United States Department of Justice

Interim Report to the State of Oregon

Integration of Community Mental Health and Compliance with Title II of the Americans with Disabilities Act

January 2, 2014

I. Background

The United States Department of Justice initially opened an investigation of conditions at the Oregon State Hospital under the Civil Rights of Institutionalized Persons Act in 2006. In late 2010, we expanded our focus to look at Oregon's broader mental health system pursuant to our authority under the Americans with Disabilities Act ("ADA"). This expanded investigation included examining the community services and supports available to persons with mental illness throughout Oregon.

Shortly after we began our expanded investigation, Oregon announced a transformation of its healthcare system to include integration of the systems for delivering physical and mental health care, expanding the number of individuals and services covered under the Oregon Health Plan, and ensuring improved quality of services through an outcome-driven system. The transformation is designed to shift financial incentives from acute care to prevention, wellness, and community-based management of chronic conditions – which is exactly the point of our ADA investigation, in which we are determining whether Oregon's mental health care is being provided in the most integrated setting.

Oregon leadership and the Department agreed that this health transformation process – *if* it includes a focus on helping people with serious and persistent mental illness achieve positive outcomes through the provision of critical community services – provided a unique opportunity, through a cooperative process, to ensure that Oregon meets that integration mandate of the ADA as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999).

In order to resolve our investigation, the Department and the State agreed to a process to ensure that the health transformation initiative brought about changes to the Oregon mental health system necessary to ensure that people were not placed at a risk of unnecessary segregation. The agreement included a three-part process. In the first year, largely, although not exclusively through the managed care provider contracts, the State would collect data that would permit the mapping of services and outcomes. This was essential to the reform because statewide data was largely unavailable and the State did not have information essential for the planning process.

Once the data was collected and the systems understood, the parties agreed to discuss intermediate metrics to be placed in provider contracts. These would include a minimum array of services necessary to meet the known needs. We agreed that this was a necessary step to transition to a system driven solely by outcome measures.

In the final phase, we would work together to develop outcome measures that would be guided by individual and community health. These would be included in the provider contracts and would not measure the quantity of each service, but rather set standards to measure whether the systems are supporting people in the community and preventing unnecessary segregation.

As provided by our November 9, 2012 agreement, Oregon has submitted quarterly data and information to the Department regarding system development and outcomes regarding community mental health provisions. We also met with State officials in late March 2013 and

have had various discussions throughout the year regarding the data provided by the State. This report addresses our initial analysis of that data.

II. Executive Summary

Several themes emerge from the data provided by the State throughout this past year:

- First, and foremost, Oregon appears to have made only limited progress over the past three quarters in decreasing the use of restrictive institutional settings, decreasing the rate of readmission to these institutional settings, decreasing the average time confined in these institutional settings, and decreasing the service dollars spent on these institutional settings.

- Second, while Oregon data reports somewhat of an array of mental health services, the data reveals a lack of adequate high-intensity services like Assertive Community Treatment ("ACT"), and critical supports for housing and employment.

- Third, the data suggests that the high *quantity* of services that Oregon is reporting in some parts of the State do not meet evidence-based models for *quality*.

- Finally, the data is inconclusive whether community services are being appropriately distributed and allocated statewide, particularly throughout the more heavily populated centers in the State.

The data we have reviewed clearly shows that Oregon's community services have not begun to expand. That has led to a predictable result – Oregon is not yet transitioning to a community-based system. The State's data reveals that funding for mental health services is not yet shifting away from costly restrictive institutional settings to more effective, less costly community settings.

The State has long been aware of the gaps in its community mental health system. In 2008 and 2009, the Legislature and the Department of Mental Health funded reports from various workgroups and consultants that document the gaps in the system.[1] For years, the Department has repeatedly raised this same concern with Oregon leadership. We were assured that the State was committed to moving to a community-based system of providing mental health care.

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[1] Public Consulting Group, Oregon Department of Human Services Additions and Mental Health Division, *Assessment and Evaluation of the Mental Health Care Delivery System in Oregon*, November 2008; Public Consulting Group, Oregon Department of Human Services Additions and Mental Health Division, *Assessment and evaluation of the adult mental health system in Oregon*, March 12, 2009; Oregon Department of Human Services Community Services Workgroup Report, *A Complement to the Master Plan Phase II Report on the Replacement of the Oregon State Hospital*, March 2009.

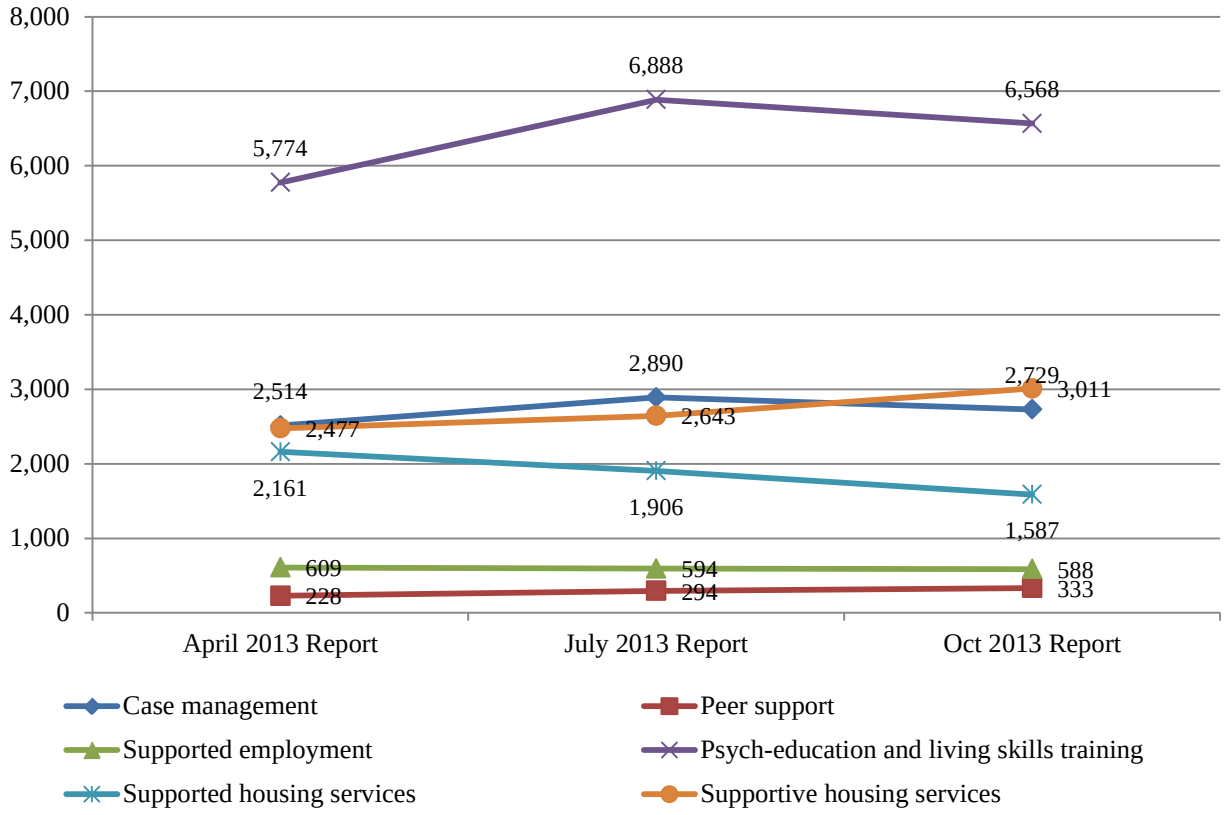
Certainly, serving individuals with highly complex mental health needs is best done through a person-centered approach delivered through an array of effective evidence-based community services. Furthermore, this approach best preserves State general funds and is more effective than institution-based services. While State officials have expressed their desire to create a community-based mental health care delivery system, this is not yet happening. We look forward to working with the State to now redirect its focus and efforts to make community-based mental health services a reality in Oregon.

III. Analysis of Data

A. Current Service Provision of Oregon Community-Based Mental Health Services

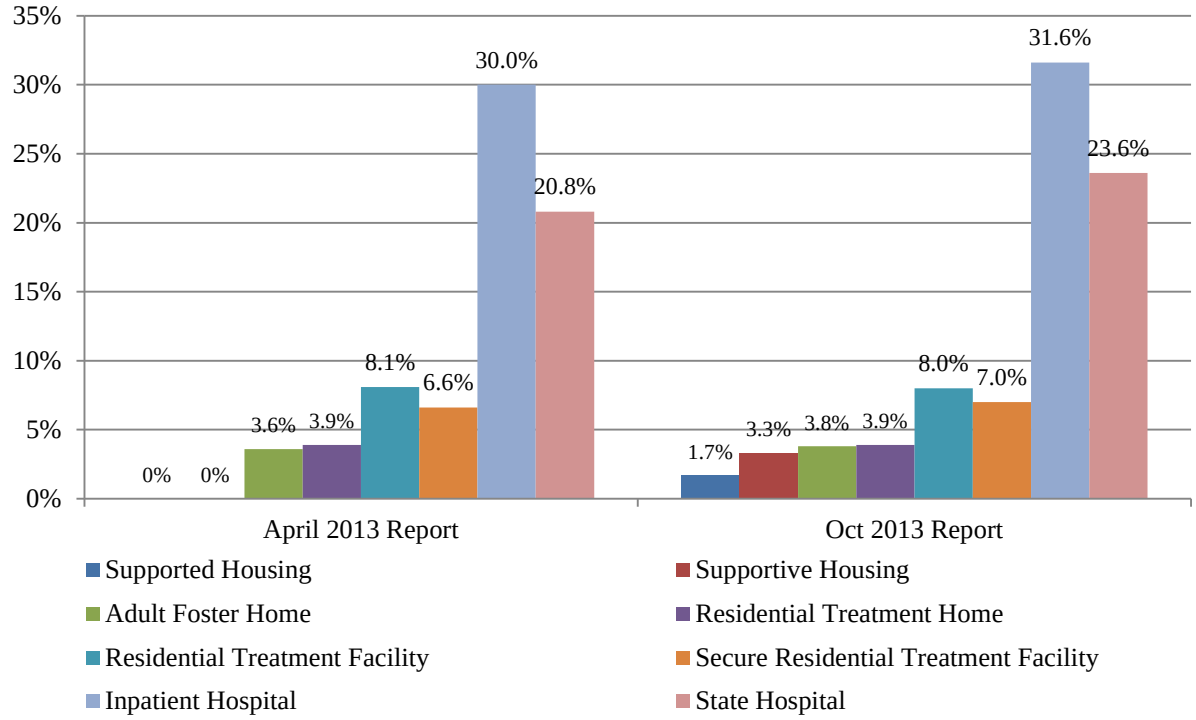
Despite the stated commitment to transform to a community-based system, the data provided demonstrates that there has not been an increase in the provision of community-based mental health services. As the State develops community services, we would expect to see an increase in the amount of community-based mental health services (service units) being provided and a decrease in the amount of institution-based services. This expected increase is not evident. Indeed, as demonstrated in Chart 1, the quantity provided for most community services has essentially stayed the same during 2013, and in the case of supported housing, has actually decreased.

Chart 1 - Service units per adult with a serious and persistent mental illness provided by Coordinated Care Organizations, per 1,000 clients



Similarly, despite Oregon's stated goal to shift from costly institution-based services to less costly preventative services, this transformation is not yet occurring. Funding has not yet shifted away from costly restrictive inpatient settings to less costly, less restrictive community settings. In fact, the percentage of spending on care for adults with a serious and persistent mental illness in more restrictive living settings has *increased* by about 5% over the two quarters of data provided, as noted in Chart 2.[2] The data provided clearly demonstrates that approximately 74% of all service dollars spent by Oregon for adults with a serious and persistent mental illness is going toward restrictive, institution-based settings. Moreover, it is worth noting that three quarters of the budgeted service dollars are being spent on less than 2% of Oregon adults with a serious and persistent mental illness.

Chart 2 - Percent of all service dollars for adults with a serious and persistent mental illness that are used for care, by reported setting[3]



The above care settings are defined herein. [4]

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[2] During calendar year 2013, as evidenced in Chart 2, service dollars spent on care of adults in institutional settings increased from 69% to74% according to data provided by the State for System Development Measure 9, items D-H. The reported data demonstrates that the State continues to spend a vast majority of its service dollars for adults with serious and persistent mental illness on restrictive settings, including the state hospital and smaller secure settings.

[3] Chart 2 includes only spending for people in select settings and, therefore, does not sum to 100%. The chart does not include spending for people who received services in other settings, such as those living in their own home, those living with family, those living with friends, and those who are homeless, for example.

Significantly, as the State itself recognizes, the movement from an institution-based system and a subsequent reinvestment into a community-based system will result in major savings. This is because the cost of providing care at the state hospital is significantly higher than the cost of providing individualized services in the community. For example, with an estimated cost of care at Oregon State Hospital of $945 per day,[5] the annual cost of a state hospital stay is approximately $344,925 per person. Given that care provided by the state hospital is generally not reimbursable through Medicaid or other insurance, these costs have largely been borne by the State of Oregon.

In contrast, providing services to individuals in the community would not only lower cost, but would draw down federal dollars through Medicaid or other programs. For example, a national estimate of the average annual total cost of effectively supporting an individual in the community with Assertive Community Treatment services is about $15,000.[6] Taking into account that ACT services are reimbursable through Medicaid and draw federal dollars, the costs to Oregon are only approximately $5,634 per person annually. The table below summarizes annual projections comparing inpatient hospitalization with intensive community services.

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[4] "Supported housing" as defined in the November 9, 2012 agreement, refers to permanent, scattered-site housing for no more than two people in a given apartment or house where housing, support, and individualized care services are provided as an integrated package. "Supportive housing" as defined in the November 9, 2012 agreement, refers to permanent housing in which tenants who live together in a single building or complex of buildings receive support services. "Residential Treatment Facility" is a state-licensed live-in facility that provides services on a 24-hour basis for six or more residents with serious and persistent mental illness. "Secure Residential Treatment Facility" is a state-licensed locked facility that provides services on a 24-hour basis for six or more residents with serious and persistent mental illness. By regulation, a resident is restricted from exiting the facility or its grounds through the use of approved locking devices on resident exit doors, gates, or other closures for the stated purpose of protecting the public. "Residential Treatment Home" is a group home for five or fewer residents with serious and persistent mental illness where services are provided on a 24-hour basis. "Adult Foster Home" is a state-licensed group home in which residential care is provided to five or fewer adults. By regulation, Adult Foster Homes are required to have written posted house rules "regarding hours, visitors, use of tobacco and alcohol, meal times, use of telephones and kitchen, monthly charges and services to be provided and policies on refunds in case of departure, hospitalization or death."

[5] Oregon Health Authority, *Oregon State Hospital Cost of Care,* http://www.oregon.gov/oha/amh/osh/Pages/cost-of-care.aspx.

[6] National Alliance on Mental Illness, *Assertive Community Treatment: Investment Yield Outcomes*, September 2007.

Chart 3 – Institutional costs compared to community services

	Annual Cost Basis	Total Annual Cost		Federal Medicaid	Net State Cost	
Institutional	Hospital Days:	Average stay (256 days)	Full year cost		Average stay (256 days)	Full year cost
	Oregon State Hospital ($945 daily rate)	$241,920	$344,925	$0	$241,920	$344,925
Community	ACT @ $15,000	$15,000		$9,366	$5,634	
Range of Annual Savings/Person:					$236,286 to $339,361	

B. Consumer Outcomes

The State's data raises concerns that Oregon continues to rely heavily on institutional settings for persons with mental illness and is not yet providing an adequate array or volume of services in the community. Assessing the data Oregon provided shows a trend of relatively unchanged use of restrictive living placements, relatively unchanged lengths of stay in these settings, and relatively unchanged rates of readmission to institutional settings. These "flat line" data trends are shown in Charts 4-7 below, and all are poor consumer outcomes.

Chart 4 - Number of adults with an identified serious and persistent mental illness in restrictive settings

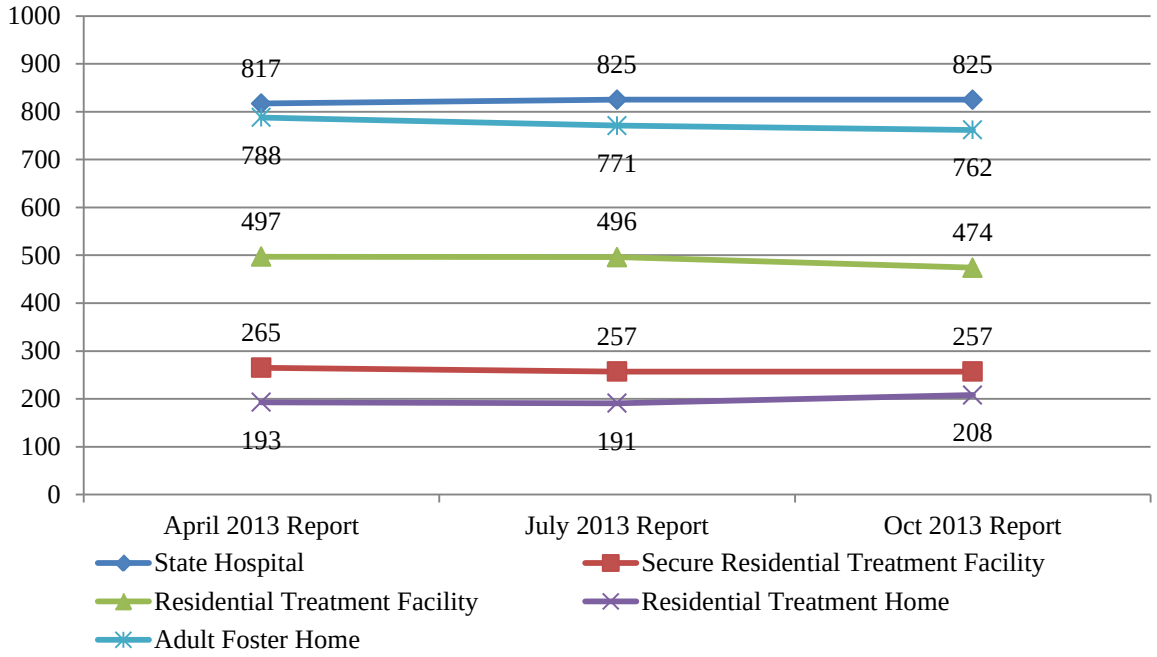


Chart 5 - Average admission rate for adults with serious and persistent mental illness, per 1,000 clients

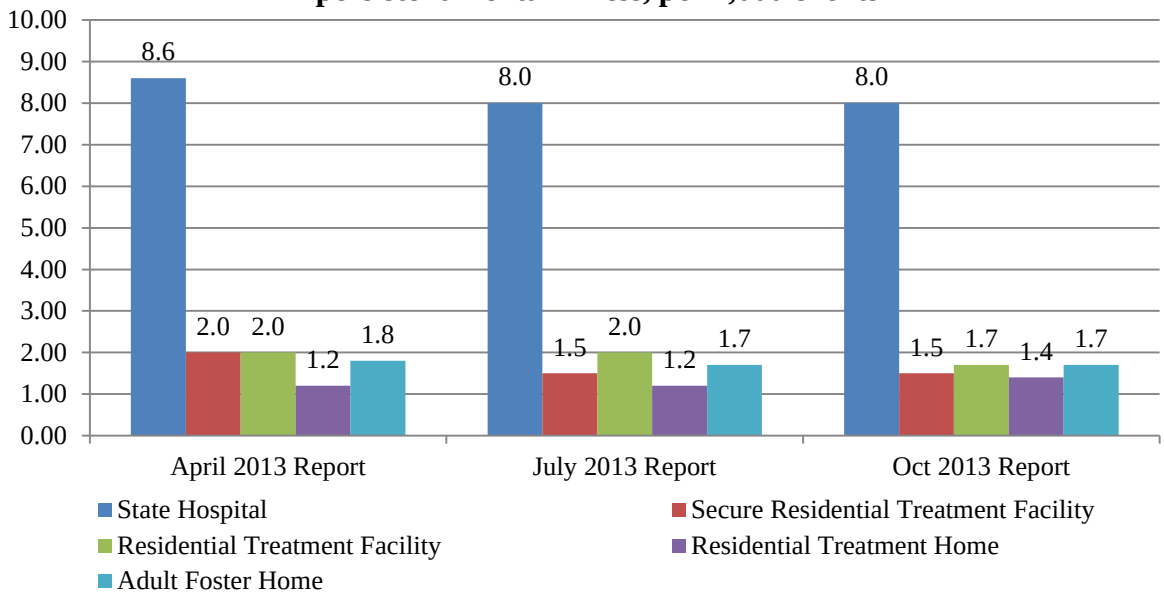


Chart 6 - Average length of stay for adults with serious and persistent mental illness, by setting

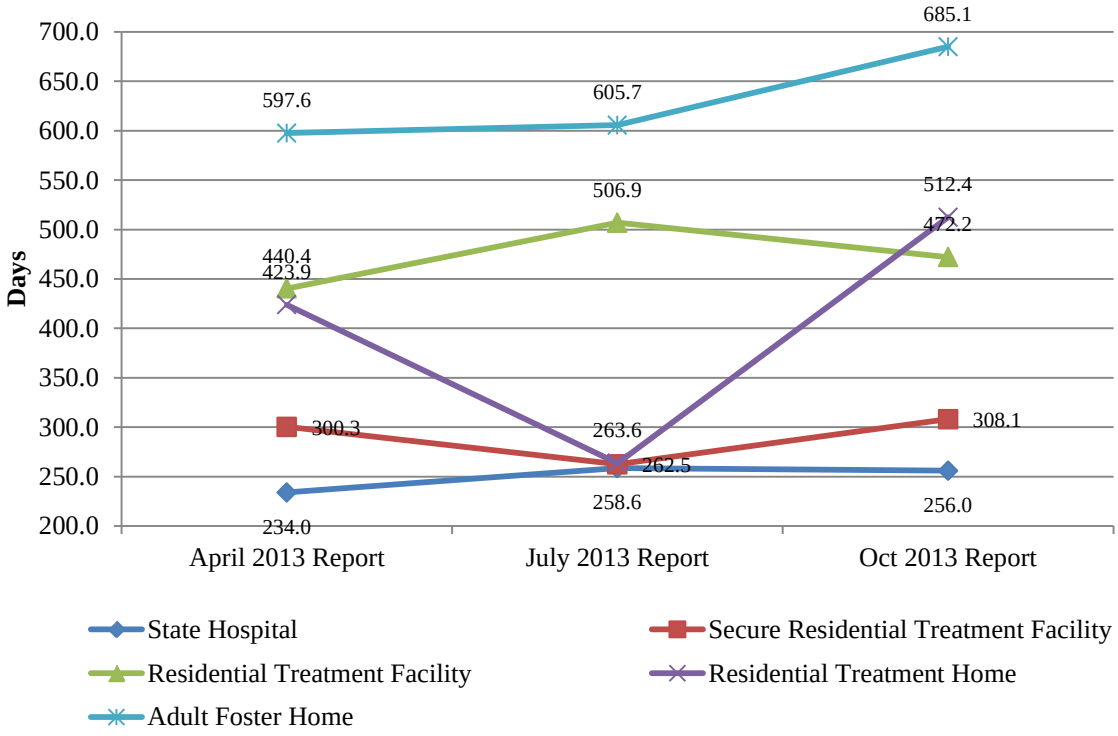
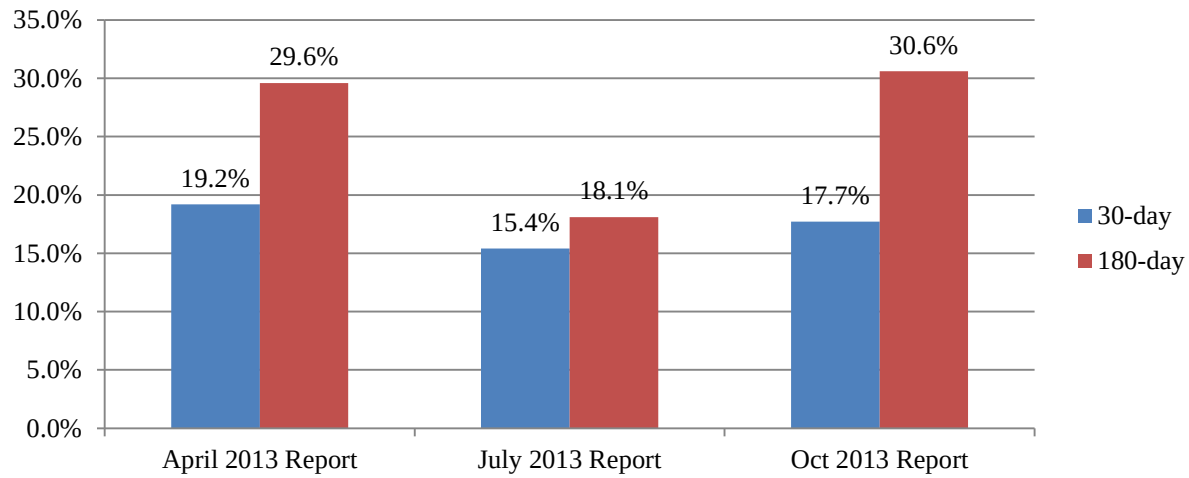


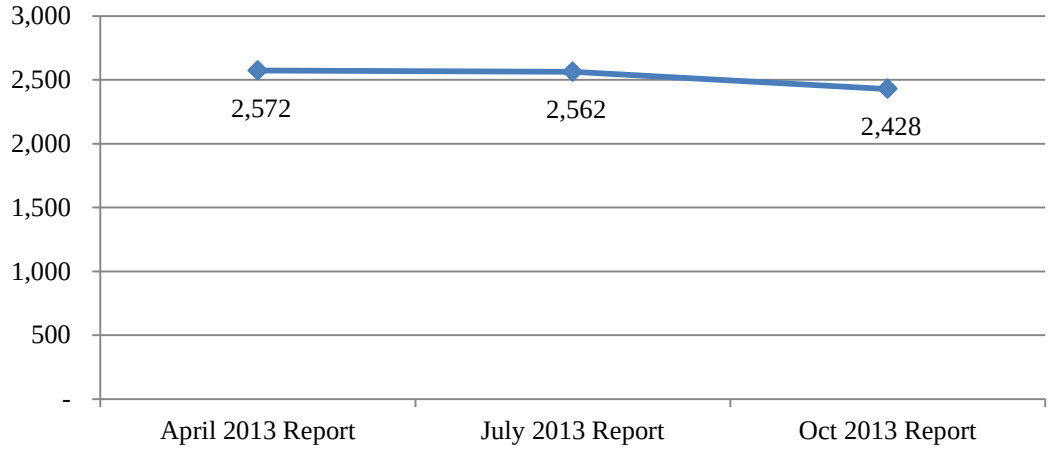
Chart 7 - Readmission rates for inpatient psychiatric care for adults with serious and persistent mental illness



Charts 4-7 reflect that mental health services in Oregon have not shifted away from restrictive settings to less restrictive settings in accordance with the integration mandate of the Americans with Disabilities Act, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). Moreover, the data provided by the State reflects that services in the community are not sufficient to keep individuals out of restrictive settings.

In addition, the State's data (Chart 8) shows only a minimal decline in the number of consumers seeking emergency room services. Again, if the State were following through on its stated goal of investing in preventative community-based services, we would expect to see the number of emergency room visits for individuals with mental illness start trending significantly downward. As evidenced by the data, this has not happened. Furthermore, while the number of total emergency room visits may appear to have decreased somewhat, the number of consumers using community-based crisis stabilization services (such as mobile crisis teams and walk-in crisis centers) has not increased as shown by the State's data for System Development Measure 3, evidencing a lack of intended outcomes.

Chart 8 - Number of emergency room visits for adults with a with a mental health diagnosis



IV. Utilization of Community-Based Mental Health Services by Adults with a Serious and Persistent Mental Illness

A. Data Integrity

Chart 9, below, summarizes the key community-based services that Oregon reports providing to people with serious and persistent mental illness, either through its counties or through managed care organizations – predominantly the fledgling Coordinated Care Organizations, but to a lesser extent Mental Health Organizations and fee-for-service providers. An analysis of the data provided calls into question both the accuracy of the data and suggests that the high quantity of services that Oregon is reporting in some parts of the state do not meet evidence-based models for *quality*.

Chart 9 - Oregon community-based mental health services: Number of adults with a serious and persistent mental illness served and number of contracted providers

Community-based mental health service	# of adults with a serious and persistent mental illness served by counties	# of county subcontractors	# of adults with a serious and persistent mental illness served by managed care organizations	# of managed care subcontractors	Total # of adults with a serious and persistent mental illness served	Total # of subcontractors
Community-Based Crisis Services [7]						
Crisis hotline	37,931	47	CCOs partner with the counties, who typically run the crisis system, according to Oregon's "Data Table."		37,931	47
Mobile crisis teams	5,579	45			5,579	45
Walk-in/drop-off crisis centers	3,803	38			3,803	38
Crisis apartments / respite	150	27			150	27
Short-term crisis stabilization units	574	25			574	25

[7] It is also likely the data includes individuals who are not diagnosed with serious and persistent mental illness, given that the counties do not appear to have a system for filtering who qualifies as serious and persistent mental illness versus someone diagnosed with serious mental illness or someone without mental illness. Additionally, the State is unable to provide unduplicated counts for these services.

Community-Based Mental Health Services and Supports						
Community-based mental health service	# of adults with a serious and persistent mental illness served by counties	# of county subcontractors	# of adults with a serious and persistent mental illness served by managed care organizations	# of managed care subcontractors	Total # of adults with a serious and persistent mental illness served	Total # of subcontractors
Assertive Community Treatment	169	17	349	24	518	41
Intensive Case Management	2,610	41	310	289	2,920	330
Case Management	Data not provided for counties		5,553	289	5,553	289
Peer Support	409	39	404	62	813	101
Supported employment	248	27	534	36	779	63
Psych-education and living skills training	692	35	2,366	62	3,058	97
Assessment	3,330	72	6,783	564	10,113	636
Community-Based Housing						
Supported housing services (DOJ definition)	460		0		460	
Supportive housing services	873		0		873	
Own Home					21,419	
Total Adults Served					22,752	

In conversations with Oregon since this data was provided, State officials were confident that the information provided is accurate. The data regarding Intensive Case Management illustrates why some of the data may be flawed. If the information provided is accurate, Oregon provides this service to almost 3,000 individuals – the vast majority of whom receive Intensive Case Management through the counties. The counties are reported to have 41 subcontractors – which the State asserted represents 41 teams – providing services to 2,610 individuals. The managed care organizations are reported to have 289 subcontractors or 289 teams, serving 310 individuals. Thus, the counties have an average case load of 64:1 which is more than 60 times greater than the caseload provided by the managed care organizations for the exact same service. Although it is likely the discrepancy arises from how managed care organizations count the number of subcontractors providing ICM, the data shows an obvious discrepancy.

In addition, the data reflects the inadequacy of the totality of services currently being provided. Given the total number of adults with a serious and persistent mental illness being served in the community, the level of services that they are receiving is extremely low. For example, we would expect that most of these individuals would receive some type of case management or care coordination. The data reveals, however, that only 41% of these individuals received case management or care coordination services.

B. Current Service Caseloads

Setting aside the accuracy issue, the current service population data illustrates a critical point: many service teams in Oregon report caseloads dramatically lower than what we have seen in states using evidence-based models.

The Intensive Case Management data also highlights this point, as shown in Chart 10, below. Looking at just the county-level data and excluding the managed care data, Oregon county Intensive Case Management teams serve caseloads of roughly 64 people per team with caseloads varying from 0 people per team to 527 people per team.

Chart 10 - Comparison of Oregon Intensive Case Management team caseloads, by county

County	Number of Intensive Case Management teams	Unique number of people with serious and persistent mental illness served	Average caseload per team
Gilliam	1	0	0.00
Grant	1	0	0.00
Harney	1	0	0.00
Morrow	1	0	0.00
Wheeler	1	0	0.00
Clatsop	1	1	1.00
Columbia	1	1	1.00
Lake	1	3	3.00
Wallowa	1	3	3.00
Clackamas	3	12	4.00
Union	1	4	4.00
Coos	1	5	5.00
Sherman	1	5	5.00
Tillamook	1	5	5.00
Yamhill	1	5	5.00
Deschutes	1	7	7.00
Hood River	1	12	12.00
Multnomah	4	55	13.75
Josephine	1	18	18.00
Jackson	1	20	20.00

County	Number of Intensive Case Management teams	Unique number of people with serious and persistent mental illness served	Average caseload per team
Douglas	1	29	29.00
Baker	1	33	33.00
Lane	2	73	36.50
Wasco	1	51	51.00
Benton	1	65	65.00
Linn	1	86	86.00
Jefferson	1	135	135.00
Polk	2	274	137.00
Washington	3	440	146.67
Lincoln	1	214	214.00
Marion	2	1,054	527.00

As shown in Chart 11, below, the ACT team caseloads are similarly low and reflect substantial variation among ACT providers. These caseload numbers are not consistent with full-fidelity ACT services, which typically serve a caseload of 75 to 100 people per ACT team. In Oregon, ACT teams serve, on average, 10 people.[8] When broken down by provider, though, the caseloads vary wildly. The data also raises the question of whether there are sufficient ACT services in the State. For instance, Multnomah County ACT team serves only 25 of the roughly 13,173 estimated adults with a serious and persistent mental illness in the county.[9] By any measure, this is woefully inadequate as researchers have estimated that ACT teams should be provided to between 20-40% of those with serious mental illness.[10] Given that consumers with serious and persistent mental illness present greater needs than people with serious mental illness do, that number may need to be even higher, particularly when there has previously been a high rate of institutionalization.

[8] Assuming full- fidelity, these lower caseloads would result in extremely high costs per individual – way beyond what we would expect for full-fidelity, evidence-based ACT teams.

[9] This includes only individuals served by the county ACT team, not those served by Coordinated Care Organization ACT teams covering Multnomah County. Two Coordinated Care Organizations – Family Care and Health Share – cover Multnomah County. These Coordinated Care Organizations reported having one ACT team and three ACT teams, respectively. These teams – which also partially cover Clackamas, Marion, and Washington Counties – serve 78 people with ACT. This means even if all of the ACT services provided by these Coordinated Care Organizations were actually provided in Multnomah County, *at most* only 103 people would be receiving ACT services in the Portland area.

[10] Gary R. Bond, et al., *Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients*, Dis Manage Health Outcomes, 141-159 (2001); Gary S. Cuddeback, et al., *How Many Assertive Community Treatment Teams Do We Need?,* Psychiatric Services, 1803-1806 (December 2006).

Chart 11 - Comparison of Oregon ACT team caseloads, by provider

County or CCO	Number of ACT teams	Unique number of people with a serious and persistent mental illness served	Average caseload per ACT team
County: Columbia	1	0	0.00
County: Douglas	1	0	0.00
County: Gilliam	1	0	0.00
County: Morrow	1	0	0.00
County: Wheeler	1	0	0.00
County: Union	1	1	1.00
County: Wallowa	1	1	1.00
CCO: FamilyCare	1	1	1.00
CCO: Western Oregon Advanced Health	1	1	1.00
County: Lane	2	5	2.50
CCO: PrimaryHealth Josephine	2	8	4.00
County: Josephine	1	5	5.00
CCO: Columbia Pacific	3	18	6.00
CCO: Yamhill County Care	2	12	6.00
County: Hood River	1	8	8.00
CCO: Intercommunity Health Network	2	16	8.00
CCO: Eastern OR	3	33	11.00
County: Benton	1	12	12.00
CCO: PacificSource	2	30	15.00
CCO: Trillium	4	71	17.75
County: Deschutes	1	19	19.00
CCO: All Care	1	20	20.00
County: Washington	1	22	22.00
County: Multnomah	1	25	25.00
CCO: Health Share	3	77	25.67
County: Wasco	1	27	27.00
County: Yamhill	1	44	44.00

C. Geographic Distribution of Current Services

Given the data provided by the State to date, we do not have enough information to map precisely where services are concentrated. While we have information about what the counties provide, the complication arises for the services provided by Coordinated Care Organizations. Several Coordinated Care Organizations cover multiple counties, and several counties are covered by multiple Coordinated Care Organizations. In places where overlap exists, we do not

have a way to accurately overlay where services are available.[11] The State should amend its data collection process to permit this analysis to be done. It will be essential to its ability to address gaps in services and successfully move to an outcome-based system.

V. Conclusion

Although the accuracy of the data provided by Oregon over the past year is concerning, our review of intended outcomes does show substantial gaps in the community mental health services being provided. Despite our expectation that changes in the service system would help reduce Oregon's reliance on institutionalization, that key outcome for consumers has not taken hold. Likewise, key consumer outcomes in general have not appeared to improve over the past three quarters. Further, despite data reporting a high quantity of some services, the data suggests those services likely do not meet the quality of evidence-based models for care. Oregon is far behind where it needs to be in providing the high-intensity community services that are most necessary for serving people with serious mental illness in the most appropriate integrated settings.

[11] We have reached out to the State about this issue. Oregon informed us that it expected to provide us this breakdown by January 1, 2014, but we have not yet received this information. Receiving this information will assist in conducting a mapping of services throughout Oregon.