Oregon Performance Plan
Semi-Annual Narrative Report
July 2019

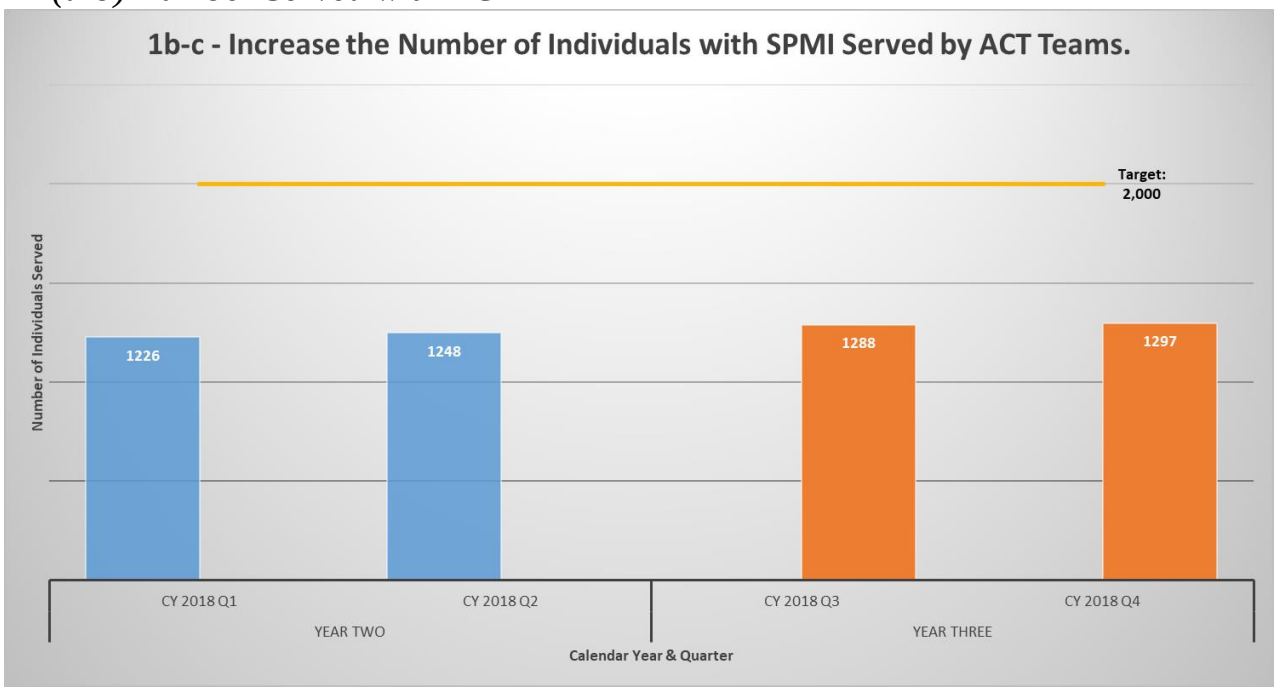
The Oregon Performance Plan (OPP) requires that Oregon Health Authority (OHA) provide data to USDOJ on a quarterly basis and a narrative report about the data every six months. This is the fifth semi-annual report about data.

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) and the methodology for collecting the data, and the progress of each metric for the time period ending 12/31/18. 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, via the Oregon Center of Excellence for ACT (OCEACT). 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 12/31/18, a total of 1,297 individuals were being served by ACT, an increase of 59% over the baseline year, but short of the year two target by 703. Growth in ACT numbers has increased slowly over the last four quarters.

Activities Associated with Metric

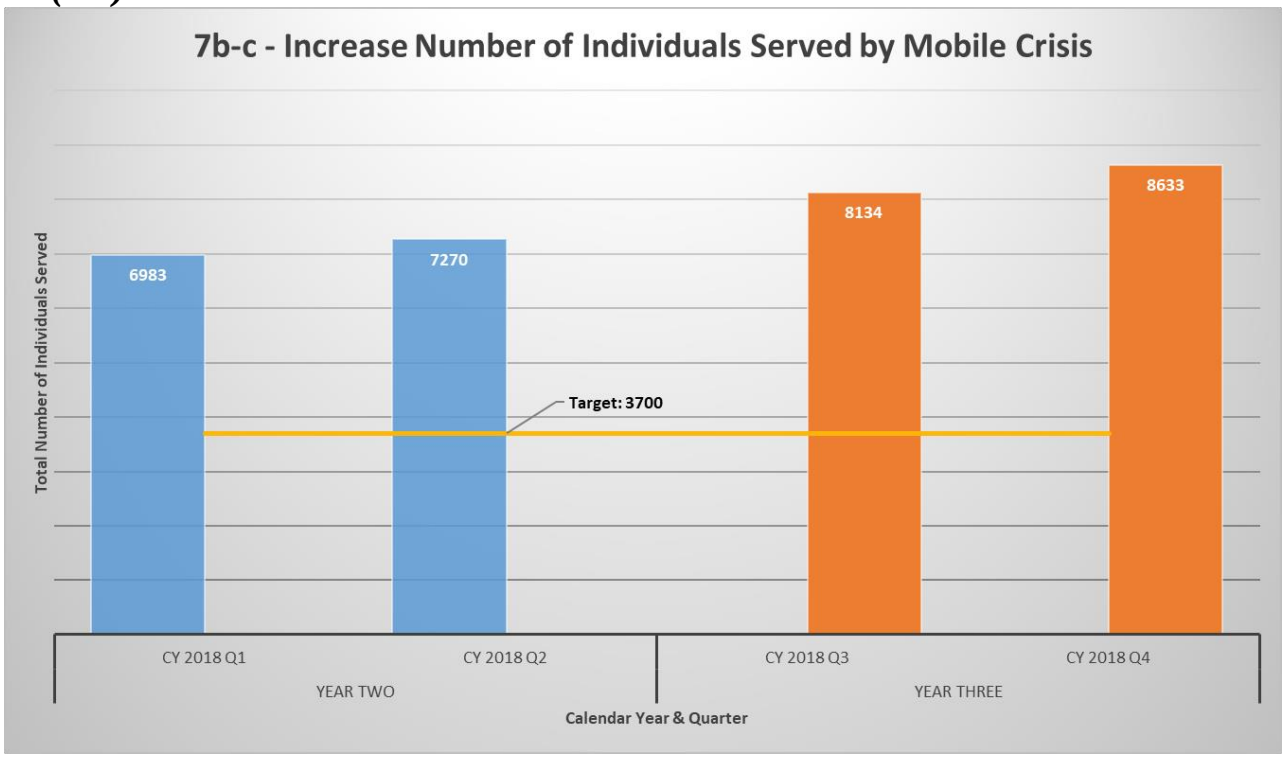
OHA's 2019 – 2020 budget includes $4 million to expand ACT. OHA will work with CCOs to identify and target areas in need of expanded ACT capacity.
OHA has discovered that some CCOs are diverting some individuals referred from ACT to Intensive Case Management (ICM). Since the person is denied ACT a Notice of Adverse Benefit Determination should be issued and this has not been happening. OHA has informed those CCOs that they should issue a Notice when diverting someone from ACT and inform them that ICM is not equivalent to ACT. There has also been some confusion among providers, and they have not billed for ACT when the individual is on open card Medicaid, even though the individual is receiving ACT. Some providers do not have contracts to bill for open card Medicaid members. OHA will provide technical assistance to providers regarding this issue.

OHA has met with the three metro area counties which are all part of the CCO HealthShare. Corrective action plans have been developed to expand ACT. OHA will be monitoring the implementation of these plans.

OHA has identified other issues among various CCOs regarding the delivery of ACT. Some include the expense of ACT and concern about housing and strategies to meet ACT needs. Together with OCEACT OHA is providing technical assistance which includes connecting providers with providers in other areas regarding how they have met some of these challenges.

Crisis Services

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



Baseline (Calendar Year 2015)

As of the end of calendar year 2015, a total of 3,150 individuals received mobile crisis services.

Comments on Methodology

OHA captured mobile crisis services through 3/31/18/, utilizing the Measures and Outcomes Tracking System (MOTS). Beginning 4/1/18, OHA is collecting data for mobile crisis via a quarterly reporting template. This allows for tracking response times and dispositions. This also ensures OHA is counting only the data for mobile crisis responses that occur in the community and not in Emergency Departments (ED) or other settings not considered to be a mobile response. The number of individuals receiving these services in both methodologies is unduplicated. For instance, if the same individual received mobile crisis services multiple times through the year, they are still only counted as one. The metric for individuals receiving mobile crisis services is based on a rolling 12-month period, whereas the response times and dispositions are reported quarterly and counts incidence of mobile crisis events.

Comment on Progress

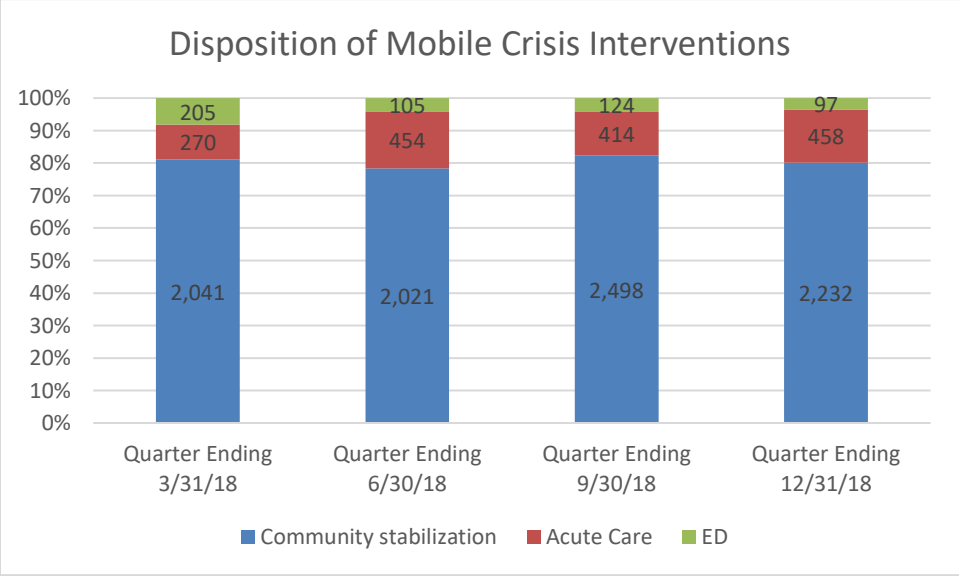
Pursuant to the OPP, OHA will increase the number of individuals served with mobile crisis services, so that during fiscal year two (July l, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis. There were 8,633 individuals who received mobile crisis services during the quarter ending 6/30/18. This is 4,933 over the target of 3,700. The number of individuals receiving mobile crisis services has steadily increased over the year.

Activities Associated with Metric

The 2017 Legislature allocated $15 million to OHA to address the goals of the Oregon Performance Plan. OHA utilized $10 million of the $15 million to increase mobile crisis services to address statewide coverage. The funding has been allocated through the County Financial Assistance Agreement (CFAA). All counties now have mobile crisis programs in place. The increase numbers are a reflection of that investment.

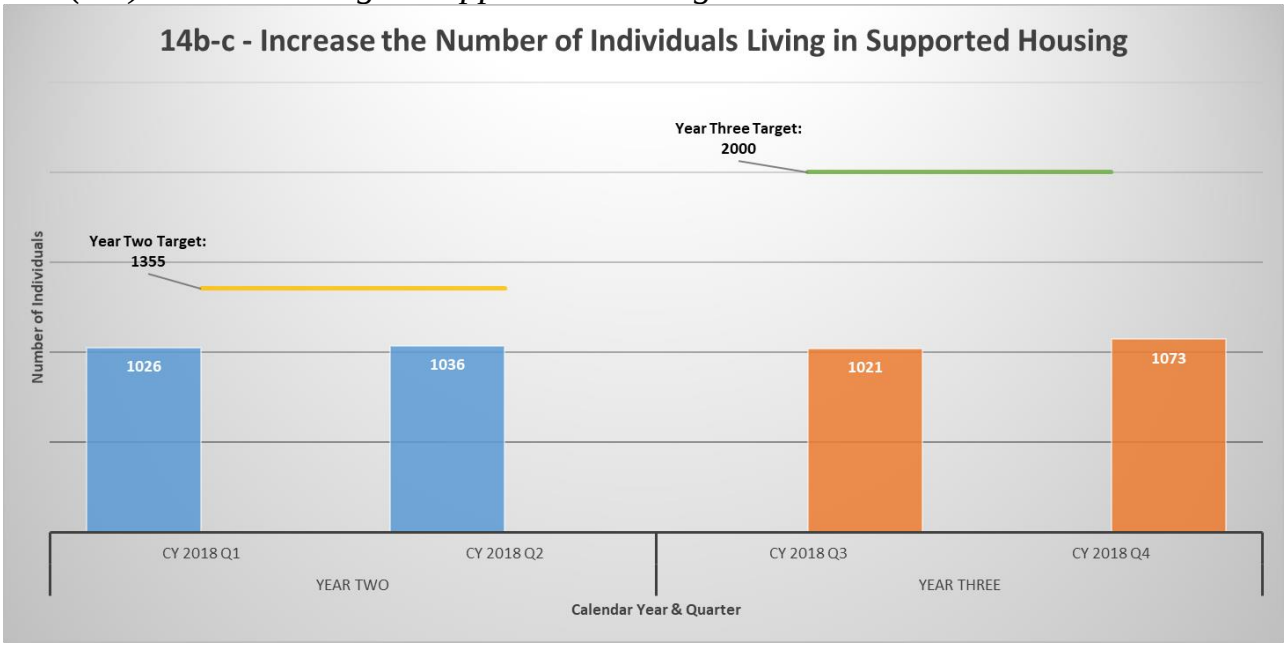
#8 (c) The Number of Dispositions resulting in Stabilization in a Community Setting Rather than Arrest, ED, or Admission to Acute Care

Dispositions following a mobile crisis response for January 2018 through December 2018 are indicated in the graph below. The graph indicates that approximately 80% of individuals among these dispositions are stabilized and remain in the community following a mobile crisis service.



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 by individuals with a SPMI 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 additional units of Supported Housing that have been developed and in which adults with SPMI are living for a combined overall count.

Comments on Progress

The numbers have modestly increased to 1,073 at the end of 2018 which is still short of the second year goal and the June 30, 2019 goal. This number was not as high as expected because there were 26 individuals that moved out of the residence and the rental assistance program. The landlord is obligated to take the next person on their waitlist, so the spot can't be held for the OHA rental assistance program.

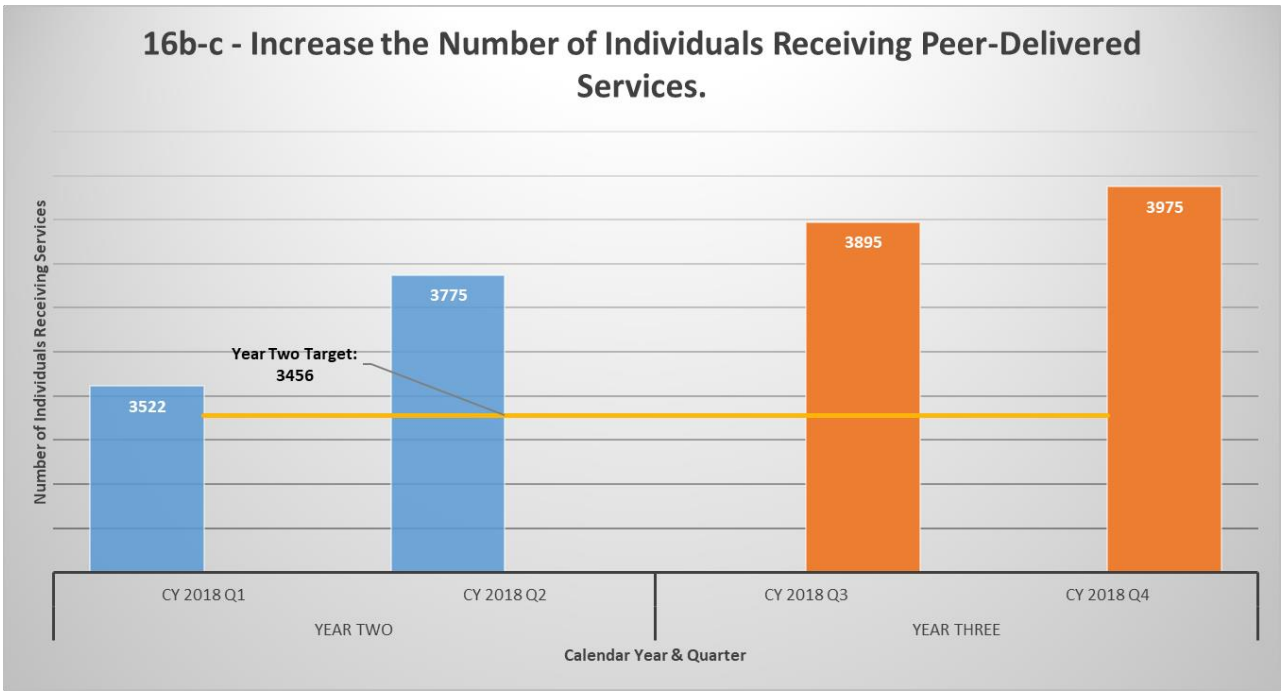
OHA also tracks the number of individuals with SPMI receiving Supportive Housing, applying the definition for that term found in the November 2012 letter of agreement with USDOJ. Supportive Housing is another form of housing support provided for the SPMI population. As of 12/31/18, there were 1,795 individuals with SPMI living in Supportive Housing in addition to those living in Supported Housing. This is an increase of 380 individuals living in supportive housing compared to the data ending June 30, 2018.

Activities Associated with Metric(s)

OHA continues to work with Oregon Housing and Community Services (OHCS) to increase development of Supported and Supportive Housing units for both individuals with SPMI and individuals with substance use disorder (SUD). The 2019 Legislature provided $4.5 million for services and rental assistance for 500 supported/supportive housing vouchers. Details of how and when this funding will be allocated are still being worked out.

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.

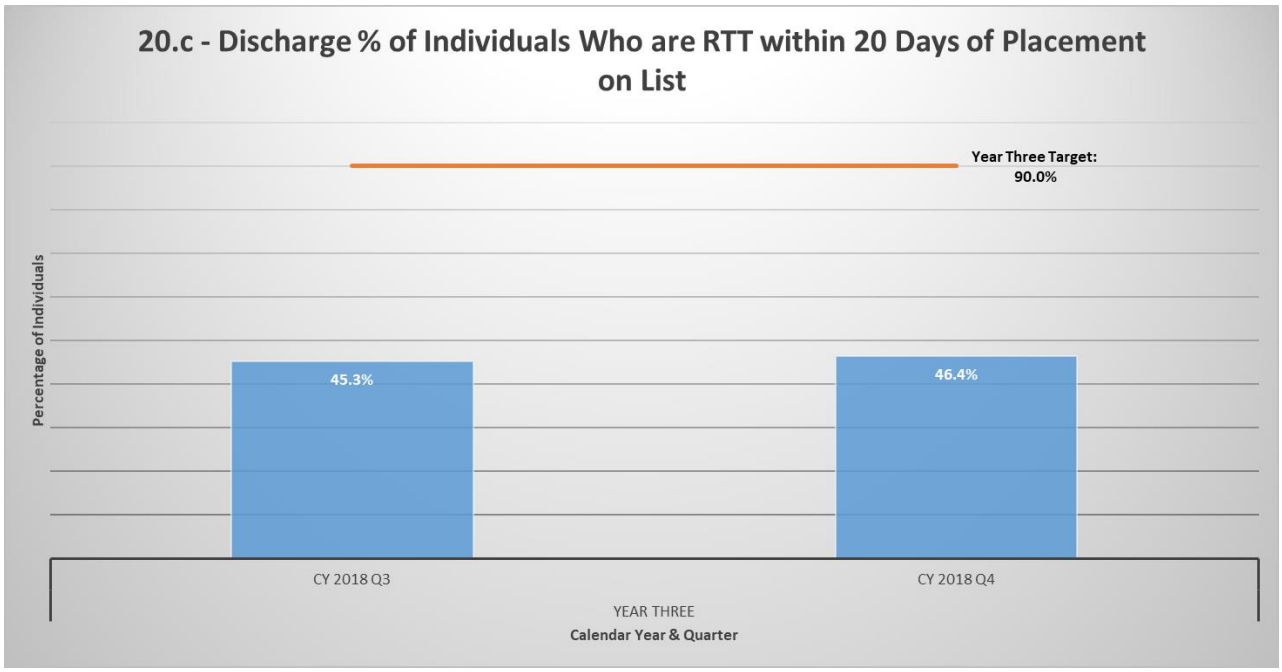
Comments on Progress
Pursuant to the OPP, OHA will increase the availability of PDS, in that by the end of fiscal year two (June 30, 2018), OHA will increase the number of individuals who are receiving PDS by an additional 20% more than the actual number at the

end of fiscal year one, that is, the higher number of 3,456 individuals. As of 12/31/18, there were 3,975 individuals who received PDS. OHA has exceeded the year two target by 519. The number of individuals receiving PDS has steadily increased over the last four reporting quarters.

Activities Associated with Metric(s)
OHA continues to work across stakeholder groups to increase opportunities for education regarding PDS and its positive 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 who was discharged shortly after the 30 days due to a weekend/holiday.

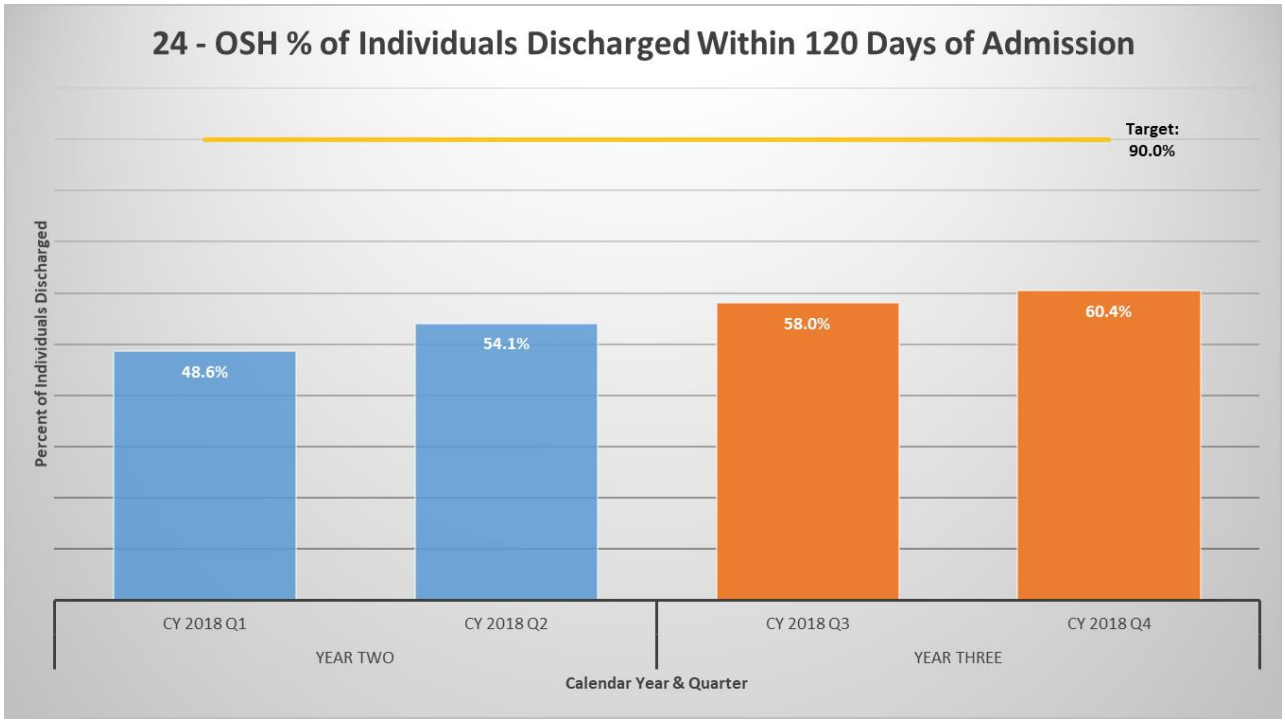
Comments on Methodology

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

The OPP goal was that by the end of fiscal year three (June 30, 2018), 90% of individuals who are RTT will be discharged within 20 calendar days of placement on that list. As of 12/31/18, the cumulative percentage of those discharged within 20 days of being placed on the RTT list was 46.4%. There was one discharge that was 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 individuals who are civilly committed, pursuant to the OPP, who were discharged within 120 days of admission, divided by the total number of individuals who are civilly committed and were discharged.

Comments on Progress

As of 12/31/18, the cumulative percentage of discharges within 120 days of admission was 60.4%. While this is below the 90% target OSH has made steady progress.

Activities Associated with Metric(s)

Oregon State Hospital (OSH) continues to be active to address these OSH discharge metrics. The following are some of their activities:

- Weekly meetings are held with Kepro, Choice Model Contract Administrator, APD, OSH psychiatry and Social Work representatives to identify and help remove the barriers to discharge for patients on the RTT list;
- Monthly meetings are held with Multnomah, Clackamas, and Marion County to discuss and problem solve specific cases of patients at OSH who will return to these counties. The emphasis has been on identification of needs for services in the community and resolving the gap in services;
- OSH conducted chart audits to ensure that documentation related to RTT, ACT screening and follow up is available and timely;
- Social Work supervisors for the civil programs continued to attend the clinical meetings for each interdisciplinary team (IDT) dealing with civilly committed individuals. The primary focus of the Social Work supervisors is discharge planning and ensuring that IDTs are consistently applying the RTT criteria as the IDTs are reviewing each patient weekly;
- OSH posted a solicitation for another contractor for the Person Directed Transition Team to intensify efforts and allocate extra resources for working with patients that have significant barriers to discharge primarily caused by their reluctance to discharge from OSH or the communities' reluctance to receive them back;

- OSH completed a process mapping of the Admission to OSH with representatives from Unity and Providence Hospitals in order to streamline the admission process but also to strengthen the acute care facilities' diversion to the community strategies in order to prevent inappropriate admissions to OSH.

OHA is consulting with Pam Hyde, the Independent Consultant to examine the OSH metrics and look for opportunities to impact OSH utilization.

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 was offered and/or occurred. This process will also identify any refusals of 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 (ACPF) will receive a warm handoff to a community case manager, peer bridger, or other community provider. As of 12/31/18, the cumulative percentage of those who received a warm handoff was 30%. The hospital association believes the numbers are low due to documentation issues and that there are actually more warm handoffs occurring. OHA is below the year two percentage for this metric. Steps being taken to address this are described below 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 seven days of discharge, and that OHA will report this data. As of 6/30/18, the percent of individuals receiving follow up within seven days was 74.1.7%. In order to benchmark Oregon's work in this area the National Center for Quality Assurance (NCQA) 2018 Benchmarks and Thresholds are used. The Medicaid national 95th percentile is 68%. Oregon's number is in the 95th percentile.

#31 (a) Readmission Rates

Baseline (Calendar Year 2015)
The cumulative 30-day readmission rate to ACPFs for calendar year 2015 was 9.23%. The cumulative 180-day readmission rate to ACPFs 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 12/31/18, the cumulative percentage rates of readmission at 30 and 180 days were 11.6% and 23.5% respectively. See Appendix C for the breakout by hospital. OHA researched national data. OHA did not find a consistent benchmark in use for these measures. One 2012 report indicates that 30-day readmission rates for any diagnosis of schizophrenia was 18.6%.[1] During the initial reporting periods for the OPP there was an increase in the 30 and 180 readmission rates. The last two quarters of data shows the beginning of a reversal of that trend. Even with the increase, the Oregon 30-day readmission rate is also well below found national statistics. Oregon will continue to monitor these admission rates.

#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 12/31/18, the cumulative average length of stay of individuals with SPMI discharged from ACPFs was 10.8 days. When broken down by hospital, the range of length of stays at the ACPFs (see Appendix D) ranges from 7.65 days to 13.96 days. Of the 4,439 discharges, the length of stay for 464 (10.0%) exceeded 20 days. Of the 464 individuals, 125 were on the OSH Waitlist. See Appendix D for the detail by hospital.

Activities Associated with Metric(s)

OHA is taking steps to improve performance on warm handoffs and readmission rates OHA has hired the Acute Care Coordinator and that person is actively working with the ACPFs to improve documentation and increase the frequency of

[1] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

warm handoffs. A guidance document to improve documentation was distributed to all ACPFs in February 2019. The Acute Care Coordinator is following up with visits to each ACPF to reinforce the guidance document and identify barriers to warm handoffs. Once the visits are completed a revised guidance document based on issues identified in the visits will be distributed to ACPFs in August 2019 the guidance document will also be presented to CCO, CMHP and Choice related meetings.

Emergency Departments (ED)

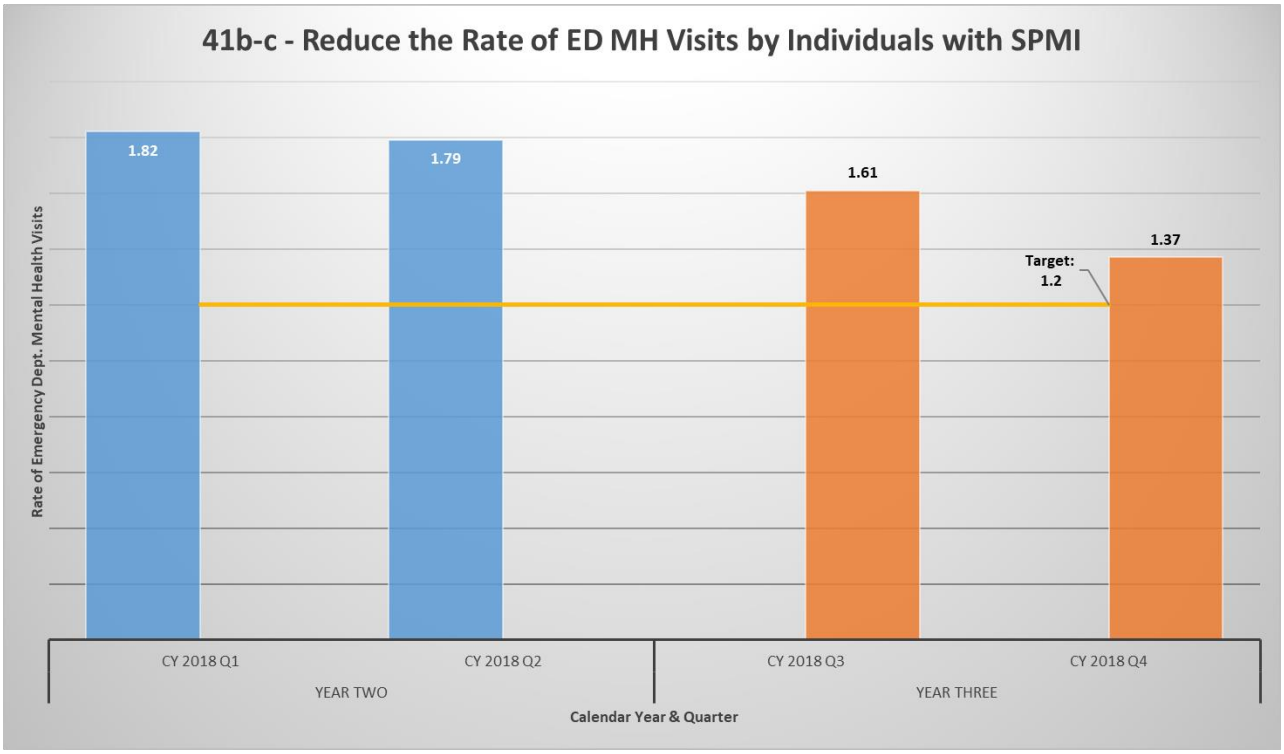
#40 (a) Number Readmitted Two or More Times within 6 Months

Baseline (Calendar Year 2015)
During calendar year 2015, 1,067 individuals with SPMI were re-admitted to an emergency department (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 an ED (which is equal to two readmissions) within a six-month period of time. As previously discussed with Pam Hyde, the Independent Consultant, and as discussed 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 12/31/18, a total of 717 individuals with SPMI were readmitted to an ED two or more times in a six-month period. There is no target associated with this metric, although the data shows a reduction in readmissions and are relatively unchanged over the last four quarters.

#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 Oregon Health Plan (OHP) members who visited the ED for psychiatric reasons.

Comments on Methodology

The OPP provides that OHA will reduce the rate of visits to general emergency departments by individuals with SPMI for mental health reasons, and that by the end of 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 12/31/18, 1.37 individuals per 1,000 OHP members with SPMI visited the ED for mental health reasons. This rate is still above the target of 1.2%. However, this rate has been trending down over this 12-month reporting period. The rate has decreased 24.7% within that 1 year period.

Activities Associated with Metric(s)
As previously reported, the CCO contract has more explicit language for 2019 and will also be reflected in the CCO 2.0 contract.
As stated above the Acute Care Coordinator has been hired and ED utilization is in the scope of that position.

OHA will continue to monitor the other services in the OPP that affect the rate of ED utilization.

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 CIE without receiving supportive services from a Supported Employment specialist at discharge.

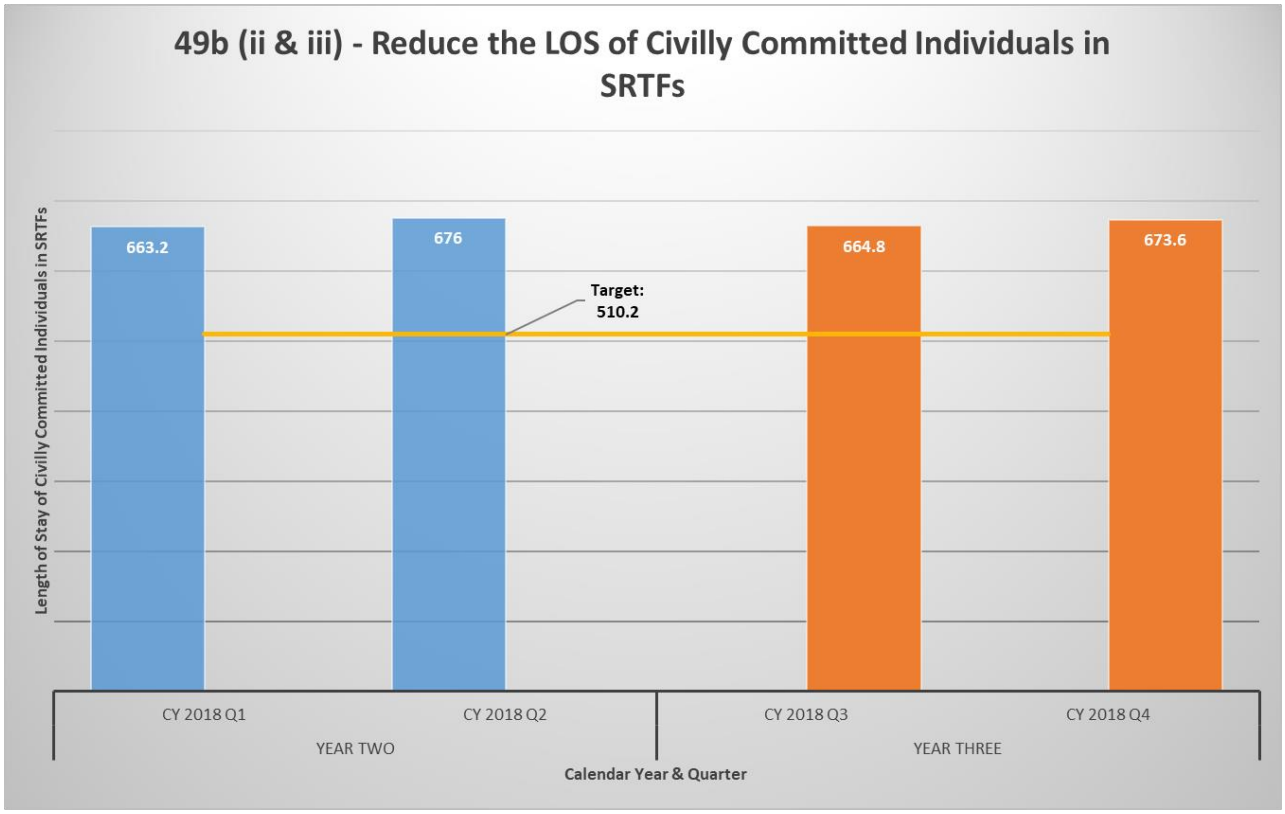
Comments on Progress
Pursuant to the OPP, OHA will report the number of persons receiving Supported Employment who are employed in CIE and the number of individuals who no longer receive Supported Employment and are employed in CIE. As of 12/31/18, a total of 770 individuals were receiving Supported Employment services and employed in CIE. There were 128 individuals who no longer receive Supported

Employment and are employed in CIE without currently receiving supportive services from a Supported Employment specialist. The number of individuals receiving SE services has increased slightly since reported in January 2019 Semi-Annual Narrative Report.

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 SRTFs, in that by the end of fiscal year two (June 30, 2018), there will be a 20% reduction from the baseline. As of 12/31/18, the average length of stay for an individual who was civilly committed and discharged from an SRTF was 673 days.

Activities Associated with Metric(s)
OHA hired an Adult Mental Health Residential Services Coordinator and that position will focus on utilization of services in residential programs. including SRTFs. This person will work with the providers on the development of supportive transition plans to improve the frequency and outcomes of transitions from residential programs.

OHA's Independent Qualified Agent (IQA) contractor continues to perform prior authorizations for individuals referred to SRTFs from OSH. The IQA conducts continued stay reviews for individuals receiving treatment in an SRTF. OHA is reviewing those assessments that are considered for transition to another level of care and makes the determination. OHA is working with its contractors to assure only those who need this intensive 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 who received Jail Diversion services. The number of individuals 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 12/31/18, a total of 1,676 individuals received Jail Diversion services. Of these 1,676 individuals, 398 were pre- booking and 1,278 were post-booking.

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

OHA has been keeping Pam Hyde, the Independent Consultant 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 State Police so that data can be shared. A path forward to collect this data has been worked out.

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

Appendix C

Rates of Readmission by Acute Care Facility (31a-b)
2018 Q4 (January 1, 2018 – December 31, 2018)

Acute Care Psychiatric Hospital	Location	30-day	180-day
Asante Rogue Regional Medical Center (Rogue Valley)	Medford	9.3%	20.0%
Bay Area Hospital	Coos Bay	15.6%	26.6%
Good Samaritan Regional Medical Center	Corvallis	8.8%	18.1%
Unity/Legacy Emmanuel Medical Center	Portland	13.5%	25.9%
Peace Health - Sacred Heart Medical Center	Eugene	13.0%	25.9%
Providence Portland Medical Center	Portland	11.5%	25.6%
Providence St. Vincent Medical Center	Portland	12.8%	23.6%
Salem Hospital	Salem	10.0%	21.2%
St Charles Health System Sage View	Bend	9.5%	19.4%
UBH of Oregon (Cedar Hills)	Portland	8.5%	21.8%
	Total:	11.6%	23.5%

Appendix D

Average Length of Stay in Acute Care Facilities, by Facility (35)
2018 Q4 (January 1, 2018 – December 31, 2018)

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	8.5	26
Bay Area Hospital	Coos Bay	7.65	10
Good Samaritan Regional Medical Center	Corvallis	13.96	43
Unity/Legacy Emmanuel Medical Center	Portland	12.39	150
Peace Health - Sacred Heart Medical Center	Eugene	10.99	54
Providence Portland Medical Center	Portland	12.14	58
Providence St. Vincent Medical Center	Portland	9.54	44
Salem Hospital	Salem	11.05	31
St Charles Health System Sage View	Bend	8.48	31
UBH of Oregon (Cedar Hills)	Portland	9.82	17
	Total:	10.81	464

Appendix E

Count of Individuals with 2+ Readmissions to ED in 6 Months (40a) 2018 Q4 (January 1, 2018 – December 31, 2018)

Coordinated Care Organization	2+ Readmissions within a Six Month Period
Advanced Health	15
AllCare CCO Inc	19
Cascade Health Alliance LLC	3
Columbia Pacific CCO LLC	6
Eastern Oregon CCO LLC	8
FamilyCare CCO	13
Health Share of Oregon	252
Intercommunity Health Network	25
Jackson Care Connect	16
PacificSource Community Solutions Gorge	7
PacificSource Community Solutions Inc	31
PrimaryHealth Josephine County CCO	2
Trillium Community Health Plan	71
Umpqua Health Alliance DCIPA	15
Willamette Valley Community Health	36
Yamhill Community Care	7
Fee-for-Service	191
Total:	717

Appendix F

Secure Residential Treatment Facility Discharge Disposition
Quarter 4: October 1, 2018 – December 31, 2018

Disposition	Count
Acute psychiatric hospital	0
AFH	2
AMA	1
Homeless	0
Independent living	3
Jail	0
RTF	6
RTH	2
State Hospital	0
Supported Housing	0
Supportive Housing	0
Grand Total	**14**

NOTE: This contains data from the fourth quarter only.

Oregon Performance Plan
July 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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).			2,000		1,280	1,260	1,226	1,248
	1c		# of individuals served by ACT Teams				2,000	1,288	1,297		
Crisis	7a	OHA will increase the number of individuals with mobile crisis services, as follows:	During year one (July 1, 2016 to June 30, 2017), 3,500 people will be served by mobile crisis.	3,150	3,500			3,587	3,472	3,564	3,832
	7b		During year two (July 1, 2017 to June 30, 2018), 3,700 people will be served by mobile crisis.			3,700		4,208	5,027	6,983	7,270
	7c		# of individuals served by Mobile Crisis				3,700	8,134	8,633		
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:								
			stabilization in a community setting rather than arrest (FY2)					*n/a*	2,401	2,041	2,021
			presentation to an emergency department (FY2)					*n/a*	349	270	454
			admission to an acute care psychiatric facility (FY2)					*n/a*	169	205	105
			stabilization in a community setting rather than arrest (FY3)					2,498	2,232		
			presentation to an emergency department (FY3)					414	458		
			admission to an acute care psychiatric facility (FY3)					124	97		
SH*	14a	OHA's housing efforts will include an increase in the number of individuals with SPMI in supported housing, as follows:	In year one (July 1, 2016 to June 30, 2017), at least 835 individuals will live in supported housing.	442	835			767	834	876	966
	14b		In year two (July 1, 2017 to June 30, 2018), at least 1,355 individuals will live in supported housing.			1,355		1,008	1,002	1,026	1,036
	14c		In year three (July 1, 2018 to June 30, 2019), at least 2,000 individuals will live in supported housing.				2000	1,021	1,073		
PDS	16a	OHA will increase the availability of peer-delivered services, as follows:	By the end of year one (June 30, 2017), OHA will increase the number of individuals who are receiving peer-delivered services by 20%.	2,156	2,587			2,434	2,461	2,538	2,880
	16b		By the end of year two (June 30, 2018), OHA will increase the number of individuals who are receiving peer-delivered services by an additional			3,456		3,022	3,289	3,522	3,775
	16c		# of individuals receiving peer-delivered services				3,456	3,895	3,975		

* 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 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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%			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.	41.6%	*n/a*	85.0%		53.9%	49.0%	47.1%	48.4%
	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.	30.1%			90.0%	45.3%	46.4%		
	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*			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)					5	2	3	3
			OSH will track and report discharges that are extended to and occur on the business day following a weekend day or holiday. (FY3)					1	1		
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%			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%	48.6%	54.1%
			The percentage of individuals discharged withing 120 days of admission				90.0%	58.0%	60.4%		
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%	29.6%	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.				85.0%	26.0%	30.0%		

* 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 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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)			*Measure without Target*		75.7%	77.8%	77.2%	76.7%
			% of individuals receiving a follow up visit with community mental health provider within 7 days of discharge.				*Measure without Target*	75.7%	74.1%		
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)			*Measure without Target*		11.0%	10.8%	11.8%	12.2%
			30 day rates of readmission.				*Measure without Target*	12.0%	11.6%		
			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)			*Measure without Target*		23.8%	22.9%	23.4%	24.0%
			180 day rates of readmission.				*Measure without Target*	23.5%	23.5%		

* 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 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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	31b 32		Two or more readmissions to acute care psychiatric hospital in a six month period. (FY1)	*Baseline Not Applicable*	*Data for Process Measure*			*n/a*	346	280	284
			Two or more readmissions to acute care psychiatric hospital in a six month period. (FY2)			*Data for Process Measure*		305	314	291	302
			Two or more readmissions to acute care psychiatric hospital in a six month period. (FY3)				*Data for Process Measure*	315	302		
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	11.2	11.16
			OHA will measure the average length of stay of individuals with SPMI in acute care psychiatric facilities, by hospital. (FY3)				*Measure without Target*	10.8	10.8		
	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)			*Measure without Target*		534	529	509	518
			OHA will also report the number of individuals with SPMI in each facility whose length of stay exceeds 20 days. (FY3)				*Measure without Target*	470	464		

Oregon Performance Plan
July 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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
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)			*Measure without Target*		828	935	838	622
			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). (FY3)				*Measure without Target*	765	717		
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.			1.2		1.97	1.9	1.82	1.79
	41c		**Rate of visits to general emergency departments				1.2	1.61	1.37		
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*							
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)			*Measure without Target*		749	756	731	762
			The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment… (FY3)				*Measure without Target*	791	770		

* 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 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome		Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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*	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)			*Measure without Target*		121	127	139	137
			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). (FY3)				*Measure without Target*	123	128		
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	663.2	676.0
			Length of stay of civilly committed individuals in secure residential treatment (FY3)				510.2	664.8	673.6		
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	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.	*Not Available*							

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

Oregon Performance Plan
July 2019 Data Report
Note: Yellow shading indicates Year 2 data.
Note: Green shading indicates Year 3 data.

Metric Category	Metric Number	Performance Outcome	Baseline 2015	Target Year 1 6/30/2017	Target Year 2 06/30/18	Target Year 3 06/30/19	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 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	1,884	2,086
		Number of individuals with SPMI receiving jail diversion services. (FY3)				*Measure without Target*	1,888	1,676		
	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)			*Measure without Target*		356	350	393	502
		Number of reported diversions. (Pre-Booking) (FY3)				*Measure without Target*	421	398		
	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)			*Measure without Target*		1,466	1,416	1,491	1,574
		Number of reported diversions. (Post-Booking) (FY3)				*Measure without Target*	1,396	1,278		
	52d	As of July 2016, OHA will track arrests of individuals with SPMI who are enrolled in services and will provide data by quarter thereafter.	*Baseline Not Applicable*				*Data Not Available*			

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