter ending 12/31/17.

Activities Associated with Metric
The 2017 Legislature allocated $15 million to OHA to address the needs in the Oregon Performance Plan. Approximately $10 million of the $15 million is being used to increase mobile crisis services to address statewide coverage. The funding has been allocated through the County Financial Assistance Agreement (CFAA). Programs are working to implement mobile crisis services with the new funding. This is an area of the OPP that was included in the Independent's Consultant June 2018 Site Visit. We will be working with the IC to improve mobile crisis services based on information obtained during the Site Visit.

Supported Housing

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



Baseline (Calendar Year 2015)
As of the end of calendar year 2015, there were 442 individuals living in Supported Housing.

Comments on Methodology
Supported Housing is calculated using a combination of Supported Housing units developed and occupied and individuals receiving rental assistance in existing affordable housing units that meet the definition of Supported Housing. The Rental Assistance provider reporting requirements were enhanced this year to distinguish individuals in Supported Housing and those in Supportive Housing. For the Rental

Assistance Program, although data are collected on both supported and supportive housing, only the Supported Housing is counted. This is then combined with units of Supported Housing that have been developed, for a combined overall count.

Comments on Progress

Pursuant to the OPP, OHA's housing efforts will include an increase in the number of individuals with SPMI in Supported Housing, in fiscal year two (July 1, 2017 to June 30, 2018), so that at least 1,355 individuals will live in supported housing. As of 12/31/17 there were 1,002 individuals residing in Supported Housing. To meet the year two, June 30, 2018 target of 1,355, OHA will have to increase that number by 353 individuals. OHA appears behind pace on this this metric. Steps taken to address the performance on this metric are described in the section below.

OHA also tracks the number of individuals with SPMI receiving Supportive Housing, applying the definition for that term found in the November 2012 letter of agreement with USDOJ. Supportive Housing is another form of housing support provided to the SPMI population. As of 12/31/17, there were 1,361 individuals with SPMI living in Supportive Housing in addition to those living in Supported Housing.

OHA is also maintaining an inventory of affordable housing statewide, available at http://www.oregon.gov/oha/amh/Pages/affordable_housing.aspx. As of the end of calendar year 2017, there were 54.615 units of affordable housing throughout Oregon. This is an increase from the baseline at the end of calendar year 2015 of 1.290 units.

Activities Associated with Metric(s)

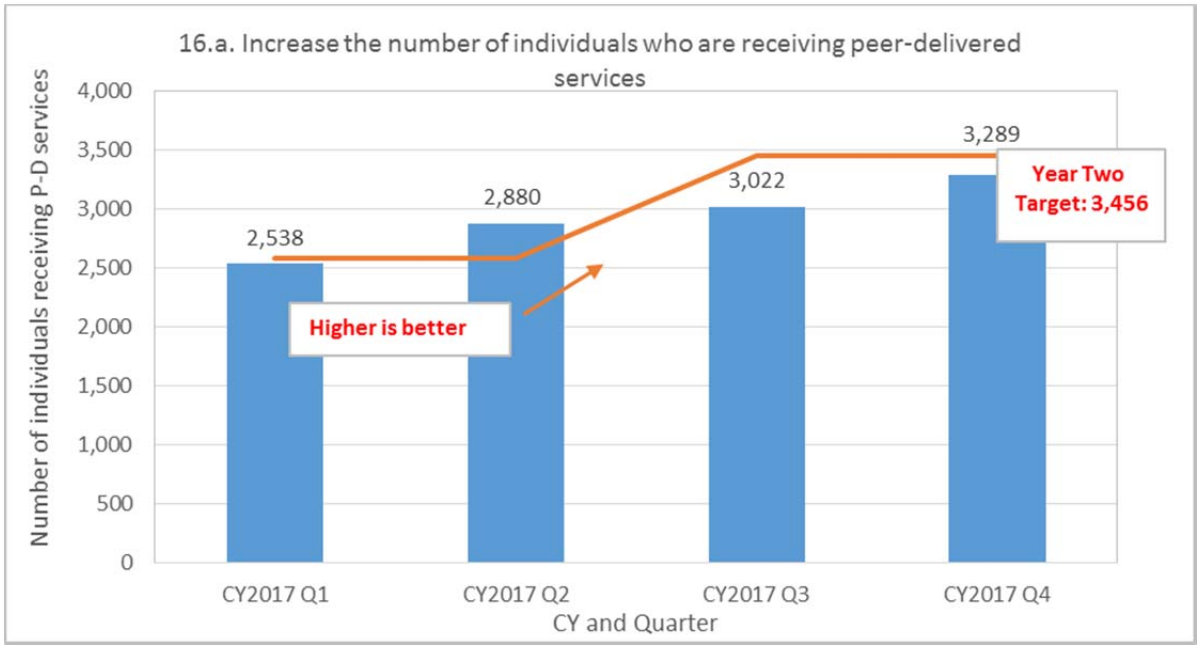
OHA continues to work on increasing Supported Housing. OHA meets quarterly with the Technical Assistance Collaborative (TAC) to develop strategies and mitigate challenges.

OHA continues to work with Oregon Housing and Community Services (OHCS) to increase Supported Housing opportunities. Using traditional competitive funding rounds, as of February 2018, OHCS in collaboration with OHA had awarded $11.2 of the $20 million provided by the 2015 Legislature for development of Supported and Supportive Housing. The most recent round of Notice of Funding Availability was veteran focused. $700,000 of the Mental Health Housing Fund (MHHF) was awarded to three Substance Use Disorder projects; however, no projects proposing to serve Veterans with SPMI were funded. OHA and OHCS brokered an

agreement to braid $2.5 million of OHCS's MHHF into OHA's Community Mental Health Housing Trust Fund, Mental Health Services Fund, and General Fund to increase Supported and Supportive Housing. OHA released its application with the combined OHCS and OHA funds in May 2018. The application described the importance of integrated housing and incented Supported Housing over Supportive Housing, by awarding a higher unit subsidy. A combined total of up to $5 million was made available in two separate applications, one for serving people with substance use disorder and one for serving people with SPMI. For SPMI, the amount available was $3.06 million. Applications closed July 18, 2018 and are currently under review.

Peer Delivered Services (PDS)

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



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

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

Comments on Progress

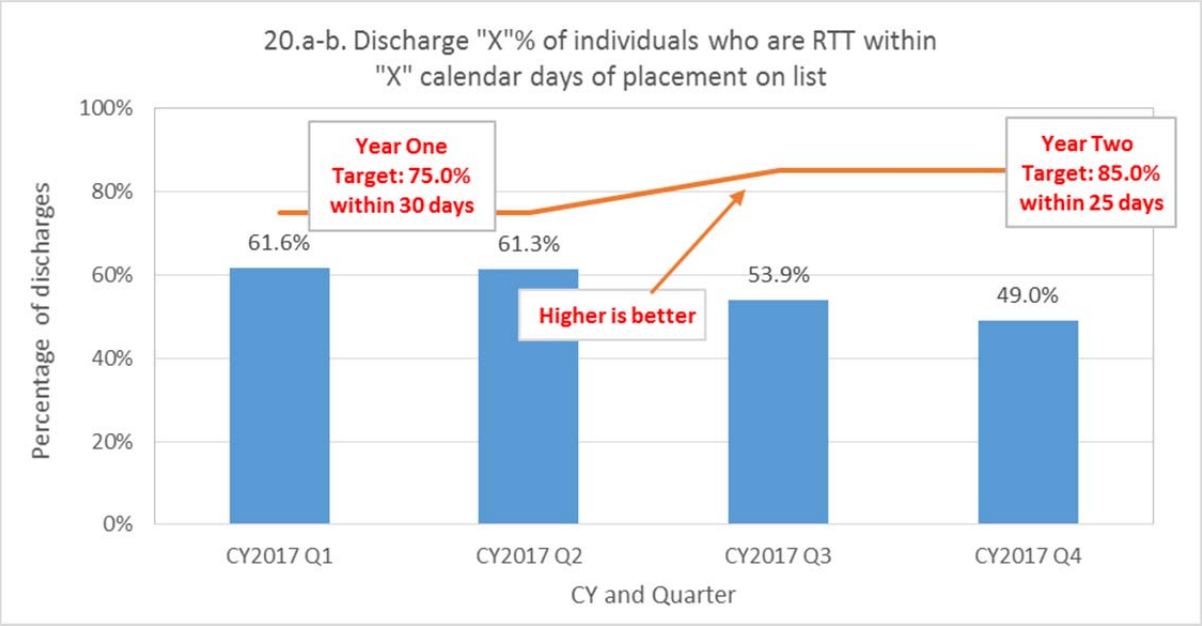
Pursuant to the OPP. OHA will increase the availability of PDS, in that by the end of fiscal year two (June 30, 2018), OHA will increase the number of individuals who are receiving PDS by an additional 20% more than the actual number at the end of fiscal year one, that is, the higher number of 3,456 individuals. As of 12/31/17, there were 3,289 individuals who received PDS. PDS continues to show an increase.

Activities Associated with Metric(s)

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

Oregon State Hospital (OSH)

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



Baseline (Calendar Year 2015)

The cumulative percentage of civilly committed patients discharged within 30 days of being placed on the Ready to Transition (RTT) list was 51.7% for the 12-month

period ending December 31, 2015. This includes one individual that was discharged shortly after the 30 days due to a weekend/holiday.

Comments on Methodology

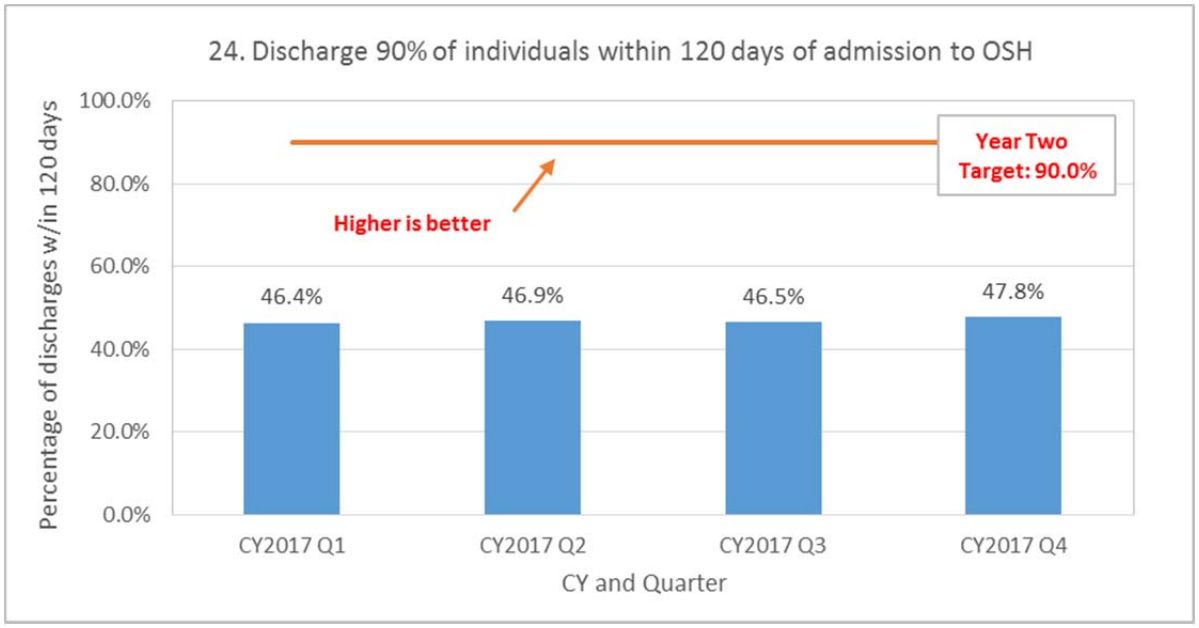
In order to provide the most accurate RTT data possible, a new tracking system was developed and implemented as part of the OSH Electronic Health Record (Avatar) on July 1, 2016.

Comments on Progress

Pursuant to the OPP, by the end of fiscal year two (June 30, 2018), 85% of individuals who are Ready to Transition (RTT) will be discharged within 25 calendar days of placement on that list. As of 12/31/17, the cumulative percentage of those discharged within 25 days of being placed on the RTT list was 49.0%. This percentage is down as of the middle of year two due to the increased targeted percentage of individuals and the shorter number of days within which discharge is targeted to occur. Efforts to address the shortfall on OSH metrics are addressed on page 11, in the section "Activities Associated with Metric(s)."

There were 2 total number of discharges that were extended to and occurred on the business day following a weekend day or holiday.

#24 Percentage Discharged within 120 Days



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

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

Comments on Progress
As of 12/31/17, the cumulative percentage of discharges within 120 days of admission was 47.8%.

Activities Associated with Metric(s)
OHA continues to work internally with OSH and also externally with Choice program contractors. There have been several process improvements since the revision of the Choice contract, which incorporated these OPP metrics as incentive payments. We are currently working on revisions to the Choice contract for the 2019-2021 biennium. While performance on this metric has improved somewhat, OHA is committed to improving this metric further and will be including the fiscal year three metric in the 2019-2021 Choice contract, which reads 90% of individuals who are Ready to Transition will be discharged within 20 calendar days of placement on that list.

A Memorandum of Understanding has been agreed to between OSH and the Health Systems Division (HSD) responsible for managing the Choice contracts, to improve timely discharge. OSH and HSD will be meeting regularly to ensure traction on the metrics specific to OSH.

OHA has transitioned the continued stay (90-day and subsequent 45-day) review process to one of its contractors (KEPRO). That review process is going well and all reviews are current.

OSH Salem and Junction City welcomed independent reviewers during the OPP June 2018 Site Visit, conducted by the Independent Consultant Review Team. During this visit, OSH made available charts for review as well as demonstrated

processes used at OSH and looks forward to continued conversations with the Independent Consultant on her recommendations moving forward.

Acute Psychiatric Care

#29 Percentage Receiving Warm Handoff

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

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

Comments on Progress
Pursuant to the OPP, by the end of fiscal year two (June 30, 2018), 75% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider. As of 12/31/17, the cumulative percentage of those who received a warm handoff was 27.7%. OHA has begun discussions with the Oregon Association of Hospitals and Health Systems (OAHHS) to assure performance on this metric improves over time. OHA is behind pace on this metric. Steps being taken to address this are described at page 14, in the section for "Activities Associated with Metric(s)."

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

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

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

Comments on Progress

The OPP provides that OHA will continue to require that individuals receive a follow-up visit with a community mental health provider within 7 days of discharge, and that OHA will report this data. As of 12/31/17, the percent of individuals receiving follow up within seven days was 77.8%. Oregon still continues to do well as compared to other states. According to the 2015 Benchmarks and Thresholds Report by the National Center for Quality Assurance (NCQA), the Medicaid national 90th percentile was 70%. Oregon's numbers continue to be above the 90th percentile.

#31 (a) Readmission Rates

Baseline (Calendar Year 2015)

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

Comments on Methodology

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

Comments on Progress

As of 12/31/17, the cumulative percentage rates of readmission at 30 and 180 days were 10.8% and 22.9% respectively. See Appendix C for the breakout by hospital.

#35 Average Length of Stay

Baseline (Calendar Year 2015)

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

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

Comments on Progress
As of 12/31/17, the cumulative average length of stay of individuals with SPMI discharged from acute psychiatric care facilities was 11.4 days. When broken down by hospital, the range of length of stays at the 12 acute psychiatric care facilities ranges from 7.4 to 14.0 days. Of the 4,486 discharges, the length of stay for 529 (11.8%) of them exceeded 20 days. Of the 529, 145 were on the OSH Waitlist. See Appendix D for the detail by hospital.

Activities Associated with Metric(s)
OHA continues to work with the OAHHS regarding the revised Oregon Administrative Rules addressing the Warm Handoff requirement. OHA staff along with Independent Consultant Pam Hyde and a representative from Health Insights attended a meeting in February 2018 with the Metro Area Council on Acute Care to discuss warm handoffs. OHA continues to engage with the Acute Care Hospitals and Health Insights to better understand the barriers. Upon preliminary review, the low percentage of warm handoffs appears to be partly a documentation issue. Processes are being discussed to make improvements to promote consistent documentation across hospitals.

Emergency Departments (ED)

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

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

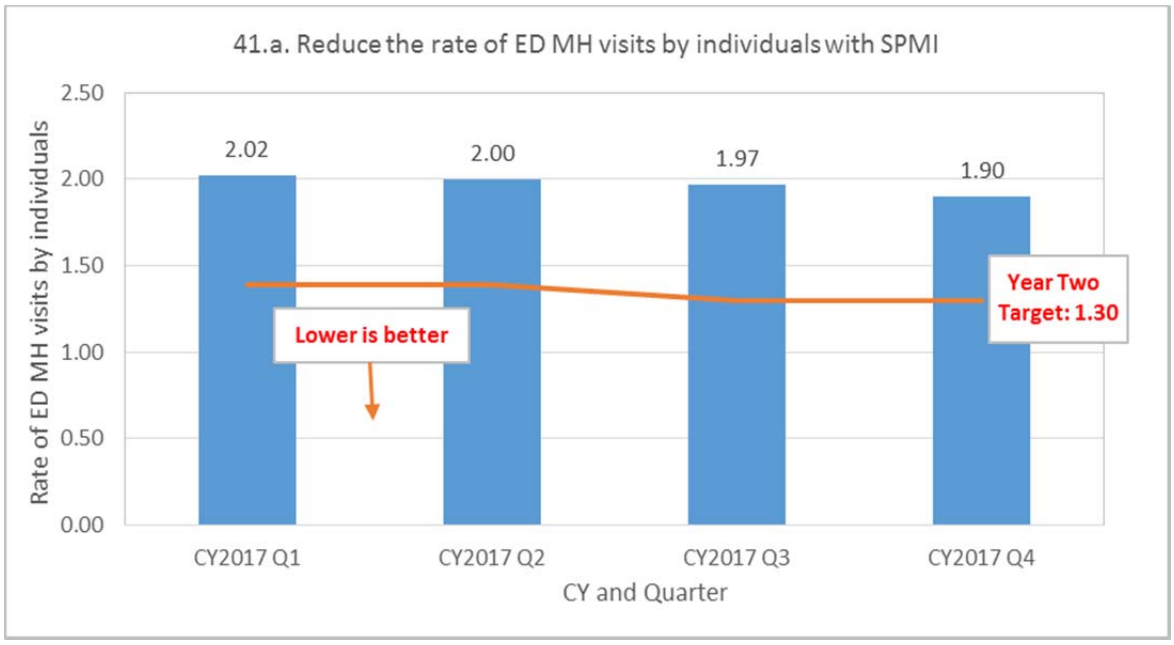
Comments on Methodology

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

Comments on Progress

As of 12/31/17, 935 individuals with SPMI were readmitted to the ED two or more times in a six-month period. There is no target associated with this metric.

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



Baseline (Calendar Year 2015)

During calendar year 2015, the rate was 1.54 persons per 1000 OHP members who visited the ED for psychiatric reasons. The red line in the chart above is the target number. The blue bar shows the actual performance OHA has been able to measure thus far. OHA continues to study the performance on this metric and the reasons behind these numbers, as described below.

Comments on Methodology

The OPP provides that OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, and that by the end of fiscal year two (June 30, 2018), there will be a 20% reduction from the baseline. The rate of ED visits for mental health reasons is the number of

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

Comments on Progress

As of 12/31/17, 1.9 individuals per 1,000 OHP members with SPMI visited the ED for mental health reasons. This rate has remained approximately the same for the last few reporting periods.

Activities Associated with Metric(s)

Initial analysis identifies the metro area and Fee-For-Service members are the highest utilizers of this service. OHA will continue to work with its system partners to further understand what is impacting the rate.

Supported Employment

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

Baseline (Calendar Year 2015)

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

Comments on Methodology

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

Comments on Progress

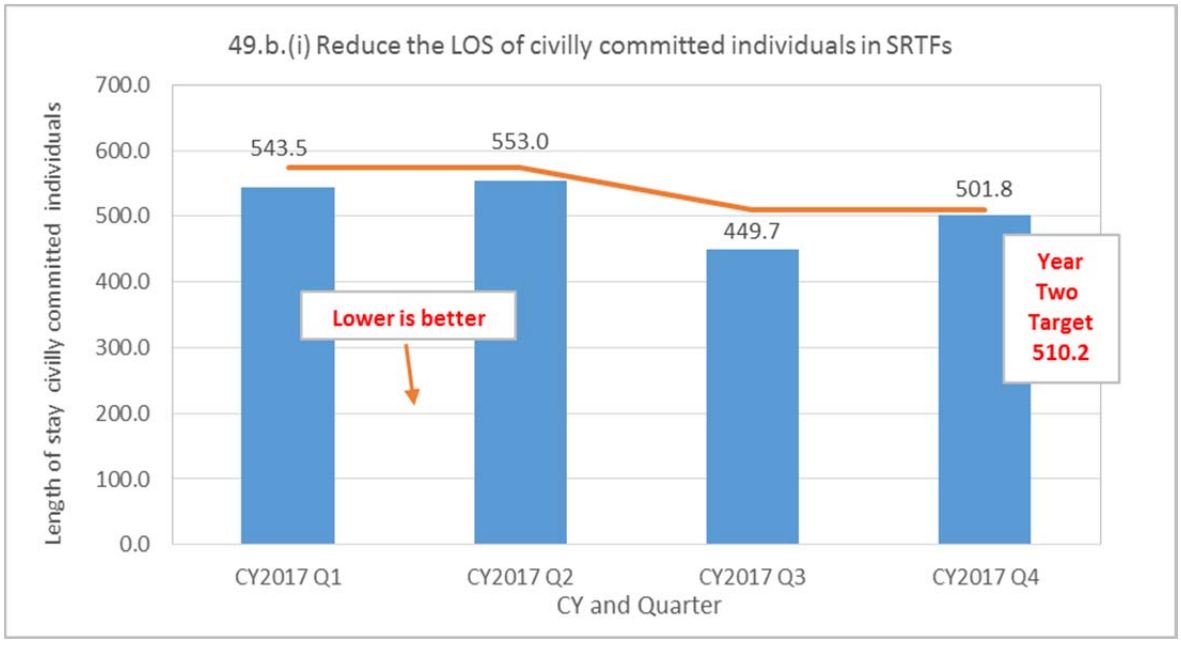
Pursuant to the OPP, OHA will report the number of persons receiving Supported Employment who are employed in CIE and the number of individuals who no longer receive Supported Employment and are employed in CIE. As of 12/31/17, 756 individuals were receiving Supported Employment services and employed in CIE. There were 127 individuals who no longer receive Supported Employment

and are employed in CIE without currently receiving supportive services from a Supported Employment specialist.

Activities Associated with Metric(s)
OHA will continue to work with the Oregon Supported Employment Center of Excellence to monitor fidelity and provide technical assistance.

Secure Residential Treatment (SRTF)

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



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

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

Comments on Progress
Pursuant to the OPP, OHA will seek to reduce the length of stay of civilly committed individuals in secure residential treatment facilities, in that by the end of fiscal year two (June 30, 2018), there will be a 10% reduction from the baseline. As of 12/31/17, the average length of stay for an individual who was civilly committed and discharged from an SRTF was 501.8 days. While the length of stay has increased since last quarter, it is still significantly below baseline. This increase may in part reflect efforts to assure that those who can be served in more integrated settings have been transitioned to other settings or are no longer being admitted to SRTFs.
Activities Associated with Metric(s)

OHA's contractor (KEPRO) continues to perform prior authorizations for individuals referred to SRTF from OSH as well as the continued stay reviews for individuals receiving treatment in an SRTF. OHA is working with its contractors to assure only those who need this intensive a level of care are admitted and to promote timely discharge from SRTFs for those who can transition safely to more integrated settings.

Criminal Justice Diversion (CJD)

#52 (a) Numbers Served With Jail Diversion

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

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

Comments on Progress
Pursuant to the OPP, OHA will continue to report the number of individuals with SPMI receiving jail diversion services and the number of reported diversions. As of 12/31/17, 1,766 individuals received diversion services, an increase over the

baseline year of 357 individuals. Of these 1766 individuals, 350 were pre-booking and 1,416 were post-booking. The Independent Consultant's Review Team spent considerable time during its June Site Visit reviewing Criminal Justice Diversion programs and doing chart reviews of individuals receiving such services. OHA will work with the Independent Consultant to determine ways to improve services and to assure consistency in reporting of pre- and post-arrest services for adults with SPMI.

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

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

APPENDIX A

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

Report Quarter	Previous Rolling One-Year Period
Q1 (January)	July 1 to June 30 of the previous year
Q2 (April)	October 1 to September 30 of the previous year

Q3 (July)	January 1 to December 31 of the previous year
Q4 (October)	April 1 to March 31 of the previous year

Oregon Performance Plan
July 2018 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACT*	1a	OHA will increase the number of individuals with SPMI served by ACT teams.	1,050 individuals will be served by the end of year one (June 30, 2017).	815	1,050		1,098	1,120	1,140	1,170
	1b		2,000 individuals will be served by the end of year two (June 30, 2018).	*n/a*	*n/a*	2,000	1,280	1,260		
Crisis	7a	OHA will increase the number of individuals with mobile crisis services, as follows:	During year one (July 1, 2016 to June 30, 2017), 3,500 people will be served by mobile crisis.	3,150	3,500	*n/a*	3,587	3,472	3,564	3,832
	7b		During year two (July 1, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis.	*n/a*	*n/a*	3,700	4,208	5,027		
Crisis*	8c	OHA will track and report the number of individuals receiving a mobile crisis contact.	By the end of year two (June 30, 2018), Oregon will report the number of individuals whose dispositions after contact with mobile crisis result in:	*End of year two deliverable*						
			stabilization in a community setting rather than arrest							
			presentation to an emergency department							
			admission to an acute care psychiatric facility							
SH*	14a	OHA's housing efforts will include an increase in the number of individuals with SPMI in supported housing, as follows:	In year one (July 1, 2016 to June 30, 2017), at least 835 individuals will live in supported housing.	442	835	*n/a*	767	834	876	966
	14b		In year two (July 1, 2017 to June 30, 2018), at least 1,355 individuals will live in supported housing.	*n/a*	*n/a*	1,355	1,008	1,002		
	14c		In year three (July 1, 2018 to June 30, 2019), at least 2,000 individuals will live in supported housing.	*Year Three Deliverable*						
PDS	16a	OHA will increase the availability of peer-delivered services, as follows:	By the end of year one (June 30, 2017), OHA will increase the number of individuals who are receiving peer-delivered services by 20%.	2,156	2,587	*n/a*	2,434	2,461	2,538	2,880
	16b		By the end of year two (June 30, 2018), OHA will increase the number of individuals who are receiving peer-delivered services by an additional			3,456	3,022	3,289		

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

Oregon Performance Plan
July 2018 Data Report
Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
OSH	20a	Discharge from OSH will occur as soon as an individual is ready to return to the community, as follows:	By the end of year one (June 30, 2017), 75% of individuals who are Ready to Place/Ready to Transition will be discharged within 30 calendar days of placement on that list.	51.7%	75.0%	*n/a*	55.4%	59.6%	61.6%	61.3%
	20b		By the end of year two (June 30, 2018), 85% of individuals who are Ready to Place/Ready to Transition will be discharged within 25 calendar days of placement on that list.	61.3%	*n/a*	85.0%	53.9%	49.0%		
	20c		By the end of year three (June 30, 2019), 90% of individuals who are Ready to Place/Ready to Transition will be discharged within 20 calendar days of placement on that list.	57.7%	*n/a*	*n/a*	*Year Three Deliverable*			
	20e		OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday. (FY1)	*Baseline Not Applicable*	*Measure without Target*	*n/a*	0	1	1	1
			OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday. (FY2)	*n/a*	*n/a*	*n/a*	5	2		
OSH	24		At the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission.(FY1)	37.8%	90.0%	n/a	41.5%	41.7%	46.4%	46.9%
			At the end of year one (June 30, 2017), OSH will discharge 90% of individuals within 120 days of admission.(FY2)			90.0%	46.5%	47.8%		
ACUTE	29a		By the end of year one, (June 30, 2017), 60% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Baseline Not Applicable*	60%	*Not Available*				
	29b		By the end of year two, (June 30, 2018), 75% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.			75.0%	21.4%	27.7%		
	29c		By the end of year three, (June 30, 2019), 85% of individuals discharged from an acute care psychiatric facility will receive a warm handoff to a community case manager, peer bridger, or other community provider.	*Year Three Deliverable*						

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Note: Light yellow shading indicates Year 2 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACUTE	30		OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge, and OHA will report this data. (FY1)	79.4%	*Measure without Target*		71.5%	72.0%	73.0%	74.20%
			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. (FY2)	*n/a*	*n/a*	*Measure without Target*	75.7%	77.8%		
ACUTE	31a		OHA will monitor and report the 30 day rates of readmission, by acute care psychiatric facility. (FY1)	9.2%	*Measure without Target*		10.9%	11.1%	10.3%	10.60%
			OHA will monitor and report the 30 day rates of readmission, by acute care psychiatric facility. (FY2)	*n/a*	*n/a*	*Measure without Target*	11.0%	10.8%		
			OHA will monitor and report the 180 day rates of readmission, by acute care psychiatric facility. (FY1)	21.3%	*Measure without Target*		22.6%	22.6%	22.7%	22.80%
			OHA will monitor and report the 180 day rates of readmission, by acute care psychiatric facility. (FY2)	*n/a*	*n/a*	*Measure without Target*	23.8%	22.9%		
ACUTE	31b 32		Two or more readmissions to acute care psychiatric hospital in a six month period. (FY1)	*Baseline Not Applicable*	*Data for Process Measure*	*Data Not Available*		346	280	284
			Two or more readmissions to acute care psychiatric hospital in a six month period. (FY2)	*n/a*	*n/a*	*Data for Process Measure*	305	314		

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Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
ACUTE	35		OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital. (FY1)	8.9	*Measure without Target*		9.6	9.6	11.0	11.24
			OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital. (FY2)	*n/a*	*n/a*	*Measure without Target*	11.5	11.4		
	35		OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. (FY1)	385	*Measure without Target*		435	423	459	475
			OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. (FY2)	*n/a*	*n/a*	*Measure without Target*	534	529		
ED	40a	OHA will reduce recidivism to emergency departments for the psychiatric purposes, by taking the following steps:	OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, by CCO (previously stated by hospital). (FY1)	1,067	*Measure without Target*		924	919	865	834
			OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, by CCO (previously stated by hospital). (FY2)	*n/a*	*n/a*	*Measure without Target*	828	935		
ED	41a	OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, as follows: (excludes Unity)	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline.	1.5	1.4		2.0	2.1	2.0	2.0
	41b		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.	*n/a*	*n/a*	1.3	1.97	1.9		
ED	43	OHA is working with hospitals to determine a strategy for collecting data regarding individuals with SPMI who are in emergency departments for longer than 23 hours.	OHA will begin reporting this information in July 2017, and will provide data by quarter thereafter. OHA will report this information by region. OHA will pursue efforts to encourage reporting on a hospital-by-hospital basis.	*Not Available*						

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Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
SE*	45a		The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment… (FY1)	*Baseline Not Applicable*	*Measure without Target*		680	697	628	757
			The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment… (FY2)	*n/a*	*n/a*	*Measure without Target*	749	756		
SE*	45b		The number of individuals with SPMI who no longer receive supported employment services and are employed without currently receiving supportive services from a supported employment specialist (but who may rely upon natural and other supports). (FY1)	*Baseline Not Applicable*	*Measure without Target*		114	115	164	110
			The number of individuals with SPMI who no longer receive supported employment services and are employed without currently receiving supportive services from a supported employment specialist (but who may rely upon natural and other supports). (FY2)	*n/a*	*n/a*	*Measure without Target*	121	127		
SRTF	49b (i)	OHA will seek to reduce the length of stay of civilly committed individuals in secure residential treatment facilities, as follows:	By the end of year one (June 30, 2017), there will be a 10% reduction from the baseline. (Mean)	638.0	574.2		409.1	552.8	543.5	553
	49b (ii)		By the end of year two (June 30, 2018), there will be a 20% reduction from the baseline.			510.2	449.7	501.8		
SRTF	49c	OHA will regularly report on the number of civilly committed individuals in SRTFs, their lengths of stay, and the number of individuals who are discharged.	Starting with year two of this Plan (July 1, 2017), OHA will collect data identifying the type of, and the placement to which they are discharged.							

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Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Quarter Ending Sept 30 of each FY	Quarter Ending Dec 31 of each FY	Quarter Ending March 31 of each FY	Quarter Ending June 30 of each FY
CJD*	52a	OHA will work to decrease the number of individuals with serious and persistent mental illness who are arrested or admitted to jail based on a mental health reason, by engaging in the following strategies:	OHA will continue to report the number of individuals with SPMI receiving jail diversion services. (FY1)	*Baseline Not Applicable*	*Measure without Target*		1,553	1,610	1,736	2,499
			OHA will continue to report the number of individuals with SPMI receiving jail diversion services. (FY2)	*n/a*	*n/a*	*Measure without Target*	1,822	1,766		
	52a		OHA will continue to report the number of reported diversions. (Pre-Booking) (FY1)	*Baseline Not Applicable*	*Measure without Target*		284	385	346	515
			OHA will continue to report the number of reported diversions. (Pre-Booking) (FY2)	*n/a*	*n/a*	*Measure without Target*	356	350		
	52a		OHA will continue to report the number of reported diversions. (Post-Booking) (FY1)	*Baseline Not Applicable*	*Measure without Target*		1,269	1,225	1,390	1,984
			OHA will continue to report the number of reported diversions. (Post-Booking) (FY2)	*n/a*	*n/a*	*Measure without Target*	1,466	1,416		
	52d		As of July 2016, OHA will track arrests of individuals with SPMI who are enrolled in services and will provide data by quarter thereafter.	*Baseline Not Applicable*	*Data Not Available*					

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Appendix C

Rates of Readmission by Acute Care Facility (31a-b)

2017 Q4 (January 1, 2017 – December 31, 2017)

Acute Care Psychiatric Hospital	Location	30-day	180-day
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	8.2%	20.1%
Bay Area Hospital	Coos Bay	10.2%	20.9%
Good Samaritan Regional Medical Center	Corvallis	8.2%	18.5%
Unity/Legacy Emmanuel Medical Center	Portland	13.3%	25.8%
*Legacy Good Samaritan Medical Center	Portland	11.1%	25.9%
*Oregon Health Sciences University	Portland	2.9%	11.8%
Peace Health - Sacred Heart Medical Center	Eugene	7.8%	21.4%
*Portland Adventist Medical Center	Portland	4.9%	12.2%
Providence Portland Medical Center	Portland	10.6%	24.5%
Providence St. Vincent Medical Center	Portland	13.2%	26.2%
Salem Hospital	Salem	9.4%	18.5%
St Charles Health System Sage View	Bend	9.8%	19.5%
UBH of Oregon (Cedar Hills)	Portland	14.4%	28.1%
	Total:	10.8%	22.9%

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

Appendix D

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

2017 Q4 (January 1, 2017 – December 31, 2017)

Acute Care Psychiatric Hospital	Location	Average Length of Stay	Number of Individuals whose Length of Stay exceeds 20 days
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	9.55	37
Bay Area Hospital	Coos Bay	7.40	11
Good Samaritan Regional Medical Center	Corvallis	14.00	41
Unity/Legacy Emmanuel Medical Center	Portland	13.77	169
*Legacy Good Samaritan Medical Center	Portland	12.56	7
*Oregon Health Sciences University	Portland	7.63	3
Peace Health - Sacred Heart Medical Center	Eugene	12.46	64
*Portland Adventist Medical Center	Portland	13.54	9
Providence Portland Medical Center	Portland	12.33	61
Providence St. Vincent Medical Center	Portland	9.15	36
Salem Hospital	Salem	12.45	44
St Charles Health System Sage View	Bend	8.18	20
UBH of Oregon (Cedar Hills)	Portland	11.19	27
	Total:	11.44	529

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

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

2017 Q4 (January 1, 2017 – December 31, 2017)

Coordinated Care Organization	2+ Readmissions within a Six Month Period
AllCare CCO Inc	31
Cascade Health Alliance LLC	1
Columbia Pacific CCO LLC	19
Eastern Oregon CCO LLC	13
FamilyCare CCO	91
Health Share of Oregon	269
Intercommunity Health Network	2
Jackson Care Connect	21
PacificSource Community Solutions Gorge	20
PacificSource Community Solutions Inc	4
PrimaryHealth Josephine County CCO	23
Trillium Community Health Plan	7
Umpqua Health Alliance DCIPA	78
Western Oregon Advanced Health	8
Willamette Valley Community Health	53
Yamhill Community Care	11
Fee-for-Service	284
Total	935