INDEPENDENT CONSULTANT REPORT #4

OREGON HEALTH AUTHORITY

ACTIVITIES TO IMPLEMENT

THE OREGON PERFORMANCE PLAN

Mobile Crisis Services
Criminal Justice Diversion Services
Discharges from Oregon State Hospital
Supported Housing

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

September 2018

ACKNOWLEDGEMENTS

Many Oregon Health Authority (OHA)[1] staff and Oregon behavioral health system stakeholders continue to help me and the Oregon behavioral health system improve and report on the status of various activities to implement the "Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness" (OPP). During the last few months, not only OHA staff, but program staff and leaders of 29 Counties throughout Oregon helped me and a Review Team of independent experts I assembled to review programs and charts of individuals served. These individuals shared information, challenges, and materials to help us learn about the efforts underway throughout the State to improve the lives of adults with serious and persistent mental illness (SPMI) and other community residents in need of assistance in a crisis.

In addition to Cissie Bollinger, Melanie White, and Michael Morris, other OHA staff advised, traveled with, and/or sat with Review Team members as we interviewed local program staff and reviewed records at County programs and Oregon State Hospital (OSH). These staff include Sam Carl, Cody Gabel, Heather Gramp, Michael Oyster, Richard Wilcox, Jennifer Rees, Tamara McNatt, Lisa Rivers, Christy Springer, Elaine Sweet, Arthur Tolan, Cheryl Meyers, Tyler St. Clair, Tyler Jones, Chasee Trillier, and Rachel Bradbury. OSH Superintendent Dolly Matteucci and Chief Operating Officer John Swanson also met with two Review Team members to help us understand the status of changes underway at OSH and its plans for the future, as well as data collection and documentation processes.

Many other staff and stakeholders too numerous to name – especially those in Community Mental Health Programs, Coordinated Care Organizations (CCOs), and local providers met with us, welcomed us, provided input and materials, asked good questions, and identified challenges and areas for improvement locally and statewide. The openness and commitment of all these staff bodes well for Oregon as it continues to work to implement the OPP.

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

Respectfully and with continuing gratitude,

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

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INTRODUCTION

Scope of IC Report #4

This is the fourth report of the Independent Consultant (IC) regarding the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP). The context of the development of the OPP and the commitments of the State of Oregon represented in the provisions of the OPP were described in IC Report #1, dated March 2017.[2] Contract and regulatory implications of the OPP were discussed in IC Report #2, dated October 2017. IC Report #3, dated April 2018, reviewed efforts and status of the State of Oregon's compliance with four services utilizing year one data and process information about the State's efforts to comply with specific provisions of the OPP regarding peer-delivered services, supported employment, Oregon State Hospital (OSH), and Assertive Community Treatment (ACT). This IC Report #4 describes Oregon's work to implement OPP commitments regarding mobile crisis services,[3] criminal justice diversion, discharges from OSH, and supported housing, as of the end of calendar year (CY) 2017, or half-way through the three years of the OPP. Appendix C to this report summarizes the status of compliance with OPP commitments in these four areas as of the end of CY 2017, or programmatically through June 2018.

IC Report #5 – to be released sometime in mid-2019 – will address the three remaining subsections of the ten (10) Performance Outcomes in Section D of the OPP, namely acute psychiatric care, emergency departments, and secure residential treatment facilities. The sixth IC report, to be released in 2020, after the State of Oregon's final narrative and data report is released, will address Quality and Performance Improvement commitments in OPP Section E as well as compliance overall with all provisions of the OPP.

As required by Subsection F.3 of the OPP,[4] USDOJ and OHA were provided a draft of this Report and had 30 days in which to comment. However, the September date of this report is based on the date it was drafted by the IC rather than the date it was finalized after the 30-day review. This report is the IC's work product and represents my judgments as IC. It has been revised to reflect comments of USDOJ and OHA determined by me to be appropriate to improve the accuracy of the report, with the intent of all involved to aid in the resolution of this matter, as directed in the OPP.

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[2] IC Reports #1, #2, and #3, as well as other materials related to the OPP, can be found on OHA's website at https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx

[3] Subsection D.6 – 13 of the OPP identifies these services generally as "Crisis Services." However, all references within the OPP are specifically to *mobile* crisis services except for Subsection D.13 which references standards for hotline services and County crisis lines. Hence, the attention of this report is on mobile crisis services rather than crisis services more broadly.

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

Review Team Process

A five-person Review Team comprised of clinical and management consultants from around the country reviewed programs, charts, and supported housing units in multiple Oregon Counties in June and I reviewed other charts and housing units in early September. All five of us have extensive experience in clinical behavioral health and/or government and advocacy as well as management and leadership of public and/or private sector behavioral health and human services agencies and programs. All have worked to review and assure the quality of programs and services; some are currently participating as court monitors or reviewers in court cases about issues and populations similar to those covered by the OPP. As a result, members of this Review Team have seen what works and what does not in many states and multiple jurisdictions. Consistent with OPP parameters, each brought to this process a commitment to do an impartial review and to help Oregon succeed in improving its services and outcomes for adults with SPMI.

During the month of May 2018, Review Team members met for two days for training with the IC, two members of the OHA staff working closely on OPP issues, and a highly experienced behavioral health professional working as a court monitor and reviewer in various jurisdictions. This latter individual helped the Team coalesce and understand its role and functions. Many of the same service issues and challenges are present in Oregon as in other jurisdictions where courts have been engaged to oversee system changes. OHA staff helped provide information about the structure and funding of Oregon's behavioral health delivery system. This two-day training gave the Team members an opportunity to learn about and understand Oregon's behavioral health system, understand and ask questions about the OPP, and work together to finalize program review and chart review tools for use during the Team's on-site review. These tools were developed to assure consistency among reviewers and to ask about those elements of the programs reviewed that were specific to OPP definitions and commitments.

Programs in a total of 29 of Oregon's 36 Counties were reviewed in this process. During the first two weeks of June and in early September 2018, the Review Team and/or IC traveled the State interviewing program/community staff and reviewing almost 500 charts of approximately 475 individuals who had received mobile crisis, criminal justice diversion, supported housing, or discharge assistance services by various Oregon programs.[5] When on site, each Review Team member was accompanied by an OHA staff person who helped drive and helped Team members understand context and process. These staff were invaluable; however, they did not participate directly in the Team's review of programs or charts. Review Team members visited rural, frontier, and urban/suburban areas interviewing program staff for each of the areas in this IC Report #4 and reviewing randomly selected[6] charts of individuals served during the third quarter of CY 2016 (first quarter of FY 2017, year one of the OPP) and the third quarter of CY 2017 (first quarter of FY 2018, year two of the OPP). At OSH, reviewers met briefly with OSH leadership before reviewing records of randomly selected individuals discharged from OSH during the fourth quarter of CY 2016 (second quarter of OPP year one) and the fourth quarter of CY 2017 (second quarter of OPP year two). The idea was to understand how the four elements of the OPP were being implemented early in the OPP process and a year later. The results of this process should help set a baseline for further quality reviews by OHA staff in the future and/or show progress from year to year of the OPP timeframe.

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[5] Team Members reviewed 438 charts in 21 different Counties, 39 charts in the two facilities comprising OSH, and 19 charts of Choice providers for some of the 38 individuals whose charts were reviewed at OSH. See Appendix B for a summary of Counties visited and the number of charts reviewed.

[6] Charts for review were randomly selected by the IC from a list provided by OHA. The goal was to select a sample that fairly represented the number and types of individuals receiving services, but was not intended to be a perfect statistically valid sample. It should be noted that considerable confusion occurred in some locations about charts to be reviewed. In some cases, the individual identified by OHA as receiving a service or being a service recipient in a particular County was unknown to that system. In other cases, dates of incidents and/or types of services provided did not match lists provided by OHA. Adjustments were made as the Team identified these issues so that in most cases, some records were able to be reviewed. However, overall, somewhat fewer records were reviewed than originally planned. OHA staff were engaged in this process, understand the issues, and are working to refine reporting tools and instructions to correct this problem for future chart reviews that might be part of an OHA quality review process.

Prior to the on-site reviews of the 21 Counties, the IC talked by telephone with the leader of a community mental health program (CMHP) covering four northern frontier Oregon Counties about mobile crisis services and criminal justice diversion, to learn about services in those Counties and also test the program review tool the Team would be using. After the on-site reviews, the IC conducted telephone interviews with program staff of two other CMHPs representing four additional Counties about mobile crisis services, criminal justice diversion, and supported housing. In addition to program reviews of supported housing programs, Review Team members drove by, visually reviewed, and took pictures of 39 housing units where persons with SPMI were referred and live with the help of the State's Rental Assistance Program (RAP) in 13 of the Counties visited. The purpose of these "drive-bys" was to determine with a cursory visual review of the housing units and the neighborhoods in which they were located whether they appeared to be the types of integrated community housing anticipated by the OPP.

The goal of this Team Review was not to audit or make judgments about any given County's programs or services, but rather to provide an independent analysis of whether the programs funded by the State as a whole in the four areas reviewed were meeting the letter and intent of the OPP in year one and year two of the OPP timeframe and whether the State needs to provide additional clarification or oversight of services in these four areas in order to meet the OPP commitments by the end of year three. Likewise, this analysis provides the State with an informal baseline understanding of critical service areas as it goes forward with the Quality and Performance Improvement program envisioned by Section E of the OPP.

It should be noted that this was a program and chart review process and did not include interviewing individual service recipients to judge agreement with the facts and services as indicated in the records or their satisfaction with services provided. Nevertheless, the program and chart reviews provided ample information upon which to make judgments about overall commitments within the OPP. The rest of this report provides a summary of this analysis for each of the four service areas reviewed and the State's compliance at this point in time with the provisions of the OPP.

MOBILE CRISIS SERVICES– ***IN PARTIAL COMPLIANCE***

Mobile crisis services[7] are defined in Subsection B.6.j of the OPP as:

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

Subsections D.6 through 13 of the OPP describe the State of Oregon's commitment to:

- expand mobile crisis services so they are available statewide by the end of year two (June 30, 2018) (D.6);
- increase the number of individuals served with mobile crisis services (D.7);
- track and report the number of individuals receiving a mobile crisis contact and their dispositions (D.8);

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

- assure mobile crisis teams respond within specified time periods, and for frontier and rural areas, provide a person trained in crisis management to call the person within one hour (D.9-12); and

- develop and enforce uniform standards for hotline services and County Crisis lines (D.13).

Efforts to Expand Mobile Crisis Services Statewide

OHA has provided additional funding to Oregon Counties for mobile crisis services throughout the last two years. For the 2017-19 biennium, the legislature provided an additional $15 million for OPP related services, $10 million of which has been utilized for additional mobile crisis services. Some Counties were just beginning to receive those funds when the Review Team was in Oregon in June, so some of the chart reviews and even some of the program reviews describe services available before the State provided funds specifically for mobile crisis services. As a consequence, some of the crisis services from 2016 and 2017 that were reviewed in 2018 did not meet the full intent of the OPP commitments going forward. However, as of July 1, 2018 all Oregon Counties have some form of mobile crisis service able to respond to a crisis at a location in the community.[8] Therefore, OHA is ***in compliance*** with this OPP commitment.

Numeric Goals for Mobile Crisis Services as of December 31, 2017

OHA has made three types of quantitative commitments about mobile crisis services: 1) to increase the number of individuals served with mobile crisis services; 2) to track and report the number of individuals receiving mobile crisis contact and their dispositions; and 3) to assure a mobile crisis team member responds within specified time periods "from the initial call to face to face" (Subsection D.9 – 12). Progress on these commitments are described below.

Number of Individuals Served with Mobile Crisis Services: According to the OHA data report from August 2018 covering the 12-month period through December 31, 2017, the State reports 5,027 individuals received mobile crisis services. This is significantly above the goal of 3,700 to be served during year two (FY 2018 through June 2018) of the OPP. Pending clarification of the data regarding where these crisis services occur as indicated below, OHA is tentatively ***in compliance*** with this OPP commitment.

It should be noted that this section of the OPP uniquely applies to any adult served by mobile crisis services, not just adults with SPMI. It is neither wise nor efficient to create mobile crisis services separately for adults with SPMI and for other adults in crisis. Likewise, when a crisis is occurring, it is neither wise nor efficient to be focused first on diagnosis or even psychiatric history. As a consequence, programs are not always able to report the individual's diagnosis or whether an individual who receives a mobile crisis service is or is not a person with SPMI. When asked to estimate how many persons served by a mobile crisis team are adults with SPMI, County programs estimated between 50 and 100 percent, depending on the nature of each program (e.g., whether it also serves children/youth or also provides mobile response for elders who may have mental health issues, or adults with addiction issues in addition to adults with SPMI). Based on these responses, the Review Team estimated about 65 – 75 percent of those served by mobile crisis teams across the State are adults with SPMI.

The Review Team did find some instances during the chart reviews in which persons who walked into a crisis center or who were met at a local hospital emergency room were counted as having received a mobile crisis service. While these were concerning and require clarification by OHA about what counts and what does not count as a mobile crisis response pursuant to the OPP definition, the volume of such instances was not large enough to change the tentative finding of compliance, especially given the charts reviewed were from 2016 and 2017 and given the significant increase in the number of individuals

[8] A few Counties have minimal mobile crisis services currently, but are in the process of developing a more robust mobile crisis service with new OHA funding made available recently. For example, Clatsop County's program began in September 2018, and Tillamook County's program was expected to begin in November 2018.

receiving mobile crisis services through the end of CY 2017. OHA going forward will be reporting only those mobile crisis services delivered in the community where the crisis occurred.[9]

Number of Individuals Receiving a Mobile Crisis Contact and Dispositions: OHA committed to developing by the end of year one (June 30, 2017) a methodology to track dispositions after a mobile crisis contact. OHA also committed to begin reporting such dispositions six months after the development of the methodology (or no later than December 31, 2017). These data were specifically to track stabilization in the community as opposed to arrest, presentation to an emergency department, or admission to an acute care psychiatric facility. OHA has recently changed its reporting form and instructions to require reporting of the disposition at the end of each mobile crisis event for services rendered January 1, 2018 and after. Consequently, local programs will be required to provide this information for part of year two (FY 2018) and all of year three of the OPP (FY 2019). These data will be reported by OHA in future Narrative Reports. Since reporting has just begun, OHA is not yet in compliance but is ***working toward compliance*** with this aspect of the OPP commitment.

Mobile Crisis Response Times: OHA commits in Subsections D.9 – 12 by the end of year one (June 30, 2017) to specific response times of a mobile crisis team member "from the initial call to face to face." Specifically, OHA commits to response times within one hour for areas that are "not rural or the frontier" (i.e., urban and suburban areas); within two hours in rural areas; and within three hours in frontier areas. For both rural and frontier areas, OHA commits to having a person who is trained in crisis management (such as a person from a crisis line or a peer) call the individual in crisis within one hour. For all of these response times, OHA commits to reviewing during year two (through June 30, 2018) its progress against these standards and against best practices to determine if adjustments are needed.

As of March 1, 2018, OHA revised State regulations regarding crisis services (O.A.R. 309-019-0150) requiring community mental health programs (CMHPs) to provide crisis services 24 hours, seven days per week, to assure telephone or face-to-face screening within one hour of notification of the crisis event and to conduct an assessment and develop a plan to assist the individual and family to stabilize and transition to the appropriate level of care. This same regulation requires by July 1, 2018 (or when the CMHP is contracted to provide the service) the CMHP or designee to provide mobile crisis services as a component of crisis services for individuals experiencing a mental health crisis in their geographic area. The goals are noted as being to reduce acute psychiatric hospitalization of individuals experiencing mental health crisis and reduce the number of individuals with mental health diagnoses who are incarcerated as a result of mental health crisis events involving law enforcement.

The definition of "mobile crisis services" in O.A.R. 309-019-0105(72) is consistent with the definition of such services in the OPP, although "mobile crisis response time" is defined in this regulation at (73) as "the time from the point when a professional decision is made that a face-to-face intervention is required to the time the actual face-to-face intervention takes place in the community." This is different from the OPP commitment to respond within certain time frames "from the initial call to face to face." However, a call to a crisis line may not be determined to require a mobile crisis response for a few minutes or even longer after the initial call, and in some Counties, the call comes into a 911 or general community crisis line and is transferred to the behavioral health crisis line or service only after a determination by the general crisis line operator that a behavioral health issue is involved. Most of the programs the Review Team talked with indicated time is recorded based on when a mobile crisis response is determined to be needed. On the other hand, some report counting the response time as the time from when the crisis program receives the call. OHA's regulation and reporting instructions should help to clarify this so that data is consistent.

In initial analyses shared with the IC, the vast majority of response times statewide appear to be less than one hour even in Counties designated rural or frontier (in most cases response time was less than 30 minutes) with only a small portion of cases exceeding required response times. In order to have more

[9] While this report utilizes OHA data through December 31, 2017, the next OHA data report released in late October 2018 provides data through March 31, 2018. That report indicates the number of mobile crisis services is continuing to rise (6,983), while reporting only those services delivered in the community where the crisis occurs.

consistent data, OHA is working to clarify for CMHPs how to count and report the time from which point in the process, i.e., from the time a professional decision is made to send a face-to-face mobile response. Hence, at this time, OHA is ***working toward compliance*** on this performance outcome.

OHA is also requiring response times to be tracked somewhat differently than is committed to in the OPP. In the OPP, OHA commits to no more than a three-hour response time in frontier areas; a two-hour response time in rural areas; and a one-hour response time in areas that "are not rural or the frontier." The latter term is not the same as "urban" which is the term utilized in the regulation, although OHA indicates it will clarify that the word "urban" means "not rural or the frontier" as committed in the OPP any non-rural or non-frontier area must meet the shorter one-hour response time.

Additionally, OHA currently designates each County as frontier, rural, or urban even though more than one area type could exist in any given County. The OHA designations for each of the Counties the Review Team visited or talked with is noted in Appendix B. In some Counties designated as frontier or rural, a population center exists in which response times may need to be faster than the frontier parts of the County (e.g., Ontario in Malheur County, Baker City in Baker County, Klamath Falls in Klamath County, Albany in Linn County, Grants Pass in Josephine County, or Pendleton in Umatilla County). Initial analysis of actual response times in these areas indicate these Counties' programs are able to respond in most cases well under the required timeline. Similarly, some less densely populated areas in "urban" counties may realistically require a little longer than one hour for a mobile crisis team member to respond. Whether regulations or designations need to be adjusted to accommodate these differences has not yet been determined.

Many of the programs the Review Team visited indicated response times far shorter than one-hour in populated areas of rural or frontier Counties, with a goal of a response within 30 – 45 minutes and often even less. For mobile crisis service recipients in 2016 and 2017, response times were often difficult to ascertain in the charts, although documentation seemed to be somewhat better in more recent charts or after the program received specific funding from OHA. Documentation about response times is on the reporting template required by OHA. As of this Report, I have seen initial analyses of statewide response times (noted above) and will be working with OHA to understand how they are tracking and working with programs to assure response times are being met in all situations. Most programs were aware that response times needed to be as short as possible and were aware of the requirements for their area (based on the County designations), and most programs work to respond in far shorter times than required by the regulations.

At times, response times were reported by the programs as being longer because of multiple crises occurring at the same time, limited staff availability, or weather conditions or distance causing drive times to be exceptionally long. In some case, on-call mobile crisis staff are required to live or stay (when on call) in areas of the County to help ensure response times might be as short as possible. In many cases, program staff were able to identify ways they worked to ascertain the safety of the individual in crisis whether the expected crisis team member arrival time was to be short or long. That is, many programs reported they determine whether family, other caregivers, or trained law enforcement officers are on the scene, and whether the individual and his/her history is known to the crisis team. In some instances, persons who could not be safe until the mobile crises team member could arrive were sent to and met at a local hospital emergency room rather than waiting in the community, especially if there was an officer or ambulance available to transport.

In some cases, law enforcement personnel transport an individual in crisis to a local hospital emergency room and notifies the mobile crisis team in route or once there. In other cases, mobile crisis response was reported as done at another local provider such as a local crisis respite center. According to the OPP definition of mobile crisis service, when a mobile crisis team member meets an individual in crisis at an emergency room and arguably when they meet the individual at another provider agency, such instances should not be considered a mobile crisis response. Only those instances in which a mobile crisis responder is "onsite at the location in the community where the crisis arises and who provide a therapeutic response" should be counted as a mobile crisis service for purposes of OPP reporting. Some programs reported they understood that distinction, and some did not. OHA is working with CMHPs and

providing additional guidance to assure programs know exactly how to count and how to report response times to various parts of their geographic area. OHA is working to clarify that programs should not be reporting crisis walk-ins, persons met at a hospital emergency room, crisis calls taken by a mobile crisis team member but not responded to face-to-face, or other situations that are not within the OPP definition are not to be counted as a mobile crisis response. In its next Narrative Report in January 2019, OHA will be able to distinguish and report only those situations meeting the OPP definition and intent.

OHA also needs to clarify the commitment that a person trained in crisis management (such as a person from a crisis line or a peer) shall call within one-hour in frontier and rural areas, presumably when a crisis team member is not able to be face-to-face until after a one-hour period. When asked about this expectation, many program staff were not aware of this, or felt that the crisis team member may be on the phone with the individual him/herself, or that the presence of a law enforcement officer or safe family member or caregiver was enough pending arrival of the crisis team member. Others indicated their goal is a response in well under one hour, regardless of the area in which the crisis occurs. The regulations as currently written do not speak to this expectation or commitment by OHA.

Finally, the OPP commits OHA to reviewing during year two (FY 2018) its progress against these response time standards, especially in frontier and rural areas, and against best practices to determine if adjustments are needed. No consistent national standards exist as best practices in this area, although a review of several programs and other states' standards seem to indicate a somewhat shorter timeframe for response in populated areas. That said, OHA is working to clarify expectations and reporting requirements and will soon begin providing analyses of response times as reported by community mobile crisis programs so that a determination can be made whether any significant outliers are identified requiring further work. OHA is ***working toward compliance*** with this area of the OPP at the current time.

Uniform Standards for Hotline Services and County Crisis Lines: In 2017, OHA consulted with me and with the leaders of the National Suicide Prevention Lifeline[10] as well as other experts about crisis line operations. As a result, OHA developed and revised O.A.R. 309-019-0300 through 309-019-0320 regarding requirements for crisis line services, effective March 1, 2018. While these requirements are not extensive, the OPP commitment was simply to develop and enforce such standards. OHA enforces all of its regulatory requirements through its provider licensing and certification processes. OHA is ***in compliance*** with this OPP commitment as it has the standards and enforcement mechanisms in place. In a future review of the State's quality improvement process, I will work with OHA to understand how their enforcement mechanisms assure uniformity and consistency with these standards statewide.

Requirements and expectations for CMHPs providing crisis services (including mobile crisis services) are further delineated in MHS 25, a Service Element that is part of the County Financial Assistance Agreement (CFAA) with OHA. This Service Element has undergone revision for the second year (FY 2019) of the 17 – 19 CFAA agreement and offers an opportunity to clarify expectations and reporting requirements as indicated above for the next two-year CFAA beginning in July 2019 for FYs 2020 and 2021. These changes are due to be negotiated with CMHPs during the fall of 2018.

Overall Impressions of Mobile Crisis Services[11]

Overall, the Review Team found mobile crisis services in the Counties visited and reviewed to be responsive to local needs and providers, to individuals in crisis as well as their families and caregivers, and to local law enforcement. Law enforcement is almost always involved to assure the scene or the situation is safe except in some Counties and some situations in which the individual is well-known to the behavioral health system. Law enforcement dispatch or individual officers are often the ones who identify a crisis situation to the mobile crisis team. Good collaborations and working relationships were described, many of which are informal and based on local relationships. In some cases, these relationships are described in written memoranda of understanding or agreement, and in a few cases in actual contractual

[10] See https://suicidepreventionlifeline.org/.
[11] See additional impressions and recommendations regarding mobile crisis services in conjunction with criminal justice diversion services after the next section of this report.

relationships. Most programs have dedicated crisis staff, and in many cases dedicated mobile crisis staff. Often, however, crises are responded to by existing clinical staff assigned to be available or on-call during particular time periods. Increasingly, law enforcement personnel are seeing crisis staff as good collaborators and in some cases are actually identifying individuals they encounter who are at risk, thereby offering opportunities for crisis prevention or early intervention.

All the programs stated clearly their goal is to prevent arrest and incarceration as well as emergency room and acute psychiatric care facility admissions where possible. However, some local law enforcement entities are still seeing the local hospital as an appropriate transport and crisis intervention location rather than seeing the mobile crisis team as a resource to prevent such transport. In some cases, the mobile team is part of an extensive crisis clinic or walk-in center and in some cases mobile team members either ride with law enforcement or actually have an office in the local law enforcement entity's office location.

Often mobile crisis services are working with law enforcement to divert individuals who would otherwise be arrested. These instances are appropriately considered mobile crisis services and perhaps also as criminal justice diversion services (especially at SIM Intercept 0). The confusion between these two types of services for purposes of capturing and prioritizing pre-booking intervention services is discussed further as part of the next section of this report.

Many crisis programs are responding to social services crises, that is, to individuals without housing; without adequate food, clothing, or money; or without social supports. In some cases, mobile crisis services are intervening with elders who are no longer able to take care of themselves or who are suicidal due to lack of resources or supports. Significant mobile response is also utilized for persons with substance use disorders who have mental health or addiction treatment needs as well as social services needs caused by the substance use. Law enforcement entities are often involved in these situations. Mobile crisis teams in some Counties are doing significant interventions with children and youth at schools and/or with families identified as in crisis by school officials. These interventions are either informal or are done through written agreements with local school districts. In some Counties, mobile crisis response is rare, either due to lack of resources or to small populations with relatively few crises requiring such response. In all Counties reviewed, lack of available resources for crisis services, and just as importantly for immediate behavioral health services after the crisis is stabilized, were noted as critical issues.

CRIMINAL JUSTICE DIVERSION – ***IN COMPLIANCE WITH SOME BUT NOT OTHER OPP PROVISIONS***

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

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

Subsections D.51 through 53 of the OPP describe the State of Oregon's intent and/or commitment to:

- reduce the contacts between individuals with SPMI and law enforcement due to mental health reasons; and reduce arrests, jail admissions, lengths of stay in jail; and recidivism for individuals with SPMI who are involved with law enforcement due to a mental health reason (D.51);

- decrease the number of individuals with SPMI who are arrested or admitted to jail based on a mental health reason, by engaging in the following strategies (D.52):

a. report the number of individuals with SPMI receiving jail diversion services and the number of reported diversions; and require, under new contracts with entities providing jail diversion services, that contract providers report the number of diversion pre- and post-arrest,[12] as well as including this requirement in all RFPs for any new jail diversion programs;
b. by July 2016, begin to work collaboratively with the Oregon Sheriffs' Association and the Association of CMHPs to determine strategies to collect data on individuals with SPMI entering jails;
c. by July 2016, contract with the GAINS Center[13] to consult on the expansion of the use of the Sequential Intercept Model (SIM) by local jurisdictions throughout the State and encourage local jurisdictions to adopt and implement interventions in accordance with the SIM, and require Counties receiving new jail diversion services funding to adopt SIM;
d. as of July 2016, track arrests of individuals with SPMI who are enrolled in services and provide data by quarter thereafter;
e. provide data quarterly from the jail diversion programs it funds (and make contract amendments requiring quarterly reporting, per Subsection F.6);
f. collect data regarding individuals with SPMI enrolled in mental health services who are arrested, the County where these individuals encountered law enforcement, existing jail diversion services, the impacts of those services, and obstacles to the success of those services; provide the results of any mapping and any additional relevant data to USDOJ and allocate existing funding as necessary to support additional or enhanced jail diversion programs based on results; prioritize pre-charge (pre-booking) diversion activities; and

- work with local jurisdictions to develop strategies to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of individuals with SPMI who are incarcerated.

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

Unlike the mobile crisis services subsections of the OPP, this OPP language is specifically about individuals with SPMI and is written as intent rather than commitments to specific quantitative or qualitative actions. Most programs reviewed in June have worked to increase collaborations and interactions with law enforcement entities and personnel who often encounter or identify individuals with SPMI and others who are in crisis or soon could be. The Review Team was impressed with the extent of the collaborations with law enforcement, jails, courts, and even probation and parole entities. The focus of CMHP activities seems to be responsive to and with law enforcement in the community and to work with jails, courts, and probation and parole entities to divert individuals in crisis or individuals with behavioral health issues from arrest and/or to shorten their time spent in a detention setting. However, statewide data about arrests and reductions or increases of time in a detention setting for the population of adults with SPMI have not been provided to date. Therefore, I cannot assess whether the efforts have yet yielded these desired results. Like mobile crisis services, these relationships with law enforcement are often informal based on local relationships except where criminal justice diversion grants or other behavioral health dollars are specifically utilized to provide in-jail assessments and treatment, or to provide assessments for courts or probation and parole entities. In such cases, these relationships are often in writing to describe critical functions, staffing, and/or funding for these purposes.

[12] In consultation with the GAINS Center, the terms "pre-arrest" and "post-arrest" are considered to be synonymous with "pre-charge" used in Subsection D.52.f and with the terms "pre-booking" and "post-booking" utilized by the GAINS Center and by the IC in this report.
[13] GAINS Center is the SAMHSA supported Center for Behavioral Health and Justice Transformation. The acronym stands for Gather, Assess, Integrate, Network, and Stimulate.

While the State's and local programs' efforts are appropriate and to be commended, not all services funded through OHA jail diversion grants or County Financial Assistance Award (CFAA) dollars are specifically about diverting individuals with SPMI from arrest, jail time, or recidivism. The Review Team found a significant amount of assessments being done to help other systems do their jobs (e.g., drug, mental health, or criminal courts making disposition decisions) or to provide resources for other systems to address behavioral health needs of individuals in their charge (e.g., in-jail psychiatric or social work services, sometimes with an offer of in-jail services such as individual or group counseling and sometimes with a referral to post-booking community-based services upon release). Since many of these functions and services are not required, the Team found many of the individuals whose charts were reviewed refuse to participate or fail to continue in services once released or outside the jail, court, or probation/ parole jurisdiction. Critical to this issue is the paucity of documentation of true interventions (beyond assessments) designed to engage and prevent further crises or criminal justice involvement. Many charts showed multiple crises, re-arrests, and/or return to detention/jail after parole or probation violations.

Based on the chart reviews the Team conducted in June, many of the individuals served by criminal justice diversion programs are involved in the criminal justice system due largely to substance use issues. In a few cases, the diagnoses in the charts make this clear. In other cases, the diagnoses may include those included in the definition of SPMI for purposes of OPP tracking. However, a large proportion of the diversion activities are occurring because of individuals' substance use issues. It is possible that adults with SPMI, at least those known to the system and/or already involved in local behavioral health programs, are being served – and likely even being diverted sometimes – through other services such as crisis centers, mobile crisis teams, ACT teams, and other community services to help meet individuals' needs in the community in order to avoid future crises and contact with institutional settings.

Similarly, local programs' efforts – at least as indicated by the charts reviewed – are largely post-booking. Some indications of the relatively few pre-booking diversion situations are actually diversion from returning to jail due to probation or parole violation, or are efforts to prevent an individual from further penetration into the criminal justice system. These activities include efforts to assist an individual or another system avoid a criminal finding with diversion to community services or avoid being tried on a criminal charge by a determination of incompetence to proceed to trial. The latter may include admission to an inpatient program – often OSH – for treatment and competency restoration (Aid and Assist). In some Counties, community-based Aid and Assist programs are helping to prevent such admissions to OSH.[14] These efforts collectively are largely SIM Intercepts 2 through 5.[15] Again, none of this is inappropriate and is a commendable set of activities within communities' criminal justice systems.

The Review Team felt strongly that mobile crisis services are where the vast majority of pre-booking diversion services and interventions are occurring, and by definition, the criminal justice diversion services and funds are being utilized to assist individuals who are already in the criminal justice system. Indeed, some of the activities provided may very well be assisting in earlier release and/or shorter lengths of stay, along the SIM continuum. However, few are truly pre-booking in the sense of reducing arrests and jail admissions. Most pre-booking activities are being provided through CMHPs' mobile crisis services and are therefore not counted as pre-booking criminal justice diversion activities. This is as it should be. Hence, pursuant to Subsection A.8, I will work with OHA to determine whether this intent and the structure and approach to these two performance outcomes should be changed or combined to help better track the pre-booking activities in all community-based services, at these earlier SIM intercepts.

While ***compliance with the intent*** expressed in OPP Subsection D.51 is evident at State and local levels, the actions to implement this intent appear to be occurring in areas other than just criminal justice diversion grant activities, making the actual results difficult to track.

[14] While such situations are critical for such individuals whether SPMI or not, it should be noted that the Aid and Assist population is not part of the group that is the focus of the OPP.
[15] See https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf and later in this report for a description of the various SIM intercepts.

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

Subsection D.52 of the OPP commits OHA to a number of action steps "to work to decrease the number of individuals with SPMI who are arrested or admitted to jail based on a mental health reason," with specific strategies described below. The success of these strategies in actually decreasing those numbers is unclear at this point as arrest data are not yet available. However, it is clear OHA is working on most of these action steps as described below.

Reported Numbers Receiving Jail Diversion Services and the Number of Reported Diversions: OHA does collect and report the number of individuals receiving jail diversion services, and asks the local program to identify whether the service provided was pre- or post-arrest (or booking; see Footnote 12). However, programs are not required to report a distinction between a jail diversion service and a jail diversion itself. As indicated above, most programs report post-booking services, and almost exclusively provide jail diversion services for individuals who are already involved in the criminal justice system. Services to actually divert individuals from arrest and booking are generally provided through mobile crisis teams, ACT teams, intensive case management, peer delivered services, or other community behavioral health services (Intercepts 0 and 1). In some limited cases, peer support services are part of a community program's jail diversion services.

OHA also commits in Subsection D.52.a to include this requirement regarding reporting the number of diversions pre- and post-arrest in any new jail diversion programs. OHA has not provided any additional funding for new jail diversion programs since CY 2016, and therefore has not had an opportunity to implement this commitment. However, CFAA language for FYs 2018 and 2019 includes reporting requirements for pre- and post-booking jail diversion services, including the following:

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

This CFAA language requires providers to adopt the GAINS Center SIM to identify and intervene at various "points of interception" or opportunities for intervention to prevent individuals with SPMI from entering or penetrating deeper into the criminal justice system. It also allows Counties to utilize jail diversion funds to create partnerships and diversion agreements with criminal justice entities, as well as to create opportunities for individuals to access housing in addition to vocational and educational services; to provide support services to prevent or curtail relapses and other crises; to assist individuals to negotiate and minimize continuing criminal sanctions as they make progress; and to promote peer support and social inclusion of individuals with or in recovery from mental and substance use disorders. These are all activities consistent with the definition of jail diversion in the OPP. However, most programs reported the funding available from the State is insufficient to provide much beyond the assessments and staffing for their justice system interface work.

Without a clear distinction between what is to be reported as pre- and post-booking, a clear expectation of prioritization of pre-booking services, and a distinction between a jail diversion service and an actual

diversion, it is not clear whether consistent and accurate information is being provided by local programs. Similarly, as of the time of this report, OHA has not produced any statewide analyses of the reports they receive, although they are set up to be able to do so going forward and are revising their reporting instructions and templates based in part on the Team Review results. This may be a part of the State's quality performance and improvement system in the future (pursuant to Section E. of the OPP). The State is ***in compliance*** with the reporting of jail diversion services but is currently counting all diversion services as actual jail diversion so is ***not in compliance*** with this part of the Subsection. Similarly, OHA needs to do more to clarify reporting requirements and expectations regarding how to prioritize actual pre-booking diversions.

Subsection D.52.e of the OPP requires OHA to provide USDOJ with data quarterly from the jail diversion programs it funds, at least after entry into new contracts. OHA does report data regarding jail diversion services provided and does indicate whether they are reported by County programs as pre- or post-booking,[16] However, as indicated above, OHA does not provide other data from jail diversion programs at this time and is not clear about the distinction between a service and an actual diversion. As a consequence, OHA is only ***partially in compliance*** with this commitment.

Work with Sheriffs and CMHPs (and Local Jurisdictions) to Determine Strategies to Collect and Share Data: Subsection D.52.b commits OHA to begin collaborative work by July 2016 with the Oregon Sheriffs Association and the Association of CMHPs to determine strategies to collect data on individuals with SPMI entering jails. Subsection D.53 commits OHA to working with local jurisdictions to develop strategies to share information with jails regarding the mental health diagnosis, status, medication regimen, and services of individuals with SPMI who are incarcerated. OHA leaders have attended and spoken to the Oregon Sheriffs' Association and to the Association of CMHPs about individuals with SPMI entering criminal justice systems. Pursuant to an OHA contract, Eastern Oregon Human Services Consortium (EOHSC), the parent of GOBHI, has had discussions with law enforcement about strategies to facilitate data sharing about persons with SPMI who are in jail. What OHA has learned from those discussions is that interpretations of HIPAA confidentiality requirements are a major roadblock to data sharing. EOHSC is looking at how to work within HIPAA guidelines to better serve individuals HIPAA is designed to protect and to improve data sharing in this area. The primary scope of OHA's contract with EOHSC is to facilitate crisis intervention team (CIT) training and to support jail and mobile crisis services statewide. OHA requires this contractor to facilitate relationships between law enforcement and CMHPs. Local programs described a number of different ways data sharing agreements or protocols (including use of Business Associates Agreements, care coordination collaborations, and/or universal ROIs) have been adopted and implemented, but none of the programs indicated assistance provided by OHA in that process. Several local programs indicated they would welcome assistance with data sharing issues. Two projects currently underway by EOHSC on OHA's behalf are the development of a video that outlines HIPAA and 42 CFR Part 2 requirements to assist in the understanding of what information can be shared; and a pilot project with Crook County Jail to implement a Brief Jail Mental Health Screen for all intakes. This will be considered for expansion once the pilot project is complete.

OHA staff has recently begun attending quarterly meetings of the Association of Local Public Safety Coordinating Councils (LPSCCs). This group is a part of the Criminal Justice Commission's work, and LPSCCs are critical cooperating players in many local programs' criminal justice diversion and/or mobile crisis services collaborations. Staff are working with this group to implement a plan to work collaboratively on data sharing issues. In addition, the Oregon Center for Behavioral Health and Justice Intervention (OCBHJI) provides information and technical assistance for local criminal justice services programs about data-sharing approaches (see section below regarding use of SIM).

[16] In the most recent OHA report providing data through December 31, 2017, those encounters reported by local programs as pre-booking accounted for just under 20 percent of all such encounters (350 of 1,766). This compares to just over 35 percent reported for baseline CY 2015 (499 of 1,409). This suggests the proportion of criminal justice services that are post-booking is growing. However, clarity of definition about these distinctions may help the State understand what is actually happening in these programs.

Other activities indicate OHA's efforts to work with law enforcement in a number of ways. OHA's Interim Behavioral Health Director is a member of the Portland Policy Behavioral Health Advisory Committee, which advises the Portland Police on their policies and activities related to police contact with individuals with mental health issues. The Committee also discusses the interface of police officers with community mental health resources. The Council of State Governments (CSG) is working in Oregon on a project called the "Behavioral Health Justice Reinvestment Initiative." OHA is an active participant in this effort with the Director of OHA serving as one of the co-chairs of the steering committee for this project, the other co-chair being the Marion County Sheriff. The CSG consultants are working with OHA, county jails, and the Oregon Criminal Justice Commission regarding data to base recommendations for improving services that divert individuals with behavioral health issues from the criminal justice system. According to an article reported in the Lund Report October 31, 2018,[17] the group is using jail booking and OSH data to understand how many OSH individuals have frequent contact with Oregon's criminal justice system. The group is discussing how to help such individuals obtain access to permanent supportive housing, social supports, addiction treatment, and career services. Recognizing that there is no consistent process across the jails to collect data, the consultants will also be working with County jails in Oregon to develop a process for collecting jail data regarding individuals with a mental illness entering the jail.

These efforts are certainly evidence of OHA working on data-sharing issues. However, I believe Subsection D.52.b and certainly Subsection D.53 is about more than just working on these issues. Rather, I believe the intent is to actually develop strategies to share information. Collecting data for research and evaluation and collecting data on individuals entering jails for care coordination purposes are two different issues, both of which often require specific protocols and strategies in order to conform to federal and sometimes state laws regarding confidentiality which can be seen as a barrier to coordination. An individual release of information (ROI) consent form signed by the individual being served is often needed for care coordination purposes, although for some efforts, detailed and written relationships between providers (e.g., jail psychiatric services and community behavioral health providers) can help to facilitate data sharing.

At this time, OHA is working on these issues so is ***in compliance*** with Subsection D.52.b. and is ***working toward compliance*** with Subsection D.53 of the OPP.

Work with the GAINS Center and Expansion of the Use of the Sequential Intercept Model (SIM): OHA committed to and did contract with The GAINS Center by July 2016 to consult on the expansion of the use of SIM by local jurisdictions across the State (Subsection D.52.c). The GAINS Center conducted a statewide summit in January 2016, and produced a report of that summit in the Spring of 2016.[18] The GAINS Center did additional SIM training and mapping in various Oregon Counties during fall of 2016 and 2017 to augment work done earlier in Oregon Counties in 2010 and 2014. The GAINS Center continues to work with and assist the OCBHJI along with the Oregon CIT Center of Excellence (CITCOE)[19] both operated by Greater Oregon Behavioral Health, Inc. (GOBHI) and funded in part by OHA. OCBHJI helps jurisdictions across Oregon implement and improve systemic and programmatic efforts to successfully divert individuals with serious behavioral health needs from entering various points within the justice system including avoiding arrest entirely. The Center's website provides resources and toolkits to assist with best practices. Center staff provides technical assistance, project management, program development for interested Oregon Counties and providers, and training on SIM and Crisis Intervention Team/Training (CIT) as well as SIM mapping[20] for interested communities.

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[17] See https://www.thelundreport.org/content/collaboration-aims-help-metally-ill-caught-criminal-justice-system and https://www.orgon.gov/oha/ERD/Pages/OregonKidsOffData-DrivenReviewOfStateCiminalJusticeAndBehavioralHealthSystems.aspx.

[18] See https://www.oregon.gov/oha/HPA/CSI-BHP/Oregon%20Performance%20Plan/OR%20Summit%20Report-%20with%20Appendices.pdf for a copy of this report.

[19] See http://www.ocbhji.org/ and https://okb.oregon.gov/portfolio-item/citcoe/ for more information about these two centers.

[20] See https://www.prainc.com/what-exactly-is-a-sequential-intercept-mapping/ for a discussion of SIM mapping.

As of the drafting of this report, 11 of Oregon's 36 Counties have done SIM mapping and seven more have dates set to do so. Seven other Counties are in discussion with the Center about SIM mapping.[21] OCBHJI reports that the State's requirement that Counties adopt SIM for their jail diversion services is not sufficient without a requirement that all Counties engage in the SIM mapping process. Some Counties do not understand the importance of SIM mapping or have used only the National Institute of Corrections' mapping for just their criminal justice systems. Some Counties reportedly are not familiar with or do not understand the importance of the relatively new Intercept 0,[22] which includes the idea of utilizing mobile crisis and other community services to prevent engagement with law enforcement and the criminal justice system in the first place. This is an important construct for OHA to encourage, given the commitment to prioritize pre-booking diversion.

While the State might be able to do more in this area, OHA is ***in compliance*** with the OPP commitments to engage The GAINS Center, encourage local jurisdictions to adopt and implement interventions in accordance with SIM, and require Counties to adopt SIM with any new jail diversion funding.

Tracking and Reporting Arrests of Individuals with SPMI Who Are Enrolled in Services: Subsection D.52.d commits OHA to tracking arrests of individuals with SPMI who are enrolled in services as of July 2016 and to providing data by quarter thereafter. Subsection D.52.f commits OHA to collecting additional data for those arrested including the County where individuals encountered law enforcement, existing jail diversion services, the impact of those services, and obstacles to the success of those services. OHA also commits in this Subsection to providing the results of mapping and "additional relevant data" to USDOJ and to allocating existing funding as necessary to support additional or enhanced jail diversion programs based on the results. The mapping results are provided on the OCBHJI website for all to see. What constitutes "additional relevant data" is unclear, and may need to be the subject of future discussion with USDOJ.

OHA as experienced some challenges regarding legal interpretations with system partners resulting in not yet being able to share mental health and criminal justice data. OHA is continuing to work on avenues for collaboration to obtain these data. Similarly, OCBHJI staff reported to this IC that when they tried to determine whether the Oregon Criminal Justice Commission's Law Enforcement Data System (LEDS) could be utilized to notify behavioral health programs when one of their enrollees encounters law enforcement, they were told access to LEDS is highly regulated and restricted to criminal justice agencies and non-criminal justice agencies with specific statutory authority to access the LEDS data. In the meantime, OHA is ***not in compliance*** with Subsection D.52.d. Since arrest records are generally considered public records, OHA should consider seeking legislative approval to have access to the Commission's arrest data and to LEDS for purposes of fulfilling these commitments while maintaining individual confidentiality and for purposes of providing better care for persons enrolled in behavioral health services and diversion of such individuals from detention facilities.[23]

Finally, Subsection D.52.f commits OHA to prioritize pre-charge (pre-booking) diversion activities. As discussed above, OHA does require reporting regarding pre-booking services, but does not require these types of services to be prioritized. As also indicated above, the OPP may be incorrect in trying to prioritize these services and this outcome in the criminal justice diversion performance outcome section. Rather, the State's future plans may need adjustment to reflect pre-booking services (SIM Intercepts 0 and 1) to be prioritized or at least documented in mobile crisis services and other community-based services performance outcomes. At this time, OHA is ***not in compliance*** with the commitment to prioritize pre-booking diversion activities through its jail diversion grants, but may actually be prioritizing pre-booking diversion activities through other community-based services.

[21] Information about mapping conducted is on the Center's website; see Footnote 13.
[22] See https://www.prainc.com/introducing-intercept-0/ regarding the 2016 introduction of this intercept.
[23] See the National Association of Counties' Data Driven Justice initiative efforts to share data between criminal justice and behavioral health systems at http://www.naco.org/resources/signature-projects/data-driven-justice.

Overall Impressions of Criminal Justice Diversion (Together with Mobile Crisis Services)

Overall, the Review Team found local community collaborations and partnerships, both formal and informal, are foundational and essential to program success. To the extent improved program performance is prioritized, these partnerships will need to be tapped, leveraged, and built upon. Most of these collaborative relationships are informal – not memorialized in written agreements. Communication, generally speaking, seems very good. Whether through daily briefings, weekly meetings, or monthly forums, positive intersection and integration is occurring between and among behavioral health professionals, multiple law enforcement and public safety entities (State, County, and City), jail officials, and those associated with the courts and judiciary system.

In many places there appears to be a gap in services and interventions between crisis/mobile crisis response and the subsequent actions of criminal justice diversion teams. Many charts of individuals seen by criminal justice diversion staff showed prior crisis or mobile crisis intersection without that being noted in the mobile crisis system records. Each program's value and success in addressing very challenging and highly complex situations is clear; however, opportunities exist to close the gaps in effective intervention through an enhanced synergy between these two programs resulting in a better use of community resources and perhaps a better outcome for individuals served and for system collaborators.[24]

As indicated above, mobile crisis response often results in transport to jail, a hospital emergency department, a crisis center, or de-escalation with no need to transport the resident and a referral to or follow-up in outpatient services. Frequently, these actions indicate pre-booking criminal justice diversion, but they are reported as mobile crisis services rather than a diversion from the criminal justice system. Opportunities exist for more effective handoffs between the two programs relative to the interventions that occur subsequent to initial crisis response and the interventions that take place further along the service continuum in post-booking diversion activities. Some communities partially fill this gap through use of a crisis center or transitional residential center services. These facilities often fill a significant role as a service hub for those communities fortunate enough to have them. However, what happens after the crisis is stabilized and the individual no longer needs this residential setting is always a big question. The lack of or high cost of available housing and post-crisis intensive services often results in losing track of the individual or in additional crises or criminal justice involvement in the future. In some communities, ACT teams, mental health or drug courts, supported housing, and extensive peer supports help to fill the after-crisis service needs for some individuals with SPMI and help to maintain individuals' engagement with services over time.

Criminal justice diversion services are most often occurring in the jail subsequent to (post) booking and are infrequently focused on preventing incarceration or reducing the length of incarceration. Significantly more assessments and service planning rather than interventions and service provision are indicated by the chart reviews.

Clarification is required on defining, documenting and reporting of events as criminal justice diversion, mobile crisis, or as both, and on the priority populations for these services. Local programs are not always clear on the distinction between the two service types and find the reporting requirements extensive and onerous at times. Some reported counting a single incident as both while others clearly indicated it would be possible to count them as both but they choose to count them as one or the other based on which program staff respond. An option for the State to consider is the merging of these two programs with clear direction and criteria and sufficient resources to fill the need for more effective service delivery subsequent to crisis response and prior to post-booking and incarceration. The result might be better reporting with less reporting requirements, still focused on the goal of reducing the use of jail and criminal

[24] OHA indicates mobile crisis services are having an impact on reducing police contact with individuals with a mental illness by noting Curry County, designated as a frontier County, just received mobile crisis funding this year. The CMHP Director from that County told OHA they were getting fewer calls from law enforcement, and when the Director contacted law enforcement to see if there were any issues with accessing mental health services, the police chief said that since mobile crisis services are now available, they are receiving fewer calls for a police response to a mental health crisis.

justice systems for persons with SPMI. As OHA revises its reporting forms and directions to local programs, the numbers served in various programs and settings may change. OHA is aware of this and is considering how to best track and explain these changes in its future reports.

Data and information sharing are done on both an informal and a formal basis. In some communities, access to either jail records or databases helps with care coordination while in other communities daily or weekly meetings are utilized to share information among law enforcement, jail, and behavioral health staff about system issues as well as about individuals being served. In some cases, information-sharing is based on client signed releases of information. Understandings and methods for data sharing while maintaining confidentiality of individuals served are varied and inconsistent. Most Counties see this as a significant challenge and would welcome OHA providing additional guidance in this area.

Accurate and comprehensive documentation is a challenge as evidenced by the chart reviews. The Review Team members often had to query and review both multiple modules of a single electronic health record system and/or multiple systems (both electronic and hard copy) in search of what could be considered basic information regarding the individual, his/her diagnoses and presenting issues, services provided, and subsequent experiences with crisis or jail diversion programs. As a consequence, most of the chart reviews showed incomplete documentation, especially with regard to dispositions and follow-up actions. Often, few intensive interventions were documented beyond assessments, service plans, and/or referrals to services (usually individual or group counseling, medication appointments, and sometimes case management and/or peer services). Individuals who consented to services initially were often noted subsequently as no-shows or as unable to be located with a resulting case closure notation. Yet, individuals rarely had only one crisis service or only one criminal justice interaction noted in the charts over the course of several months or years.

Because many Counties reported effective interactions and outcomes with ACT teams, mental health courts, and peer delivered services, programs suggested the State work toward expanding the use of these interventions. Local Public Safety Coordinating Councils seem to be a helpful component in addressing particularly challenging cases in those communities that utilize them. A few communities indicated resistance from jail or law enforcement officials and some struggle with district attorneys and judges more than others in trying to secure diversion from the criminal justice system. OHA might want to consider interactions with statewide organizations representing district attorneys, public defenders, and judges to educate and engage these critical collaborators.

As described, although there are differences in the extent of training, mapping, and implementation of SIM and CIT and variations in experience and expertise, most Counties are engaged in these initiatives in one way or another. In some communities, behavioral health staff are aware of law enforcement being trained in CIT but have not been trained themselves or participated in the training. In other Counties, criminal justice diversion staff either conducted the training or participate as partners in the training. In some cases, SIM mapping has not occurred, at least not recently, but most Counties are aware of the model and the intercepts generally, and some make extensive use of SIM intercept concepts in written or oral program descriptions. To the extent a County is not yet engaged with or included in training about these approaches, OHA may want to consider incentives or directives to do so.

Average resolution time for mobile crisis and/or in-community criminal justice diversion incidents as reported by the program reviews seems to be about 45 minutes to one (1) hour although some are shorter and a few are much longer. Obviously, time periods for criminal justice diversion activities that include assessments, service planning, or service delivery vary by type of activity as well as by program design (e.g., whether the diversion staff are actually located in the jail or in the same facility as the probation and parole office).

Written materials are not consistently available about these programs (or were not consistently provided). Most Counties have program descriptions but less have written policies and procedures/protocols (including response criteria). Relatively few have regular data reports beyond the reports provide to OHA, and very few have written instructions to staff regarding documenting and recording key constructs required by the program funding. Many rely solely on the State's instructions regarding quarterly reports

provided to OHA. Relatively few have written agreements with law enforcement, courts, or jails unless funding or specific staff responsibilities in these other systems is being done by County behavioral health staff. Several Counties submitted comprehensive sets of written documents to the Review Team. OHA may want to review those materials and share the best examples with other Counties, as well as providing templates or suggestions about how written materials for the public or for staff should be developed and disseminated.

The lack of housing availability and the cost of housing in general is an issue adversely affecting individuals experiencing crises and criminal justice system interactions consistently raised in all programs visited, whether designated by OHA as urban, rural, or frontier. More funding for additional staff to provide these services was mentioned as a concern as well.

When asked what assistance they needed from OHA regarding mobile crisis or criminal justice diversion services, programs reported the following:

- More funding for additional staff for these programs, especially for the mobile and after-hours parts of the programs and funding for staff time spent on reporting/administrative requirements; some wanted assurance current specialized mobile crisis services funding will not go away at the end of the contract or OPP timeline;[25]

- More housing capacity and funding, especially for individuals with SPMI and with criminal justice involvement (especially for individuals with co-occurring mental and substance use disorders or with sex offense histories);

- More community services for follow-up after crisis or criminal justice diversion services are provided to prevent further crises and criminal justice involvement (specifically, transitional housing, crisis respite, foster homes, Living Room model peer-directed services, community-based social detoxification, supported employment with "felony friendly" employers, ACT, and intensive case management services);

- Information and guidance about how to share confidential client information for care coordination purposes, particularly with jail personnel, including but not limited to:
    - managing and working around HIPAA and 42 CFR Part 2;
    - examples of Business Associates Agreements;
    - importing of data from multiple sources;
    - real-time access to and interoperability with statewide corrections and behavioral health data sets (including OSH's), access to full discharge summaries from OSH with earlier notification about impending discharges, and information about a County's individuals in other Counties' jails, hospitals, service programs, etc.;

- Training and technical assistance, particularly on the following:
    - how to do and count diversion and crisis services for OPP purposes, including when and how to count a pre-booking diversion as criminal justice versus mobile crisis service;
    - how and when to measure beginning of response time (i.e., from "time when we say we are going" or from "time call comes in to law enforcement dispatch or community 911 line" or from "time call comes in to behavioral health crisis program" or from "time call is received by a mobile crisis team member");
    - flexible response times for different parts of a County's geographic area;

[25] The Council of State Governments Justice Center (https://csgjusticecenter.org/), a national organization working with state governments on criminal justice issues, sponsored a summit in Oregon earlier this year from which a report is expected soon. This summit and report are expected to result in specific advocacy in the upcoming 2019 legislative session for a change to criminal justice statutes to address behavioral health issues and also for specific state funding to match local dollars to provide additional diversion and mobile crisis services. These efforts are being monitored by OHA to assure consistency with approach and methods already underway to increase and improve these services.

- specific topics such as Aid and Assist, pre-trial diversion, definition of low-level crimes;
- specific requirements of OPP compared to crisis and criminal justice services in general;
- evidence-based practices or practices that are working well in other Oregon Counties;
- training for and engagement of law enforcement, jail and court personnel, district attorneys and public defenders; and
- training in locations across the State, not just in the large population areas, and specific to the circumstances of the particular jurisdiction;

- Information and feedback, specifically:
  - improved communication with OHA (clearer chain of command within OHA including a point of contact or advocate within OHA to get answers and assistance[26]); the recent OHA sponsored mobile crisis workgroup was noted as an example of good communications and assistance;
  - a framework with specificity regarding requirements, as well as technical assistance, tools, documents, and other materials to help with services consistent with OPP requirements and best practices;
  - a feedback loop regarding outcomes from all the reports provided to OHA in order to compare a particular County to State performance as a whole and to other Oregon Counties;
  - consultation, expertise, technical assistance, and support; and
  - information regarding approaches that are working in other Counties or other locations, recognizing the difference among Counties within Oregon; some suggested a digest or regular newsletter/e-mail about best practices and outcomes achieved by specific approach(es) in another Oregon County; and

- Combined reporting to reduce the number of reports and to focus on services provided and outcomes for particular individuals (pre-booking diversion versus all other kinds of diversion or service interventions without law enforcement) rather than on a sometimes artificial distinction between mobile crisis and criminal justice diversion services.

DISCHARGES FROM OREGON STATE HOSPITAL (OSH) – ***WORKING TOWARD COMPLIANCE***

Subsection D.25[27] describes specific OHA (and OSH) commitments regarding civilly committed adults with SPMI when they are discharged from OSH, as follows:

- every civilly committed adult with SPMI discharged from OSH shall be discharged to a community placement in the most integrated setting appropriate for the individual;

- discharge shall be to housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice;

- the individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated, in light of cost, availability, and the other factors noted above; and cost shall not be used as a justification for denying housing;

- discharges shall not be to a secure residential treatment facility (SRTF) unless clinically necessary; and no one shall be discharged to a SRTF without the express approval of the Director of OHA or his designee.

[26] Examples of very specific questions a couple of programs indicated are needed include how to deal with underage youth in a crisis at school when the parent is not present or available to consent and how to handle local situations where cell phone coverage is not available or spotty.
[27] This subsection is found in the part of the OPP about OSH more broadly. The status of other OSH commitments as of Spring 2018 can be found in IC Report #3. This report deals only with Subsection D.25.

Subsection B.6.e defines discharge planning as:

> . . . a process that begins upon admission to the Oregon State Hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting.[28] Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. Discharge planning teams at OSH include a representative of a community mental health provider from the County where the individual is likely to transition.

These Subsections are loaded with concepts that must be interpreted, documented, and considered for each individual leaving OSH and in some cases for each geographic area within the State. Specifically, the prohibition on discharge to an SRTF without the approval of the Director of OHA or a designee is being implemented through the KEPRO contract which must determine eligibility for SRTFs and provide prior and continuing stay authorization for each individual referred to or in an SRTF. While the KEPRO contract is consistent with the commitment to discharge to an SRTF only with a designee's express approval, I have not yet reviewed the impact of that process but will do so for a future IC Report #5 on those subsections addressing SRTFs. KEPRO is the new (as of April 2018) designee of the OHA Director for purposes of Subsection D.24 (continuing stay reviews) and is the utilization reviewer and prior authorization provider for facilities such as SRTFs, the regulation[29] for which is also undergoing revision.

While KEPRO was not engaged in these roles during the quarters reviewed in 2016 and 2017, their records may be relevant for future reviews. Choice providers are community organizations (often, but not always CMHPs) contracted to provide care coordination for individuals with SPMI (and others), including having responsibility for arranging community services before and after discharge from acute or OSH inpatient settings to assure the needs and preferences of individuals leaving those facilities are accommodated to the extent possible given cost, availability, and choices. Choice providers' records are relevant for the 2016 and 2017 quarters reviewed, so a sample of these records were reviewed in September for 19 individuals whose OSH records were reviewed in June 2018.

As has been indicated in IC Reports #2 and #3, the roles of the various organizations with responsibilities for some parts of the care and treatment or decision-making about services for individuals with SPMI causes confusion for providers, individuals served, and families. OHA needs to continue its effort to clarify these roles and consolidate responsibility in fewer organizations with performance metrics and incentives built into the contracts for those fulfilling these responsibilities. In particular, clarification is required regarding the roles of CCOs as the responsible entities for payment and oversight of residential services funded by Medicaid and for OSH inpatient care. These roles need to be clearly delineated in the CCO 2020 – 2024 contract which is in development now for a procurement process to take place in 2019.

IC Report #3 included an extensive analysis of the State of OSH discharge processes as of early CY 2018, including leadership's efforts to change the culture of the hospital and the community about OSH's role in the overall behavioral health system. The hospital, with OHA's support and assistance, is moving toward being a setting for a treatment episode, not a setting for long-term "placement" of individuals otherwise unable to be served in the community. As a result, procedures, forms for sharing information, and decision-making processes are changing. Currently, the regulation[30] regarding OSH admission and discharge is also being revised to reflect this changing culture and the revised processes with the final rule expected in early 2019.

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

[29] OAR 309-35, especially -0163 regarding admissions, temporary amendment filed 4/24/18, effective through October 2018.

[30] OAR 309-091-0000 thru 0050.

This IC Report #4 describes only the discharge documentation in place during the fourth quarters of CY 2016 (October 1, 2016 – December 31, 2016) and CY 2017 (October 1, 2017 – December 31, 2017) through a review of a sample of the charts of those civilly committed individuals discharged from OSH during those two quarters. The goal of this review was to determine whether the documentation available at the hospital's two campuses, along with a spot check of a few Choice providers' records, adequately described the State's and communities' efforts to meet the OHA commitments in OPP Subsection D.25 during the early part of the OPP timeline. This review helps to set a baseline for future review of hospital and community records regarding discharge of civilly committed individuals with SPMI from OSH, as the changes underway are settled and documentation and data systems are revised.[31]

Summary of Review of OSH Charts for Individuals Discharged in Q4 CY 2016 and CY 2017

OSH is comprised of two campuses – one in Salem and one in Junction City. Together these campuses admit about 1,500 patients each year, most of whom are forensic patients admitted from Oregon courts and a few individuals admitted by consent of their guardians. About one-quarter of the total OSH population on the two campuses at any given time is civilly committed adults with SPMI[32] subject to OSH provisions of the OPP.

In June 2018, a Review Team member visited both campuses and reviewed 39[33] charts of 136 civilly committed individuals with SPMI discharged from OSH during Q4 of CY 2016 and Q4 of CY 2017 as indicated in Table 1 below.

Table 1: Number of OSH Charts Reviewed by Location

CAMPUS	# DISCHARGED Q4 2016	# 2016 CHARTS REVIEWED	# DISCHARGED Q4 2017	# 2017 CHARTS REVIEWED
Junction City	30	8	14	6
Salem	47	13	45	12
TOTALS	**77**	**21**	**59**	**18**

The review tool utilized directed the Reviewer to identify whether a person-centered plan was completed; the date the individual was determined to be Ready To Transition (RTT), evidence of the individual's choices/preferences upon discharge, eligibility and referral to ACT if appropriate, the setting to which the individual was discharged, and if discharged to SRTF, evidence of clinical necessity and review by OHA Director's designee. Prior and subsequent admissions and discharges were also noted. From this information, the Reviewer[34] made a judgment regarding whether the individual's preferences were considered and met, whether the discharge setting seemed integrated and consistent with the individual's preferences and treatment needs, and whether the person might have been eligible for ACT and was appropriately referred.

The completed review tools for all of the charts reviewed have been provided to OSH and OHA for use in understanding the strengths and weaknesses of their discharge process during year one and year two of the OPP and for improving their processes and documentation about discharge of civilly committed adults

[31] OSH's electronic clinical record-keeping system is called AVATAR, which incorporates most of the information about care and treatment of individuals admitted to OSH. However, not all the forms and other documentation such as initial forms received from the community upon admission, client choice forms, and discharge summaries are yet available in AVATAR. As a consequence, the Review Team had to look in multiple systems and at hard copy records for each individual reviewed. OSH indicates its goal is to have all such documentation in AVATAR eventually (sometime during 2019) to make management and review of patient care available in one data system and location.
[32] OPP Subsection D.19 specifically notes that paragraphs D.20 to D.26 apply only to civilly committed adults with SPMI at OSH, except to the extent specifically noted in D.26 regarding use of interim housing. OHA has indicated it does not use such housing for persons with SPMI at this time.
[33] This number represents 38 individuals as one individual was discharged in 2016 and again in 2017.
[34] The Reviewer of these records is a clinically trained forensic psychologist with extensive clinical and management experience in a state hospital and private practice, as well as experience as a reviewer in a number of states.

with SPMI going forward. A summary of the documentation within all charts reviewed is provided in Table 2 below. This summary is based on the documentation available in the chart and is not necessarily a complete account of the individual's situation or treatment interactions at all times pre- and post- this admission to OSH.

Table 2: Characteristics of Documentation in OSH Charts Reviewed

	JUNCTION CITY 2016 (8 Charts)	JUNCTION CITY 2017 (6 Charts)	SALEM 2016 (13 Charts)	SALEM 2017 (12 Charts)
AREA OF REVIEW	**# Charts**	**# Charts**	**# Charts**	**# Charts**
Evidence of person-centered planning[35]	8	6	13	12
Date on RTT included	8	2	13	11
Evidence or person's choice/preferences upon discharge	6	2	11 (4 w/ no Client Living Pref Form)	11 (8 w/ no Client Living Pref Form)
Evidence of CCO or Choice provider involvement	1	5	12	11
Eligible for or already in ACT and referred	1	2 (1 refused)	9 (3 went to SRTF or RTH instead)	6
Possible eligibility for ACT without referral	5	0	4	6
Evidence of ineligibility for ACT	2	4	0	0
Discharge setting was most integrated and appropriate based on treatment goals and clinical needs	7	3	12	11
Discharge setting consistent with choices and preferences	6	4	11	11
Discharge setting inconsistent with choices and preferences	1	2	1	1 (Waitlisted)
Discharge to SRTF w/o evidence of clinical necessity or OHA Director designee approval	2 of 2 (w/o either)	0 of 1 (1 to SRTF w/ designee approval)	2 of 2 (w/ evid of clinical nec but w/o evid of designee approval)	1 of 1 (w/ designee approval but w/o clinical nec form)
Evidence of hospitalizations or ED visits prior to OSH	7	2	12	8
Evidence of mobile crisis, criminal justice diversion, or jail events prior to OSH admission	3	5	2	7
Evidence of admissions to OSH prior to and after this episode	3	2	2	5
Evidence of multiple interactions with BH services	6	4 (w/ hx of assaultive behaviors)	-	1 (w/ hx of invol meds refused)

Summary of Review of Choice Contractor Charts for Individuals Discharged in 2016 and 2017

As indicated earlier, in September, the IC along with OHA staff reviewed the charts of 20 of the 38 individuals whose charts were reviewed at OSH in June 2018. These chart reviews indicate individuals receive assistance from local providers but follow-up to assure success in the community is not clear from

[35] At the time of these discharges, a specific "person-centered plan" document was not in use or was not completed by OSH. Therefore, this measure simply indicates whether there was evidence in the chart of person-centered planning activity by OSH staff with the individual. KEPRO is now responsible for developing person-center plans.

these records alone. Often, multiple providers or parts of local systems are responsible for serving individuals discharged from OSH (e.g., ACT, residential, or outpatient programs in addition to the ENCC from the Choice program). As a consequence, multiple records or record systems may have documentation about the individual after discharge. Similarly, the records reviewed indicated wide variance in documentation about Choice provider involvement. In some Counties, records showed little more than the information contained in copies of OSH's records. In other cases, local Choice provider records were thorough and showed significant interaction with individuals while at OSH, after an RTT date was determined,[36] and during and subsequent to the discharge process. In some instances, individual's needs as determined by clinical and program staff were well documented, but little documentation of client preferences was evident. In other cases, client preferences and staff attempts to help the client achieve those preferences were well documented. Often, 2017 showed better efforts about Choice provider engagement than 2016 records. In only one record was a person-centered plan developed by KEPRO in the chart, and in a few cases peer workers' efforts to engage the individual to develop a person-directed plan was documented with at least two such plans completed and in other instances, documentation of the individual's refusal to engage was evident.

In some of these charts, it is evident that Choice provider staff appear actively engaged in connecting or staying connected with the individual while they are in OSH. In these situations, Choice provider staff are active participants in hospital IDTs offering suggestions, advocating for places in residential programs, and/or facilitating applications for ACT or supported housing upon discharge. Similarly, attempts to stay connected with individuals after discharge to assure they continue to receive the services they need were well documented in some of these charts. Sometimes the individual's continuing improvement and movement toward increased independence is recorded. In other cases, the chart shows relatively passive engagement by the Choice provider, or little to no engagement at all while the individuals is in OSH and sparse documentation of continuing services for and improvements of individuals post-discharge. Some charts show engagement while the individual is in an emergency department or acute care psychiatric facility prior to or sometime after OSH discharge. Many do not.

The discharge process at OSH, regulatory language, and contract language regarding expectations for Choice providers as well as KEPRO is changing due to OPP implementation. Similarly, discussions with Choice provider staff suggest more engagement and attention to individuals' preferences may be happening but not being documented. OHA staff has committed to working with Choice providers to clarify expectations about their role and about documentation of their efforts. As a consequence, documentation of Choice provider involvement is likely to improve and show better outcomes over time. I will discuss with OHA how to assure charts of Choice providers and Choice provider engagement are reviewed later in the OPP implementation process to assess improvements in these relationships and services.

Overall Impressions Regarding Discharges from OSH

Overall, OSH charts regarding treatment planning, social work and psychiatry notes, and discharge summaries, were quite thorough and complete. The documentation reviewed shows significant engagement of the individual in care to determine choices and preferences upon discharge from OSH. However, the person-centered plan itself is not in the OSH chart. Likely it will be in KEPRO's records for those discharged in the future. The fact that multiple parties are involved – OSH, community Choice and other local providers, and KEPRO – means it is difficult to see what has or is happening with the individual as they enter the hospital, prepare for discharge, and leave the hospital to other independent or treatment settings. The documentation reviewed indicates little CCO involvement while the community

[36] It should be noted that the RTT date in OSH records and Choice provider records do not always match. Variation of a day or two was evident in some charts, and in some cases notification by OSH to the Choice provider regarding the RTT date did not occur for up to a week after the individual's readiness to transition was determined by OSH staff. Similarly, OSH final progress notes and discharge summaries did not appear to be sent consistently to all Choice providers. Given Choice providers are being held to OPP timelines about individuals who have been determined to be RTT, it will be critical that OSH and Choice providers communicate quickly and accurately about these dates and about all information created by or available to OSH.

Choice provider is involved some of the time, and this involvement was clearly better in 2017 than in 2016, therefore improving over time. From OSH records alone, it is impossible to know whether follow-up appointments and arrangements for services are implemented and whether they meet the individual's needs after discharge from OSH. This is consistent with the idea of OSH as an episode of care like any other hospital rather than as a long-term stay option in which the hospital staff does discharge planning and stays engaged after discharge. In those cases where OSH readmissions or court/jail/law enforcement interaction occur within a short time after discharge suggests on-going services may need to be intensified (see section above). KEPRO's role in this process will need to be documented in the future with chart reviews (perhaps as part of OHA's or OSH's quality and performance improvement activities) to determine if the OPP obligations are being met and documented going forward.

In the charts reviewed, Identification of those eligible for ACT and referrals for this service were clearly inadequate and/or inadequately documented by OSH in 2016 and 2017. Likewise, for those eligible and referred, little documentation exists about efforts to connect individuals to ACT services prior to leaving OSH. Determination of ACT team acceptance, better connection with the team prior to discharge, and better documentation about ACT engagement is needed and is being worked on by OSH and OHA,[37] but OHA is ***not yet in compliance*** with Subsection D.23.b.

Discharges to SRTFs are few, and when they do occur, there is inconsistent documentation of clinical necessity or approval by the OHA Director's designee. Time will tell whether this changes with the revision of the regulation governing SRTF admission, KEPRO's utilization review role as the Director's designee, and the revised referral and clinical necessity form in use by OSH. IC Report #5 will explore this further when the SRTF performance outcomes in the OPP are considered.

The CCOs' role in managing and financing inpatient care at OSH and in residential facilities is under review for CCO 2.0 (for CYs 2020 – 2024). These changes over time could be extremely helpful in assuring a more consistent approach to admission to and discharge from OSH and residential facilities. Similarly, OHA clarification about ACT's role in helping to facilitate discharge from residential care facilities of those individuals receiving ACT services could help reduce reliance on these high intensity services and make these transitions to and from these facilities more seamless in the future.

Overall, OHA provided the locations for all individuals discharged in the last quarter (Q4) of CY 2016 and CY 2017 as indicated in Table 3 below.

Table 3: Discharge Locations of All Individuals Discharged in Q4 CY 2016 & CY 2017[38]

DISCHARGE LOCATION	2016 (77 Discharged)	2017 (59 Discharged)
ACT (various living arrangements)	8	5
AFH	11	10
Hotel	2	1
Independent – Alone or w/ Family	18	8
Jail	2	0
Respite	0	6
RCF	0	3
Room and Board	0	2
RTF	12	9
RTH	10	5
Supported Housing	5	4
SRTF	7	5
Unknown or Other	2	1

[37] See IC Report #3 for a description of work underway.
[38] See Appendix A for acronyms utilized in this table and in all IC reports. See O.A.R. 309-035-0105 at https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=243738 for definitions of the various residential options noted in this table.

It should be noted that relatively few individuals discharged during these two quarters in 2016 and 2017 were discharged to ACT or SRTFs with a significant number discharged to independent living settings (including but not limited to supported housing). Many are discharged to other residential facilities of various types. Given the effort to release individuals sooner rather than waiting until the individual is completely ready for independent community living, this may continue. However, it will be important for OSH and Choice providers to consider the possibility of even more independent settings upon discharge with needed intensive services provided after discharge (e.g., ACT, intensive outpatient services, extensive peer supports, etc.) and tapering as the individual is able to live and function more and more independently in the community.

Locations to which the individuals whose charts were reviewed were discharged are indicated in Table 4.

Table 4: Discharge Locations Indicated in OSH Charts Reviewed

DISCHARGE LOCATION	JC 2016 (8 Charts)	JC 2017 (6 Charts)	SALEM 2016 (13 Charts)	SALEM 2017 (12 Charts)
ACT and Crisis Respite Center			1	
ACT w/ Independent Living	1			2
AFH		1	2	2
Hotel		1	2	
Independent – Alone or w/ Family	1[39]			2
Respite		1		1
RCF		1		
Room and Board				1
RTF	2			2
RTH	1	1	4	
Supported Housing	1	1	2	1
SRTF	2		2	1

While OSH and OHA, along with community partners, are making valiant efforts to prepare for discharge even as an individual is admitted to OSH, assure individual preferences and choices are identified and followed in the discharge process, and clinical treatment needs (including ACT) are considered and met as much as possible, these processes are not all in place and/or are not always well-documented. The changes to culture, forms, and processes described in IC Report #3 should help improve the outcomes for individuals discharged from OSH as OHA committed in OPP Subsection D.25. As of now, given the records reviewed for the first two years of the OPP, OHA is not yet in full compliance with this commitment but is ***working toward compliance*** with Subsection D.25.

SUPPORTED HOUSING – ***IN COMPLIANCE***

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

> . . . permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site housing. To be considered supported housing under this Plan, for buildings with two or three units, no more than one unit may be used to provide supported housing for

[39] This individual discharged in 2016 to independent living was readmitted to OSH soon after and was discharged again in 2017 to an RCF.

tenants with SPMI who are referred by OHA or it [SIC] contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for tenants with SPMI who are referred by OHA or it [SIC] contractors. Supported housing has no more than two people in a given apartment or house, with a private bedroom for each individual. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported housing does not include housing where providers can reject individuals for placement due to medical needs or substance abuse history.

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

The metrics regarding persons with SPMI in supported housing include:

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

In Subsection D.15, OHA commits to:

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

Numeric Goals for Supported Housing as of December 31, 2017

OHA reported in January 2018 that 966 individuals lived in supported housing during year one (FY 2017, July 1, 2016 – June 30, 2017). That number is well beyond the 835 numeric goal for year one, and over twice the number at baseline (CY 2015). As of September 2018, OHA reports 1,002 individuals living in supported housing during the time period ending December 31, 2017, halfway through year two of the OPP. An additional 353 individuals will need to live in supported housing during the second half of FY 2018 in order for OHA to meet its numeric goal for this performance outcome. OHA continues to work with its sister State agency, Oregon Housing and Community Services (OHCS), to increase supportive and supported housing opportunities for Oregonians with SPMI.[40] OHA is ***in compliance*** with its numeric goals for this service area as of the drafting of this Report.

Data Re Housing Stock and Inventory and Individuals with SPMI Receiving Supported Housing

OHA tracks the number of housing units available for persons with SPMI by tracking housing inventory as described in IC Report #1, pp 21 – 22. OHA reports in its most recent narrative report that 54,615 units are available for individuals with SPMI as of the end of CY 2017.[41] This compares to 53,323 units of affordable housing in CY 2015 reported in OHA's first narrative report in January 2017. However, these affordable housing units are not all supported housing and not all of these units are available solely to

[40] See OHA's August narrative and data report for more details on these efforts.
[41] See https://www.oregon.gov/oha/HSD/AMH/docs/Affordable%20Housing%20Inventory.pdf for the latest inventory of these housing units.

adults with SPMI. The number of individuals receiving supportive housing services is reported by OHA as remaining the same (1,361) for the period ending December 31, 2017 as for the period ending June 30, 2017. However, OHA is tracking and reporting these data and hence is ***in compliance*** with this OPP commitment in Subsection D.15.

Similarly, OHA is tracking and reporting the number of adults with SPMI living in supported housing as described above and later on in this report. It is also revising its rental assistance reporting format to clarify and assure only persons living in supported housing meeting the definition in the OPP are reported. OHA is ***in compliance*** with this reporting requirement and continues to refine its data collection efforts to assure these numbers are correct. It should be noted that it is possible and in fact probable that more adults with SPMI are living in supported housing than are reported through OHA's rental assistance program and OHCS housing development efforts. Some of the County programs reviewed noted that adults with SPMI other than those served by the State's rental assistance program are in fact living in housing that would meet the definition of supported housing – that is, scattered site, integrated, with choices made by the tenant with SPMI similar to choices made by others without SPMI, and with opportunities to interact with non-disabled individuals just as others are able to do. These County programs also indicated they sometimes provide supportive services for these individuals, albeit not through the rental assistance program. As a consequence, the numbers provided by OHA in its reports utilizing only the rental assistance program and OHCS's housing development units likely undercounts the number of individuals with SPMI living in supported housing units throughout Oregon.

Legislative Request for 2017 – 2019

OHA committed in the OPP to utilize the housing unit data it had to make a budget request for affordable housing (supportive and supported) for individuals with SPMI in connection with OHA's 2017 – 2019 biennial budget. This request was made in the 2017 legislative session with the result being $15 million in additional funding to meet OPP commitments, about $2.5 million of which was used to expand the rental assistance program beyond the initial $2.5 million invested during CY 2016. In 2015, $20 million was provided to OHCS for capital development of additional supportive and supported housing units statewide. As of February 2018, $11.2 million of these funds had been awarded. Another portion of these funds was provided for specific housing for veterans and for those with substance use disorders. The remaining $2.5 million of the OHCS Mental Health Housing Fund (MHHF) was braided with funds from OHA's Mental Health Housing Trust Fund to provide up to $5 million in two separate applications, one for serving persons with substance use disorders and one ($3.06 million) for serving persons with SPMI in supported or supportive housing, but with a higher unit subsidy for supported housing units.

Housing development is a slow process, and these housing development applications are just now being released utilizing 2015 funding. While the rental assistance program has grown, it has taken an increasing amount of available funds just to keep up with rising rents. Whether the numeric goals for adults with SPMI living in supported housing by the end of year two (ending June 2018) have been met will not be known until the January 2019 OHA data report. Similarly, the numeric goal for year three (ending June 2019) will not be known until the January 2020 OHA data report. While OHA is ***in compliance*** with its commitment regarding the 2017 legislative request and is working collaboratively with OHCS to develop more supported housing units, the State of Oregon – including the legislature – will have to do more and OHA will have to make additional requests in future years (2019, 2020, and beyond) if the need for supported housing for adults with SPMI is to be met and is to keep up with growing housing costs.

Supported Housing Program Reviews and Drive-Bys

Due to the specificity of the OPP supported housing definition and the concerns regarding the distinction between supportive and supported housing, and due to the scarcity and high cost of housing throughout Oregon, the Review Team interviewed supported housing (primarily rental assistance) program staff serving 25 Oregon Counties ranging from large urban/suburban and highly populated Counties to small rural and frontier Counties. The goal of these reviews was to ascertain whether staff implementing the programs understood the difference between supported and other kinds of housing, whether they

understood and were implementing the program with attention to the elements of the OPP supported housing definition, and whether they had information or training needs from the State that could help them in implementing their programs. The goal was not to interview individuals receiving supported housing services to ascertain their experience of their housing or the assistance they receive from the rental assistance program.

Review Team members also drove by, took pictures, and did a quick visual review of 39 housing units in 13 Counties, as well as the neighborhoods where the housing units were located. These drive-bys were not meant to be a representative sample of all housing provided by Oregon's rental assistance programs. Rather, this process was meant as a random spot check to determine if the housing that staff were using for adults with SPMI generally appeared to meet the OPP definitional elements of supported housing.

Summary of Supported Housing Program Reviews – The Review Team was impressed overall with the implementation of the rental assistance program and the staff interviewed. This program appears to be running smoothly and effectively throughout the State. According to program staff, all program participants are described to be adults with SPMI,[42] as utilized for the OPP. All individuals are offered extensive behavioral and other healthcare services and supports. In instances where a community agency other than the CMHP operates or administers the program, clear access and close working relationships with the CMHPs and/or other community behavioral health providers are evident.[43] Programs throughout the State work closely with community partners such as churches, Goodwill agencies, advocacy organizations, local businesses, consumer drop-in centers, etc. as well as with landlords to support the successful housing of individuals with behavioral health challenges,[44] many of whom have histories of homelessness and instability.

Referrals to the rental assistance programs are reportedly accepted from multiple sources including other providers, individuals directly in need, family members/caregivers, landlords, probation/parole officers, etc. Programs across the State work with community partners to secure housing items and other costs not able to be covered by the program itself. Many of these community collaborations are informal rather than in writing. Peer specialists are a critical component to the program in all geographic areas reviewed. The high presence of peer support staff is consistently reported as helping programs run effectively.

Programs report that individuals are provided choice of units and areas of town as they seek housing, to the same extent as others seeking rental units are able to choose. Programs report working to assist clients in securing more permanent housing rental support over time (i.e., HUD Section 8 assistance). Providers across the State appear clear about the difference between supported and supportive housing, and this is attributed to clear definitions, training, and direction provided by the State. Programs are also clear with regard to quarterly reporting requirements, and do not express difficulty in reporting. The rental assistance program is specifically designed to make best efforts to match the individual with housing that meets their needs and choices, hence OHA is ***in compliance*** with this commitment in Subsection D.14.

Most programs are staffed during working hours (M-F – 8am to 5pm) with flexibility of time for peer support staff and peer specialists which are a critical component of programs in all geographic areas reviewed. Collaboration with ACT teams and/or crisis services for after hour needs is evident in some locations. Adults with SPMI are not excluded from services due to SPMI, medical needs, or substance use history. Individuals may be ineligible for or denied services due to income levels, criminal histories (especially in the case of those with sex offense histories), or exceptionally poor credit scores; and program staff help to address these issues as they are able. Most reported these situations are challenges in securing housing but do not preclude an individual from being provided supported housing and related services.

[42] One program commented on the presence of significant functional impairments as well.
[43] In one case, a CMHP official sits on the board of the local Community Action Agency implementing the rental assistance program.
[44] One County reported hosting semi-annual "landlord appreciation days" and training landlords in order to foster good relationships with landlords.

In most cases, landlords are provided general information regarding the supported housing program, as well as a name/number for program staff, though limited additional information is provided about individual tenants in order to maintain confidentiality. Releases of Information (ROIs) are requested of participants as needed and information regarding the program and the various support services provided or available are discussed with individuals being served from the onset. Across the board, programs reported participants are given a choice as to whether to engage or participate in extensive behavioral health services and supports available. If clients decline to participate, they may be provided support and visitation through a case manager or peer support staff (typically once per month at a minimum) and encouraged to utilize services as needed. Program participants are consistently provided choice as they search for housing and determine whether to participate in other supportive services. Program participants are offered an array of behavioral health and other supports such as assistance with housing applications and search, service system navigation, financial budgeting, education and coaching about being a tenant, supported employment, assistance with energy/utilities, and peer support. However, service enrollment or utilization was generally reported as not being a requirement for rental assistance supported housing.[45]

Rents have been increasing steadily across the State over the past few years. While some report that rents appear to be leveling out in some locations, Oregon is still facing more and increasing demand for affordable and low-income housing than is available in most jurisdictions. Some programs report that if a program has to choose between going above the 25 percent limitation for a particular multi-unit housing complex or leaving an individual homeless, they choose to house the individual and report this in the quarterly report. OHA is clarifying that while this is the expectation (i.e., house rather than leave homeless) and that the program's best efforts to provide supported housing rather than supportive housing is what is required, the program can only report an individual as living in supported housing if the numeric limitations are met. For example, OHA is working to clarify that if a four-plex already has in it one individual with SPMI referred by the rental assistance program, and if a second unit comes open within that four-plex and an adult with SPMI would otherwise be homeless but for a referral to this second unit, the program can go ahead and refer and secure that second unit for the second adult with SPMI. However, then neither of those two individuals could be counted as an individual with SPMI living in supported housing, even though originally, the first individual could be so counted.

Programs report a wide variation in wait time to secure housing, based on location, anywhere from three days to 13 months. One program noted the need for access to cleaning supplies, as they are expensive and lack of cleanliness can be a cause for eviction. One program reported individuals being unable to receive accommodation for physical disabilities due to presence of animals/pet companions. Additionally, few reported knowing of specific incidents of discrimination by landlords due to being an individual with SPMI.[46]

When asked about challenges, program staff in many geographic areas indicated the need for additional affordable housing units and higher allowances for rent.[47] Waitlists exist throughout the majority of the

[45] As an outlier, one County's program staff reported dis-enrolling individuals if they refuse to participate in behavioral health services, indicating they believe this to be a requirement of the program. This information was provided to OHA so State staff could clarify expectations for this County. A few other programs indicated difficulty when an individual chooses not to engage in health and behavioral health services, and recommended that guidelines for service participation be tightened to require such engagement or participation in services even though they are following guidelines against such a requirement now. Of course, to do so would be inconsistent with the OPP supported housing definition.

[46] Few programs reported discrimination on the basis of disability per se as such discrimination is hard to determine. If an issue regarding discrimination comes up, programs across the State report working to address the issue directly with the landlord, and if necessary, contacting Fair Housing or local HUD programs. In addition, many programs throughout the State reported having access to a legal advocacy program such as Legal Aid, Oregon Law Center, etc. to which they refer the individual being served in such cases.

[47] Flexibility regarding the 25 percent unit limitation in the OPP definition was also cited as needed by some programs, even though they understand and follow the OPP definition requirements now. Since housing one individual in a four-plex then takes three other units out of the mix in locations where affordable housing is very limited, these programs argue that housing individuals with SPMI is more critical than adherence to a defined number

State, and the amount allowed for each qualified recipient is insufficient and does not adjust adequately for local housing and rent conditions. Some programs report other housing funding sources appear to allow higher amounts than the OHA rental assistance program. Housing families in need of more than one bedroom due to maximum payment limits, given the rents for these larger units, is difficult. Likewise, some programs believe rental assistance may be provided to an individual only once, making it difficult to assist an individual who loses their housing and is in need of assistance a second or multiple times. OHA indicates this is an incorrect understanding and they will clarify this misunderstanding for local programs.

Some programs (typically non-CMHPs) have multiple funding sources for housing, some for direct service only. These programs report additional staff are needed to help oversee services and provide support for individuals served across all funding sources. Such staff are often not funded by any funding source. Programs report the rental assistance program's barrier removal funds are helpful, though more funds are needed with additional clarification regarding specifically for what costs these funds may be used.

When asked what assistance they had received or needed from OHA, programs reported:

- Clarification regarding specific use of funds for "barrier removal;"
- Clarification regarding OHA contracts; accessibility to a point person at the State level who can assist with contract questions (quarterly meetings by OHA were reported as helpful);
- More structured feedback from the State to include universal expectations, forms, training, etc.
- Consultation with local program folk on the ground in advance of issuing RFPs for rental assistance funding and services;
- Increased subsidy amounts;
- Support for advocacy with local County boards of commissioners or local regulators; and
- Assistance to develop additional housing capacity locally and statewide.

Summary of Supported Housing Drive Bys – A total of 39 housing locations in 13 Counties were reviewed visually by Review Team members, including stand-alone single-family homes, duplexes and quadruplexes, and various sized apartment complexes. Two-thirds of the housing units appeared to be in excellent condition, and one-third in moderate condition. No units appeared run down or neglected. A majority of units were located within primarily residential areas with maintained sidewalks, access to public transportation, and with close proximity to grocery stores and/or other positive community establishments (churches, clubs, healthcare facilities, parks, etc.). All but one unit appeared to be in safe neighborhoods with clear access to well-kept communal spaces. Most of the neighborhoods appeared quiet with the exception of five locations with mainly pleasant noise surrounding the unit (children, business, etc.). It was difficult to determine the presence of other persons with disabilities (mental or physical) or individuals participating in other human services within multi-unit housing locations. However, nothing about any of the units visually suggested concentration of persons with disabilities or receiving social services any more than other similar housing locations. Likewise, no significant differences were noted in the visual look of the housing units or neighborhoods from one County to another other than the general differences in geographic location or the "look and feel" of housing in those various locations.

Rental Assistance (Supported Housing) Contract Language – The rental assistance program language for CMHPs operating this program[48] provides funding for a residential specialist position and a peer support specialist who are together "responsible for coordinating the program components such as the application process, finding a rental unit, and payments to the landlord;" as well as "support service components including but not limited to financial budgeting, community navigation, and maintaining healthy relationships, which supports Individuals in their ability to live as independently as possible in the

of units within a building being utilized for adults with SPMI. One County reported that due to the shortage of safe housing options, some individuals end up in jail. To make this change regarding percentage of units would, of course, cause much of the housing provided through the rental assistance program to no longer meet the OPP definition of supported housing.

[48] Contract language for other organizations operating rental assistance programs is the same except for boilerplate language. In 19 of the Counties reviewed, the CMHP operated the rental assistance program or contracted for its operation with a community behavioral health provider.

community." Move-in expenses, including cleaning and security deposits, pet deposits, and outstanding utility bills are also allowed. The current language does not specifically include requirements about services offered, but rather what the funds may be used to provide.

This language is being revised[49] to define SPMI consistently with other uses of this term for OPP reporting and regulations in revision. Priority individuals to be served include a requirement that the SPMI individual must meet at least one of the following conditions: "transitioning from OSH; transitioning from a licensed residential setting; without supported housing, are at risk of reentering a licensed residential or hospital setting . . . ; homeless . . .; or at risk of being homeless."

"[S]upported housing" is currently described in the rental assistance contract as "a combination of financial assistance and supportive services that allows an individual to live as independently as possible in their own home." The language further indicates that "no more than 25% of units in a building or complex of buildings may be reserved for individuals with SPMI referred by the state, its contractors or its subcontractors." While this is a good description, it is not the specific or complete definition of supported housing in the OPP. The OPP definition includes specific requirement about service flexibility and availability, about services not being mandated as a condition of tenancy, about tenants having a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities, about no more than two people being in a given apartment or house and about individuals being able to selection their own roommates. Specifically, the definition excludes housing where providers can reject individuals due to medical needs or substance abuse history. In addition, the language in the contract indicates the "County or subcontractor shall *make good faith, reasonable best efforts to facilitate the use of those units by persons with SPMI. The remaining housing is available to all tenants in conformance with Fair Housing and other related laws." [emphasis added]* Clearly, if the rental assistance program is to be the vehicle for the State's compliance with the OPP, the language in this Exhibit needs to be revised to be more specifically in line with OPP definitions and obligations, and the reporting about who is being served needs to be clarified to assure that only SPMI individuals living in housing meeting the OPP definition are counted for OPP reporting.[50] I will continue to work with OHA to determine whether this language and the reporting requirements are consistent with OPP commitments.

While this contract language and the reporting requirements need some attention, it appears from this program review OHA is currently ***in compliance*** with the supported housing performance outcomes in OPP Subsections D.14 – 15. Whether numeric goals will be met in the future remains to be seen.

STATUS OF OHA DATA AND NARRATIVE REPORTS

The most recently available narrative report from OHA at the time this Report was drafted was released in August 2018 and covered the time period ending December 31, 2017 or half way through year two and the overall OPP timeline. It is also the end of the 2017 quarter for which OSH discharges were reviewed. This Report utilizes only the data provided for the four performance outcomes described in this report.

Using the August 2018 report, OHA's performance on the OPP quantitative measures is mixed during this period. The data show continuing concerns regarding OSH discharge timelines from Ready to Transition. While the increased goals for year two impact these rates, the second quarter of year two (Q4 of CY 2017) showed a decline from the first quarter of that year. On the other hand, the rate of those discharged within 90 days of admission increased slightly. Likewise, the number of individuals in supported housing and the number of individuals served by ACT declined slightly from the first quarter of year two after increasing steadily in previous quarters. The number of individuals served in supportive housing has

[49] OHA's current and tentative timeline for revisions to the CMHP (or CFAA) agreements with local mental health authorities who operated CMHPs for FYs 2020 and 2021 (beginning July 1, 2019 and ending June 30, 2021) is to have most language revisions completed by October of 2018.

[50] All programs reviewed reported that primarily or exclusively adults with SPMI are served by the rental assistance program, although they noted that others served by CMHPs also need these services and assistance with housing.

remained the same over the six-month period from June 30 to December 31, 2017. New supported housing funds and a new ACT team in Clackamas County along with increased emphasis on ACT in CY 2019 extension of the CCO contracts may help increase these numbers in future reports.

The numbers of individuals receiving peer-delivered and supported employment (SE) services continue to increase, as did the number of individuals employed in competitive integrated employment without continuing to receive SE. The length of stay in SRTFs increased from the first quarter of year two after a significant drop at the end of year one. This may have to do with the alignment of the KEPRO utilization review function with the increasingly high level of service needs of those in SRTFs.

Rates of 30-day and 180-day readmissions after stays in acute care psychiatric facilities (ACPFs) have remained fairly steady, while the number of individuals with SPMI with two or more readmissions to emergency departments (EDs) in a six-month period has grown slightly. The percentage of individuals receiving a follow-up visit with a community behavioral health provider after an ACPF stay continues to rise slowly but remains below CY 2015 baseline. The lengths of stay in ACPFs has remained the same for three quarters and is significantly higher than baseline (CY 2015). The number of individuals with SPMI staying longer than 20 days in acute care psychiatric facilities continues to rise. OHA is exploring factors that may be impacting these data.

The rate of visits to EDs by persons with SPMI for mental health reasons has continued to decline, but not at the rates that are the goals in the OPP, and the rate has grown significantly from CY 2015 baseline. In 2019, IC Report #5 will explore these and other OPP commitments about ACPFs, EDs, and SRTFs.

In some areas OHA is tracking data but does not have a specific goal to meet, and in some cases these data show concerns about the direction or trend. For example, the rate of those receiving warm handoffs from ACPFs is quite low in the first report of these data. OHA and its contractor for these reports (Health Insights) is working with ACPFs to understand and address documentation issues. In other areas (e.g., dispositions after a mobile crisis event), OHA has not yet reported although analysis of provider-reported data has begun and reports will be available soon. OHA is cognizant of these data trends and problems and is considering how to impact the areas of concern while working to sustain areas of improvement.

Similarly, OHA has committed to provide data about individuals receiving ACT services (Subsection D.4) and has chosen to do so separately from its quarterly data and Narrative Reports since these data points "are to be collected internally as a part of the quality improvement monitoring of ACT programs to determine the effectiveness of individual programs and the statewide effectiveness of ACT." These data about individuals receiving ACT services have been provided by OHA for the period ending December 31,2017, and just recently for the quarter ending March 31, 2018. How these data are being utilized to determine the effectiveness of individuals programs and statewide will be explored further in later reports.

CONCLUSION

OHA's efforts to date continue to show its commitment to addressing the OPP provisions and indicate a willingness to tackle big issues in consultation with stakeholders and with USDOJ's and the IC's input. Significantly, Oregon is meeting its OPP commitments in supported housing at this point, but it is unclear whether it will be able to meet its numeric goals in this area by the end of the OPP timeline. Significant efforts are being made to improve discharge processes to assure appropriate, integrated community services and settings for those leaving OSH. Further review of this area will be needed in the future to determine whether these efforts are successful. Efforts and challenges in the mobile crisis and criminal justice diversion areas show substantial effort along with significant constraints and challenges. Additional work will be needed over time, including beyond the timeframe of the OPP, to meet the overall intent in these areas.

Appendix C summarizes the status of activity in the four performance outcomes covered by this IC Report #4. Future IC reports will assess whether the State's efforts have succeeded in other performance outcome areas and in the quality performance and improvement section of the OPP.

APPENDIX A

ACRONYMS USED IN OREGON INDEPENDENT CONSULTANT REPORTS

- ACPF – Acute Care Psychiatric Facilities
- ACT – Assertive Community Treatment
- ADA – Americans with Disabilities Act
- ADP – Average Daily Population
- AFH – Adult Foster Home
- A&IPS – Acute and Intermediate Psychiatric Services
- ALOS – Average Length of Stay (or mean)
- AMHI – Adult Mental Health Initiative
- APAC – All Payer All Claims
- AOCMHP – Association or Oregon Community Mental Health Programs
- BH – Behavioral Health
- CCO – Coordinated Care Organizations
- CFAA – County Financial Assistance Award
- CFR – Code of Federal Regulations
- CIE – Competitive Integrated Employment
- CIT – Crisis Intervention Team (or Training)
- CITCOE – Crisis Intervention Team Center of Excellence
- CMHP – Community Mental Health Program
- CMI – Chronic Mental Illness
- CMS – Centers for Medicare and Medicaid Services
- CSG – Council of State Govrnments
- CY – Calendar Year (from January 1 through December 31)
- DACTS – Dartmouth Assertive Community Treatment Scale
- DPSST – Department of Public Safety Standards and Training
- DSM – Diagnostic and Statistical Manual
- ECIT – Enhanced Crisis Intervention Training
- ED – Emergency Department
- EDIE – Emergency Department Information Exchange
- EHR – Electronic Health Record
- e.g. – For Example
- ENCC – Exceptional Needs Care Coordinator
- EOHSC – Eastern Oregon Human Services Consortium
- FEP – First Episode Psychosis
- FFP – Federal Financial Participation
- FFS – Fee for Service
- FMR – Fair Market Rent
- FPL – Federal Poverty Level
- FY – Fiscal Year (July 1 through June 30)
- GAF – Global Assessment of Functioning
- GOBHI – Greater Oregon Behavioral Health, Inc.
- HIPAA – Health Insurance Portability and Accountability Act
- HPB – Health Policy Board
- HUD – Housing and Urban Development
- IC – Independent Consultant
- ICD – International Classification of Diseases
- ICM – Intensive Case Management
- i.e. – that is
- IMD – Institution for Mental Diseases
- IPS – Individual Placement and Support
- JC – Junction City
- LEDS – Law Enforcement Data System
- LMHA – Local Mental Health Authority
- LPSCC – Local Public Safety Coordinating Council
- LTPC – Long Term Psychiatric Care
- LOS – Length of Stay
- M – Million
- MHAO – Mental Health Association of Oregon MHBG – Mental Health Block Grant
- MHHF – Mental Health Housing Fund (OHCS)
- MHS – Mental Health Services
- MOTS – Measures and Outcomes Tracking System
- MOU – Memorandum of Understanding
- NCQA – National Committee for Quality Assurance
- NOFA – Notice of Funds Availability
- OACP – Oregon Association of Chiefs of Police
- OAHHS – Oregon Association of Hospital and Health Systems
- OAR – Oregon Administrative Rule
- OCA – Office of Consumer Activities
- OCAC – Oregon Consumer Advisory Council
- OCBHJI – Oregon Center on Behavioral Health and Justice Integration
- OCEACT – Oregon Center of Excellence for Assertive Community Treatment
- OCJC – Oregon Criminal Justice Commission
- OEI – Office of Equity and Inclusion
- OHA – Oregon Health Authority
- OHCS – Oregon Human and Community Services
- OHP – Oregon Health Plan
- OPP – Oregon Performance Plan for Adults with Serious and Persistent Mental Illness
- OPRCS – Oregon Patient/Resident Care System
- ORS – Oregon Revised Statutes
- OSECE – Oregon Supported Employment Center for Excellence
- OSH – Oregon State Hospital
- OSJCC – Oregon Sheriff's Jail Command Council
- OSSA – Oregon State Sheriffs Association
- OSU – Oregon State University
- PATH – Projects for Assistance in Transition from Homelessness
- PDS – Peer Delivered Services
- QHOC – Quality Health Outcomes Committee
- QMHA – Qualified Mental Health Associate
- QMHP – Qualified Mental Health Professional
- QPI – Quality and Performance Improvement

- RAC – Rules Advisory Committee
- RCF – Residential Care Facility
- RFA – Request for Applications
- RFP – Request for Proposals
- ROI – Release of Information
- RTF – Residential Treatment Facility
- RTH – Residential Treatment Home
- RTT – Ready to Transition (also Ready to Place)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- SE – Supported Employment
- § – Section
- SH – Supported Housing
- SIM – Sequential Intercept Model
- SMI – Serious Mental Illness
- SOS – Secretary of State
- SPOC – Single Point of Contact
- SPMI – Serious and Persistent Mental Illness
- SRTF – Secure Residential Treatment Facility
- SSI – Supplemental Security Income
- TA – Technical Assistance
- TAC – Technical Assistance Collaborative, Inc.
- TMACT – Tool for Measurement of Assertive Community Treatment
- USC – United States Code
- USDOJ – United States Department of Justice
- w/ – with
- w/in – within

APPENDIX B

LIST OF COUNTIES REVIEWED

MC = Mobile Crisis CJD = Criminal Justice Diversion SH = Supported Housing

County	CJD Program Review	2016 CJD Chart Reviews	2017 CJD Chart Reviews	MC Program Review	2016 MC Chart Reviews	2017 MC Chart Reviews	SH Program Review	SH Drive-Bys	2016 OSH Discharge Chart Reviews	2017 OSH Discharge Chart Reviews	CHOICE Provider Chart Reviews
ON-SITE (In Person)											
Baker (frontier)	√	3	3	√	0[51]	0	√				
Benton (urban)	√	5	4	√	0	0	√				
Clackamas (urban)	√	6	5	√	0	8	√	3	1		1
Columbia (urban)	√	6	4	√	0	0	√		1		
Coos (rural)	√	5	4	√	5	5	√		1	1	
Curry (rural)	√	6	5	√	4	4	√				
Deschutes (urban)	√	6	8	√	0	0	√	3	1		
Douglas (rural)	√	5	3	√	0	0	√			1	
Jackson (urban)	√	7	5	√	10	10	√	3	2	1	
Jefferson (rural)	√	6	8	√	0	0	√	2			
Josephine (rural)	√	8	14	√	2	1	√				
Klamath (rural)	√	6	5	√	5	2	√	3	1		
Lane (urban)	√	6	6	√	12	0	√	2	4	2	3
Linn (rural)	√	13	10	√	0	0	√	2	1	1	2
Malheur (frontier)	√	10	6	√	2	3	√	3	1		
Marion (urban)	√	6	9	√	4	3	√	6	1	2	2
Multnomah (urban)	√	10	10	√	20	24	√	7	4	7	8
Polk (urban)	√	10	10	√	1	3	√	1			
Umatilla (rural)	√	5	6	√	5	5	√				
Washington (urban)	√	3	5	√	10	14	√	3	2	1	3
Yamhill (urban)	√	2	1	√	5	6	√	1		1	
Clatsop (*not visited*)	-	-	-	-	-	-	-			1	
Morrow (*not visited)*	-	-	-	-	-	-	-		1		
TOTALS		**134**	**131**		**85**	**88**		**39**	**21**	**18**	**19[52]**

[51] To the extent no charts were reviewed for a particular kind of service in a particular County or a particular year, the reason was because not enough of this kind of charts were available to make a review worthwhile or because the confusion about individuals served in a particular community made it impossible to identify quickly charts to review. In some cases, the program was just beginning or had just recently begun in that community so charts were unavailable for prior years.

[52] This number represents 20 hospitalization incidents as one individual was discharged in 2016 and again in 2017.

County	CJD Program Review	2016 CJD Chart Reviews	2017 CJD Chart Reviews	MC Program Review	2016 MC Chart Reviews	2017 MC Chart Reviews	SH Program Review	SH Drive-Bys	2016 OSH Discharge Chart Reviews	2017 OSH Discharge Chart Reviews	CHOICE Provider Chart Reviews
BY PHONE											
Morrow/Gilliam/ Wheeler/Grant[53] (frontier)	-	-	-	√	-	-	-				
Tillamook (rural)	√	-	-	√	-	-	√				
Wasco/Sherman/Hood River (rural/ frontier)	√	-	-	√	-	-	√				
OSH FACILITIES (In Person)											
Junction City	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8	6	8
Salem	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13	12	18
TOTALS									**21**	**18**	**26**

[53] As preliminary input on program review tools.

APPENDIX C

SUMMARY OF OHA COMPLIANCE WITH OPP PROVISIONS ADDRESSED IN IC REPORT #4

Blue Shading Indicates Compliance as of Report Date
Yellow Shading Indicates Efforts at Compliance Underway But Not Yet Fully Completed, Timeline Not Yet Reached, or Unknown
Pink Shading Indicates Non-Compliance as of Report Date

OPP PROVISION NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data through 12/31/17; IC Report Sept 2018)
(MOBILE) CRISIS SERVICES			
6. Expand mobile crisis services statewide	By 6/30/18 – statewide	N/A	***IN COMPLIANCE***
7a – b & 8. # served/contacts by mobile crisis	FY2017 – 3,500 FY 2018 – 3,700	3,732	***IN COMPLIANCE*** 5,027
8. Track & report dispositions	By 6/30/17 – Methodology No later than 1/1/18 – # admitted to acute care By 6/30/18 – # stabilized in community setting rather than arrest, ED, or ACPF admission	N/A	***WORKING TOWARD COMPLIANCE*** Dispositions being reported by programs on quarterly template; OHA expects to report this information in its next Narrative Report in January 2019
9, 10a – b, 11, & 12a. Mobile crisis response times	By 6/30/17: Other than Rural/Frontier – w/in 1 hr Rural – w/in 2 hrs; Frontier – w/in 3 hrs Rural/Frontier – person trained in crisis management calls w/in 1 hour FY2018 review progress & adjust if needed	N/A	***WORKING TOWARD COMPLIANCE*** Per regulation & Team Review, State appears to be in substantial compliance, but analysis of actual performance statewide has not yet been provided & clarification about reporting is needed
13. Uniform standards for hotline services and County crisis lines	Develop standards and enforce	N/A	***IN COMPLIANCE***
SUPPORTED HOUSING			
14a – c. # in supported housing	FY2017 – 835 FY2018 – 1,355 FY2019 – 2,000	442	***IN COMPLIANCE*** 1,002
14. Best efforts to match individual w/ housing needs and choice	Best Efforts	N/A	***IN COMPLIANCE***
15. Data re housing stock or inventory available for individuals w/ SPMI; track # in supported housing; use info for budget requests in 2017-2019 budget	Make inventory available w/o numeric goals; track & report # in supported housing (see 14. above); advocate for budget increases for housing[54]	53,323 (as of Jan 2017); 442	***IN COMPLIANCE*** 54,615; 1002 Funding from Legislature secured
26a – e. Interim, short-term, community-based housing for individuals discharged from OSH or SRTF no longer than 2 mo & no more than 5/unit	≤ 20 interim housing slots; # placed in interim housing for no more than 2 mo & no more than 5/unit; By 7/1/19 – Slots converted to long-term integrated housing	N/A	***NOT APPLICABLE*** No plans to discharge from OSH or SRTFs to interim housing
OSH DISCHARGES			

[54] While the OPP does not specifically reference the 2019-2021 Legislative session (beginning in January 2019), additional OHA advocacy efforts will be needed to continue to increase or even maintain supported housing numbers into the future after the OPP timeline has ended.

OPP PROVISION NUMBER & TOPIC	NUMERIC GOALS & ACTIONS IN OPP	BASELINE CY 2015	COMPLIANCE STATUS (OHA Data through 12/31/17; IC Report Sept 2018)
23b. OSH individuals who meet ACT LOC discharged w/ services appropriate to needs	Services post discharge for individuals with ACT LOC	N/A	***NOT IN COMPLIANCE*** QPI process for post-discharge services tracking for ACT LOC individuals in development
25. Discharges to most integrated setting appropriate, consistent with goals, needs, and informed choice; not to SRTF unless clinically necessary and not w/o express approval of Dir of OHA/designee	Appropriateness of discharges documented Discharges to SRTF only w/ Dir or designee approval	N/A	***WORKING TOWARD COMPLIANCE*** Efforts underway to comply; Choice provider contract under revision and additional direction being provided; KEPRO contract in place; forms and processes being revised
CRIMINAL JUSTICE DIVERSION			
51 – 52. Intent to reduce arrests, jail admissions, LOS in jail, & recidivism of SPMI individuals involved w/ law enforcement due to MH	Strategies		***IN COMPLIANCE (WITH INTENT)***
52a. # Individuals receiving jail diversion services	Report w/o goals	1,409	***IN COMPLIANCE*** 1,766 (less than previous quarter)
52a. # of diversions (pre- and post-arrest)	Include in RFP & contracts requirement to track pre- and post-arrest diversions		***NOT IN COMPLIANCE*** OHA requires reporting of pre- and post-arrest/booking services, but w/o clear guidance re the distinction; diversions (as opposed to services) not specifically defined or reported
52b. Work w/ OR Sheriffs Association & Association of CMHPs to determine data collection strategies for individuals w/ SPMI entering jails	By July 2016 – Begin work on data collection strategies	N/A	***IN COMPLIANCE*** Discussions & attempts are underway, but strategies for data collection are not yet in place
52c. Expand use of sequential intercept model (SIM)	By July 2016 – Contract with GAINS Center; New funding for jail diversion services will require adoption of SIM	N/A	***IN COMPLIANCE***
52c. Encourage local jurisdictions to adopt interventions in accordance w/ SIM	Encouragement of interventions in accordance w/ SIM	N/A	***IN COMPLIANCE*** Many Counties using; some mapping & more underway
52d. # Arrests of individuals w/ SPMI enrolled in services	As of July 2016 – track arrests; Report w/o numeric goals	N/A	***NOT IN COMPLIANCE*** Data is being requested of programs but data analysis not yet provided; State data sharing not yet in place
52e Jail diversion program data provided quarterly	Report quarterly on jail diversion programs funded w/o numeric goals	N/A	***PARTIALLY IN COMPLIANCE*** OHA reports services but does not distinguish diversions
52f. Collect data re arrests, impacts of and obstacles to success of CJD services; provide results re mapping and allocate funding accordingly; prioritize pre-charge diversion activities	Report specified data and allocate funding to support addition or enhanced jail diversion programs based on results of mapping; prioritize pre-charge diversion activities	N/A	***PARTIALLY IN COMPLIANCE*** OHA does collect/report data on CJD services & through OCBHJI on results of mapping, but does not report arrests or obstacles to success, does not allocate funding based on mapping, & encourages but does not prioritize pre-charge activities
53. Strategies for sharing information w/ jails re MH diagnosis, status, medication regime, & services of incarcerated individuals w/ SPMI	Work with local jurisdictions to develop strategies	N/A	***WORKING TOWARD COMPLIANCE*** Information and training being developed for programs regarding how to share information consistent with state and federal laws and regulations

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