Mental Health

Ability to serve adults with serious and persistent mental illness is limited and at risk

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Multnomah County Auditor's Office

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Report Highlights

What we found

Multnomah County's ability to serve adults with serious and persistent mental illness is limited and faces imminent risks. Currently, over half of people who are involved with the civil commitment system are not receiving the most intensive services the county offers, including care coordination and Assertive Community Treatment (ACT) services. For those who receive them, these intensive services seem to be working as intended for many people. However, the Mental Health and Addiction Services Division should do more work to examine outcomes.

The sustainability of some of the county's community mental health programs for people with serious and persistent mental illness appears to be at risk. Demand for services is not being met and is unlikely to abate. Revenue for services has essentially been flat and is unlikely to rise. The division has reserved funds for future program needs, such as housing developments. This adds risk to state funding and potentially constrains program access. Structural obstacles, like the cost of housing, are preventing more people from successfully moving through the programs.

Why we did this audit

Adults with serious and persistent mental illness, especially those involved with the civil commitment system, are a vulnerable population at high risk of institutionalization. It is important that the county serve this population well. In the last few years, the State of Oregon has lessened the availability of institutional care without sufficiently investing in community services, which has affected mental health programs and added significant risk of services being insufficient.

What we recommend

We recommend that the Mental Health and Addiction Services Division:

- Publicly report to the Board of County Commissioners on funding priority decisions, state funding status, and progress for developing housing resources.
- Obtain written approval from the state for plans to reserve state grant funding.
- Analyze and report on options for addressing ACT accessibility.
- Update county Choice policies and clarify criteria.
- Take steps to ensure that people who could benefit from services are identified.
- Advocate for more dedicated supported housing units for this population.
- Take steps to ensure data and information are available for evaluation purposes.
- Develop a process to routinely measure outcomes for Choice and ACT, including identifying racial disparities in outcomes.
- Allocate staff for ACT contract management.

The State of Oregon has control over the mental health system

The Oregon Health Authority has a significant amount of control over the mental health system because it sets policy as well as controls the flow of funding. The Oregon Health Authority and state legislature set laws and administrative rules. They make pivotal decisions about Medicaid, including setting the terms of contracts with Coordinated Care Organizations – networks of health care providers who serve Oregon Health Plan members. The Oregon Health Authority also oversees the state mental health grant that provides funding to community mental health programs. Finally, the Oregon Health Authority licenses residential programs and controls flows into and out of the Oregon State Hospital, the state psychiatric hospital.

Counties still have responsibilities and some delegated authorities

Multnomah County is the local mental health authority and is responsible for the community mental health program. According to the Oregon Health Authority, "the purpose of the community health program is to provide a system of appropriate, accessible, coordinated, effective, efficient safety net services to meet the mental health needs of the citizens of the community."

The county's Mental Health and Addiction Services Division within the Health Department manages Multnomah County's community mental health program. The program includes:

- Oversight and contracting with state-licensed residential services programs;
- Care coordination in the Choice program, which we talk about later in this report;
- Mental health crisis services;
- Involuntary commitment services, including commitment investigations, monitoring, and post-commitment services;
- Adult protective services;
- Indigent services, including culturally-specific services; and
- Mental health diversion from the justice system.

Funding to pay for these services comes from a variety of sources. Medicaid, through the Oregon Health Plan and Health Share of Oregon, pays for services provided to its members. The state contracts with the county to pay for some services via the state mental health grant, and the county provides some funding from its general fund to try to fill some gaps.

The Oregon Health Authority is under pressure to reduce length of stay in the state hospital, which affects the county

Facing legal pressure from the U. S. Department of Justice as well as local courts, the Oregon Health Authority has intensified its focus on how people with serious and persistent mental illness are treated. It made adjustments primarily associated with the operation of Oregon State Psychiatric Hospitals and residential treatment services.

In 2016, the Oregon Health Authority entered into an agreement with the U.S. Department of Justice called the Oregon Performance Plan. This agreement aims to resolve concerns that the State of Oregon was violating both the Americans with Disabilities Act and legal decisions, by serving too many people in institutions rather than in the community.

The Performance Plan is set up to provide mechanisms and incentives to treat more people in the community, rather than in institutions. It dictates specific goals for quicker discharges from the State Hospital and residential settings. It also states that community resources, such as supported housing, supported employment, and Assertive Community Treatment (ACT), should be in place in the community.

In the Oregon Performance Plan, the state pledged to, among other things:

- Reduce the length of stay in the Oregon State Hospital for civilly committed individuals – the goal for the end of June 2017 was that the state hospital would discharge 90% of individuals within 120 days of admission.
- Reduce the amount of time it takes to transition an individual who is ready to move out of the state hospital and into the community. The goal for the end of June 2019 was to have 90% of ready-to-transition individuals discharged within 20 calendar days.
- Increase the availability of ACT services so that the Oregon Health Authority will provide ACT services to anybody who is referred and eligible. The plan said 2,000 individuals statewide would be receiving ACT services by the end of June 2018.
- Eliminate the use of "interim" – temporary- housing placements for individuals discharged from the state hospital by the end of June 2019.

While it pledged to make substantial improvements, the Oregon Health Authority included a caveat in the plan that outcomes are subject to Oregon Law and that the Health Authority cannot spend money to make improvements if the Oregon legislature does not appropriate that money first. Still, the Health Authority incorporated some Performance Plan goals into contracts with community mental health programs – tying funding for community-based treatment to success in meeting Performance Plan objectives around transitioning individuals out of the state hospital more quickly.

The Oregon Health Authority's mental health priorities have been further affected by another legal decision more recently. A Washington County Circuit Court found the Oregon State Hospital in contempt of court for not promptly admitting individuals found to be unable to "aid and assist" in their defense in criminal cases due to their mental health challenges. The director of the Oregon Health Authority released a plan for addressing the aid-and-assist related capacity issues at the state hospital. The plan includes prioritizing admission to aid-and-assist patients, rather than people on civil commitments.

What we looked at

Based on pressures on the community mental health programs, the priorities set by the state, and the vulnerability of the population served, we focused the audit on two key services for people with serious and persistent mental illness:

- Choice Model Program (Choice)
- Assertive Community Treatment (ACT)

We examined these services under the lenses of **access** and **outcomes**.

Access

For access, we started with the population of people who were involved with the civil commitment process during calendar years 2016-18, and identified whether those individuals were enrolled in Choice or ACT in the same period. This population could potentially benefit from Choice or ACT services, but may not have access to them.

We defined involvement with the civil commitment process as:

- Anyone who was civilly committed
- Anyone at risk of civil commitment – we defined this as being involuntarily held at least four times in the three years we reviewed, but not committed

Civil commitment is a legal process in which a judge decides whether an individual with mental illness should be required to go to a psychiatric hospital or receive other treatment for up to 180 days. To be civilly committed, someone must be dangerous to themselves or others, or unable to provide for their own basic personal needs for food, clothing, and shelter.

The civil commitment process often starts with a doctor or other mental health official ordering someone to be **involuntarily held** at a hospital for investigation for a civil commitment. The bar for civil commitment is high in Oregon, which means that someone may be involuntarily held multiple times without it resulting in a civil commitment.

For Choice, we also looked at access to residential treatment and supported housing.

Outcomes

For outcomes, we examined the occurrences of negative outcomes for clients enrolled in Choice or ACT during the calendar years of 2016-18. We defined negative outcomes as:

- Being put on an involuntary hold
- Being civilly committed
- Being booked into jail

For Choice, we also looked at moves that Choice clients made through a continuum of care.

We looked at outcomes in part because we saw little evidence of the division examining outcomes, and had trouble finding much publicly available information on outcomes from other sources. However, because we do not have benchmarks or good comparisons, this analysis should not be considered as a judgment of how the programs are doing. But rather, as a starting point of information that the division can build upon further.

Through this process, as well as through interviews, we also identified systemic threats to the sustainability of community mental health programs. *(For more information on methods, see the Objectives, Scope, and Methodology Section.)*

A note on language

There are many terms used in the mental health field and a lack of consensus on which terms are best or preferred. For the purpose of this report, we use the term "people with serious and persistent mental illness," to be consistent with the language used by the State of Oregon in the Oregon Performance Plan. Examples of conditions that are considered serious and persistent mental illnesses include schizophrenia, bipolar disorder, and major depressive disorder. We also use the term "client" when referring to users of services. We use the term "supported housing," to be consistent with the division's data labels. However, we are using that term interchangeably with the term "supportive housing." The Oregon Performance Plan makes a distinction between those two terms, but we do not maintain that distinction in our report.

Choice program results

What is the Choice Model Program?

The Choice program is a care coordination program for people with serious and persistent mental illness. The state's goal for the program is to keep people from needing to be admitted into the Oregon State Hospital and for those in the state hospital or in residential treatment to transition to the least restrictive level of care possible.

Who is it for?

The Choice program primarily targets adults with serious and persistent mental illness and who are in the state hospital, state licensed residential treatment, or at risk of going to the state hospital. Choice clients can also be individuals who are or were under civil commitment. The Choice program does not include individuals under the jurisdiction of the Psychiatric Security Review Board.

How is it paid for?

The State of Oregon provides funding for the Choice program through grants to counties and Coordinated Care Organizations. The grants are a combination of a fixed allocation and incentive payments if the community program meets certain incentives, such as transitioning individuals into community settings within 20 days of being designated as "ready to transition" from the state hospital. The funding allocation was decided in 2009, based on overall county population (not number of clients) and state hospital utilization at that time.

How is it supposed to work?

County staff called Exceptional Needs Care Coordinators facilitate communication between the individuals, their families, and community resources. They also help to provide access to mental health treatment for individuals without adequate health insurance, as well as access to other support services, such as temporary, transitional, and permanent housing. Choice program clients stay in Multnomah County's program until they no longer require program supports or are no longer county residents.

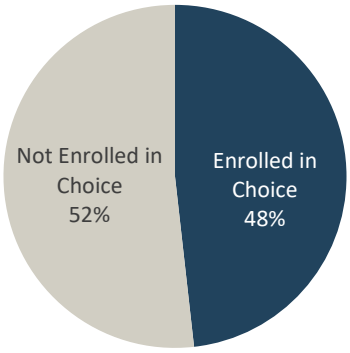
Access to Choice

Based on three years of data, the Choice program did not enroll everyone who likely could have benefited from the program. The Choice contract with the state allows for and may even require broader enrollment than the program currently practices. The county's narrow interpretation of enrollment criteria affects access. Even when in the Choice program, clients still face access barriers, particularly to residential treatment and supported housing.

Many people in the county who probably should be enrolled in Choice are not

From 2016 through 2018, 676 people were civilly committed at least once and 224 people were involuntarily held at least four times in Multnomah County. The majority of these individuals were not enrolled in Choice during the same period. This is surprising considering that the Choice program targets the population of people who have been civilly committed.

Just under half of people who were civilly committed in 2016-18 were enrolled in Choice at any time in that same time frame.



Note: For calendar years 2016, 2017, and 2018. Some people may have been enrolled either prior to 2016 or after 2018. For a small number of people committed in late 2018, enrollment may have occurred in early 2019.
Source: Auditor analysis of data supplied by the Multnomah County Mental Health and Addictions Services Division.

As shown in the figure, only around half of all people who were civilly committed were enrolled in Choice in the three-year period of 2016, 2017, and 2018. That is 350 people who were civilly committed but not enrolled in Choice. Additionally, among those at risk of civil commitment (involuntarily held at least four times) the proportion enrolled in Choice was only 8%. This very low percentage makes sense, given Choice's prioritization criteria, but also shows a potential large gap in access.

The Choice contract allows, and may require, broader enrollment

This lack of enrollment appears to go against the intergovernmental agreement with the State of Oregon in some cases. The agreement in place during our review period required Multnomah County to enroll anyone who has both been civilly committed and is going to (or at risk of going to) the Oregon State Hospital. It also allowed the county to enroll additional populations, as described below. It appears that Multnomah County uses a narrow interpretation of enrollment criteria.

Some of the individuals who were civilly committed but not enrolled in Choice probably should have been enrolled. Anyone who was referred to, or at risk of being referred to, the state hospital should have been enrolled in Choice. The contract is less clear about situations where an individual is civilly committed but receives treatment in a local hospital.

We examined records for a sample of individuals who were civilly committed and not enrolled in Choice. We found some examples of people who were not enrolled in Choice, even after being referred to the state hospital, as was required in the contract. These individuals did not end up going to the state hospital for a variety of reasons.

The remaining individuals in the sample were not formally referred to the state hospital and instead received treatment in local hospitals. Depending on their circumstances, some may have been considered at risk of referral. The county's Choice program manager reported that some people under civil commitment in local hospitals do not need the extra support Choice provides.

The 2017-19 contract for Choice states:

The county **shall** enroll anyone who has been civilly committed and has been admitted or referred or at risk of being referred to the Oregon State Hospital or anyone in a licensed residential facility or adult care home.

The county **may** enroll other individuals with serious and persistent mental illness if they meet additional criteria, including recently transitioning from civil commitment or being at risk of meeting criteria without additional supports.

Note: The above language is from the contract that was in place during our review. The new contract, starting July 2019, has changed. It now states that those meeting the criteria in the first paragraph above "shall be offered services" and those meeting the criteria in the second paragraph above "shall be offered services per contractor's policies and procedures."

Additionally, the lack of enrollment for those at risk of civil commitment (involuntarily held at least four times) shows another potential gap in access. According to the contract, the county may enroll anyone with serious and persistent mental illness, if the county believes that they

would meet Choice criteria without extra supports. However, it appears that the program rarely does this. In most cases, it seems that people have to reach the extreme circumstance of being both civilly committed and transferred to the state hospital before receiving intensive care coordination.

Multnomah County's enrollment practices appear narrower than some other counties. Representatives from the Choice programs in three other urban counties reported that their programs typically enroll people who have been civilly committed, regardless of whether they go to the state hospital. However, these representatives also agreed that some prioritization of who to serve is necessary, given funding levels. Other counties also operate under different contexts, such as serving different populations or providing other additional services, which could affect their enrollment decisions.

There are other reasons why someone who is involved with the civil commitment process would not end up in Choice. Depending on the circumstances, some individuals may be better served in another program, such as addiction services or intellectual and developmental disabilities services. Involuntary holds are often related to substance use, rather than mental health. Older clients could require aging services and younger clients could be enrolled in a program for youth.

Choice is voluntary for most participants, and individuals could decline to participate. However, enrollment can be required for those on a civil commitment. Individuals who were enrolled may still choose not to engage with services. This analysis examined enrollment, not engagement. The new Choice contract, starting July 2019, has changed language to reflect individuals' right to decline. The contract now says that the county shall offer services, rather than "shall enroll."

Choice program serves a large number of clients

The county's Choice program may be reluctant to broaden its enrollment criteria since it already serves a large number of clients. The program serves around 650 clients at any time. Even with a narrow interpretation of enrollment criteria, Multnomah County's Choice program still has more clients than other counties, in total and per capita. Part of this may be attributed to Multnomah County's unique position as the largest urban county.

The county's program also serves a large number of long-term residential clients, which it is contractually required to serve. At the end of 2018, nearly a quarter of all Choice clients had been in residential treatment for two years or longer and 11% had been in residential treatment for over five years. One service that might help people move out of residential treatment sooner

is peer support. The Marion County Choice program manager reported that peer support services have helped some clients in residential treatment see living independently as increasingly possible and have moved out more quickly.

Choice clients cannot readily access residential treatment and supported housing

Once individuals enroll in Choice, they still run into access barriers. We examined the moves that Choice clients made through the continuum of care, to identify additional access issues.

Choice clients exiting the Oregon State Hospital were not always able to go directly to the appropriate level of care, such as residential care or supported housing. If a more permanent living situation is not available at the time of discharge, clients are sometimes placed temporarily in interim housing, such as a motel or "room and board" arrangement, while waiting for something more permanent to become available.

Room and board providers offer a room and meals, similar to a group residential treatment home, but without treatment or other support services attached.

Residential treatment is treatment provided in a group setting, where clients live on-site with other clients. Residential treatment may or may not be secure (locked). Includes larger facilities, smaller homes, and adult (foster) care homes.

Supportive/Supported housing is an apartment or other rental, with additional supportive services.

In our three-year timeframe, at least 40 clients went directly from the state hospital to motels or room and board, twice as many as went to supported housing. In addition to lacking mental health supports, both motels and room and board are expensive. The county generally pays for these placements with Choice funds.

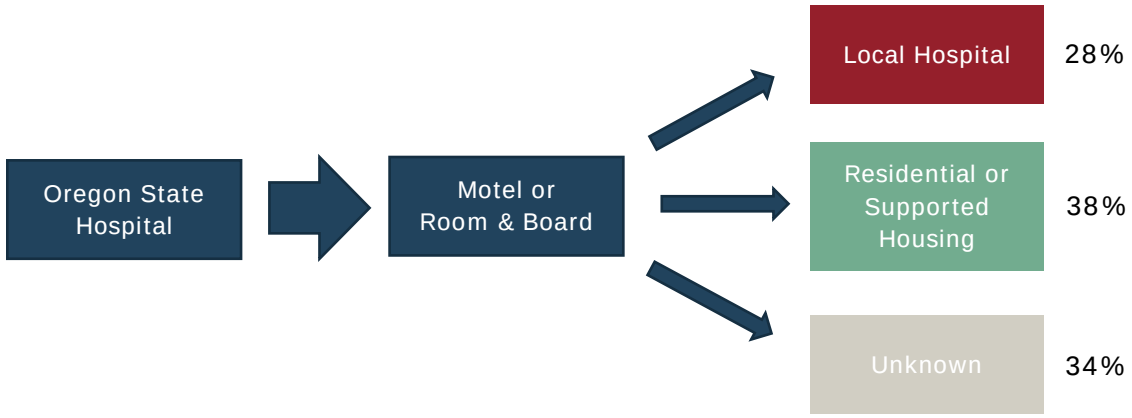
The use of motels and room and board indicates a key barrier to access is a shortage of residential treatment and supported housing. People in room and board stayed in that setting an average of seven months. The Oregon Performance Plan set a statewide goal of phasing out interim housing placements for individuals discharged from the state hospital, with placements lasting no more than two months, before July 2019, and not using interim housing at all, after July 2019. However, achieving that goal seems unlikely given the current situation.

The use of motels and room and board indicates a lack of access in residential treatment.

Interim housing presents an increased risk to clients. Of the 40 clients in our sample who went to room and board or motels after the state hospital, some moved next to residential treatment

or supported housing, as expected. However, around a quarter of moves from interim motels or room and board were to inpatient units at local hospitals, not the intended outcome for someone recently discharged from the state psychiatric hospital. Others may have disappeared from services or moved to an unsupported situation; we could not tell because records for a third of moves were missing data or data was unclear on where they moved next.

Interim housing may add risk of hospitalization or disengagement
Percent of moves from interim motels or room and board



Source: Auditor analysis of data supplied by the Multnomah County Mental Health and Addictions Services Division.

As discussed below, the division intends to develop supported transitional housing, which would likely help the current situation. However, we could not confirm with the state whether this would be considered the type of temporary housing the state is trying to phase out.

A small number of clients may be unable to access residential treatment due to violent behavior

Additionally, whether clients are discharging from the Oregon State Hospital or are in another living situation, a small number of Choice clients may end up in motels, shelters, or even outside, if they have had recent violent behavior or an eviction for behavior. Residential providers can screen out people who have had a violent episode within the last 14 days. ACT teams, which we discuss in the next section of the report, also deny some people based on recent violent history. However, it should be noted that one type of ACT team, specifically geared towards serving people involved with the criminal justice system, is better equipped to serve clients with a violent history.

Choice care coordinators have few options in these circumstances. They try to avoid disruptions in treatment while these individuals are in unstable living situations, and wait for enough time to elapse without a violent episode, so the client can apply to residential treatment.

Residential and supported housing capacity is limited

Not counting adult care homes, there are 26 residential facilities or homes in Multnomah County. Program staff told us that residential waiting lists in the county are usually closed and when they do open up, are open only for minutes or seconds at a time, due to high demand. Once on a waiting list, clients still have to be screened, accepted, and wait for an opening.

Residential treatment is a state resource and clients could theoretically go to other parts of the state. However, that is challenging since not many clients want to leave the county, other providers in the state are also full, and the system for checking availability in other parts of the state is not always updated regularly.

Supported housing capacity is also limited. The Multnomah County Choice program has 51 supported housing units, at various properties reserved for its program. These units are usually full. For comparison, Marion County, which has a third as many Choice clients as Multnomah County, has around 70 units of supported housing reserved for its Choice program.

There are additional supported housing units in the Multnomah County community, though many are reserved for the homeless population and would be unavailable for Choice clients who do not meet the federal definition of homeless. These waiting lists are also generally long or closed.

Choice program is reserving funds, potentially limiting current access

For the past two fiscal years (2018 and 2019), the Choice program has spent less than it received in funding from the state. Management reports that they intend to use some of the remaining funds for developing new supported transitional housing. Dedicating funds for future housing means that less funding is available for current programs, including enrolling more Choice clients under broader criteria. Choice funds can be used for direct client support, such as housing assistance, treatment for non-Medicaid clients, or miscellaneous expenses such as paying for IDs or moving expenses. Choice funds can also be used to hire additional staff to decrease caseloads.

Recent history suggests that reserving funds can be risky

Over the last two fiscal years, the division has accumulated unspent funds. Management reports that they intend to use some of it on supported transitional housing. Developing additional transitional housing should help to move individuals out of the state hospital more quickly. However, recent history shows that building reserves of unspent Choice program funding also carries some risk.

In the past, the state cut funding in response to reserves, and reserves were spent on unsustainable contracts

The Choice program entered FY 2016 with $2.5 million in unspent state grant funding reserves. At the same time, the program had committed to a new contract for permanent supported housing units and services, which was aligned with a central goal of the Oregon Performance Plan.

According to the program manager, the state responded to the county's accumulation of unspent grant funds by reducing base funding levels starting in FY 2016. The supported housing contract proved unsustainable. It would have been unsustainable even if the state had not reduced the grant funding.

Over FYs 2016 and 2017, the Choice program spent all of its funding and reserves, plus $650,000 in division general fund when it went over budget in FY 2017. The amount of reserves and general fund spent totaled over $3.1 million, while the reduction in the state grant contracts totaled just over $1 million.

Choice program ended a contract and received general funds

In FY 2018, after unsuccessful attempts to reduce costs with the contractor and obtain increased funding from the state, division leadership determined that they had to end the housing contract mentioned in the previous section, due to cost. This resulted in the closure of 18 units of supported housing and 13 units of room and board. Division leadership asked the Board of County Commissioners for $280,000 in general funds, through a budget modification. The goal of the additional funding was to help transition clients out of the supported housing units that were closing. The Board approved the request.

The budget modification process lacked transparency. The budget modification paperwork presented the request as a response to a new reduction in state funds in FY 2018, which was inaccurate. There had been a reduction two years prior, as described in the section above, but

that was already reflected in the division's FY 2018 budget. The modification paperwork and presentation did not accurately describe the circumstances leading to the request.

The Choice program is again reserving funds

Over the rest of FYs 2018 and 2019, the Choice program transitioned from overspending back to underspending. This can be attributed, at least in part, to ending the expensive supported housing contract and to an increase in state funding when the county's Choice program took over another Choice program.

The program again accumulated unspent funds. By the end of FY 2019, it had accumulated $1.4 million in unspent state grant funds – about 26% of the total grant amount. Division management reports that they had planned a supported transitional housing project in 2018, which fell through and would have used some of the funds. They told us they now plan to use some of the funds for transitional housing in the new Behavioral Health Resource Center, which the county is just starting to develop.

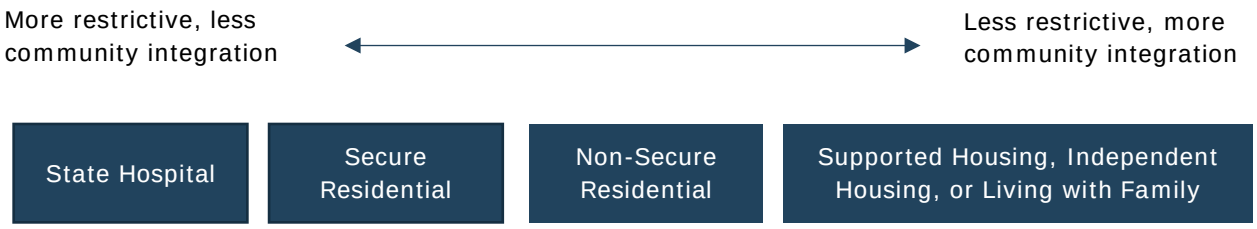
As noted in this report, permanent supported housing and residential treatment are in short supply and Choice clients can end up waiting in interim settings. Additional supported transitional housing would likely help with transitions from the state hospital.

However, the division's current approach carries the risk that the state will withhold the reserved money or cut future funding. Management has told us that they believe the state will allow the county to keep the $1.4 million. However, we were not able to confirm with the state that they approve of the division's plans. We did confirm that Choice funding from the state for FY 2020 has not been cut. As the division moves forward with any new project, it should obtain written state approval for its plans and should not use accumulated reserves on ongoing expenses, to avoid the situation that it was in previously.

Choice outcomes

The goal of Choice is to help clients live as independently as possible in the community. Our analysis suggests that this aim is met for many clients, without adverse occurrences, but not all. While most clients moved to settings that are more independent or stayed at the same level of care, around 20% of all moves were to settings that were more restrictive. Additionally, hundreds of Choice clients had negative outcomes, such as involvement with the civil commitment process or being booked into jail, while enrolled in Choice.

Continuum of care: The goal of Choice is to move people to greater independence



Since Choice serves people with serious and persistent mental illness, including people with severely active symptoms, some level of negative outcomes can be expected. The recovery trajectory is very individualized and what constitutes success may be different for different individuals. Thus, the outcome information that follows should be considered one piece of information. The division should develop a process to routinely measure outcomes for Choice, to determine if the program is meeting its goals.

Most Choice clients do move to more independent living situations, but some move to more restrictive care

While enrolled in Choice, most people moved to living situations with greater independence or stayed at the same level of care. However, some people moved to settings that are more restrictive. Among all the moves that Choice clients made over three years, roughly 20% were to more restrictive levels of care. This includes over 200 moves to either the Oregon State Hospital or a local hospital from residential, supported housing, or elsewhere in the community.

Between 400 and 500 moves were to greater independence (excluding motels, room and board, or homelessness). Examples of this are from the state hospital to residential treatment or from residential treatment to supported housing. The exact number is unknown because the way the program categorizes data leaves uncertainty in some situations, as discussed below.

Over 200 Choice clients experienced negative outcomes while in the program, a reduction for some

Over a quarter of Choice clients had at least one negative outcome from 2016 through 2018, while enrolled in Choice. A fifth of clients (185 individuals) were put on an involuntary hold at least once, 13% (122) were civilly committed at least once, and 7% (54) were booked into jail at least once. Some people experienced multiple occurrences across multiple categories. With that overlap, overall 29% of clients (266) experienced at least one of these occurrences. Outcomes varied by a number of factors. A higher proportion of people of color were booked into jail than white clients. Higher proportions of young people (25 and under) were involuntarily held and booked in jail than other age groups.

Even though many people experienced negative outcomes while enrolled in Choice, there is also some evidence that the program may help reduce negative outcomes for individuals. Of the roughly 75 Choice clients who enrolled mid-way through our timeframe (allowing us to look at data from both before and after enrollment), nearly all either had reduced occurrences of negative outcomes or had the same number after program enrollment (compared with before). This was true for involuntary holds, civil commitments, and jail bookings.

Better information could help the division proactively examine outcomes

The division should examine outcomes of clients in key programs in more detail and monitor them regularly. The Choice program provides regular reports to the state and is aware on an individual level what is happening with clients in the program. However, there are missed opportunities to examine data more systematically. There are opportunities for the division to combine Choice data with other data sources both internal to the division and in other parts of the county government (such as the Sheriff's Office or the Joint Office of Homeless Services), as well as examining outcomes over time.

Furthermore, data that the division collects in its electronic records system has limitations. Most notably, the Choice program collects data on where people live and one of the categories is called, "independent living." This category could include an independent apartment, room and board, a motel, living with family, being homeless, or living in a shelter. Without being able to disaggregate further, this category is clearly problematic for assessing outcomes. Additionally, unless someone is in a specific program, such as supported employment, the division does not collect data on positive outcomes for Choice and residential clients, such as an increase in income. Nor were we aware of any satisfaction studies for Choice or residential clients. This makes it difficult, if not impossible, to measure positive outcomes.

Assertive Community Treatment (ACT) results

What is Assertive Community Treatment (ACT)?

ACT is an intensive team-based mental health treatment model. ACT teams include several interdisciplinary professionals, including psychiatric nurses and social workers, as well as substance abuse, vocational rehabilitation, housing, employment, and peer support specialists.

Who is it for?

ACT treatment is primarily for individuals with serious and persistent mental illness who are living independently, but are not able to manage significant aspects of their daily lives, such as consistently taking medication, on their own.

How is it paid for?

ACT treatment costs $18,500 per individual per year. The majority of Multnomah County ACT clients have their treatment paid for by Medicaid via the Oregon Health Plan and Health Share, a Coordinated Care Organization. ACT is generally not a covered service for Medicare beneficiaries or individuals with private health insurance. For Choice program participants who are also ACT clients and are not Oregon Health Plan members, the Choice program pays for ACT treatment.

How is it supposed to work?

ACT is the highest level of outpatient mental health treatment. ACT teams spend a majority of their time in the field meeting with their clients multiple times each week and are generally available 24 hours a day. It is an evidence-based practice fidelity model, which means that research studies have shown that services provided by ACT teams that meet certain requirements (have a sufficiently high fidelity score) are successful in reducing negative outcomes, such as re-admission to psychiatric acute care hospitals.

The county contracts for ACT providers with Cascadia, Central City Concern, Native American Rehabilitation Association (NARA), Outside In, and Telecare. When new Medicaid contracts from the state go into effect on January 1, 2020, Care Oregon will take over the Medicaid-funded ACT contracts. This will leave the county with two ACT contract providers.

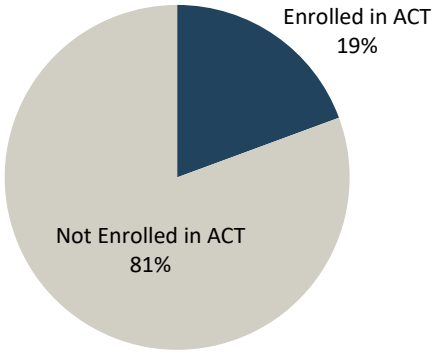
Access to ACT

ACT programs did not enroll or receive referrals for many individuals who potentially could have benefited from their services. Access is limited for people not on Medicaid. However, even for those with Medicaid, around half of referrals do not result in enrollment, either because the program denied the applicant or because the applicant chose not to participate.

Some people are not enrolled in ACT, who likely could be

The majority of individuals who were civilly committed or at risk of civil commitment were not enrolled in ACT services. Only around 20% (131 out of 676) of all people who were civilly committed during 2016, 2017, and 2018, were enrolled in ACT in the same period. Additionally, around 9% (20 out of 224) of people at risk of civil commitment (put on an involuntary hold at least four times) were enrolled in ACT.

One in five people who were civilly committed from 2016-18 were enrolled in ACT within that same period.



Note: Data is for the calendar years 2016, 2017, and 2018. Some people may have been enrolled either prior to 2016 or in 2019. A small number of people who were civilly committed in late 2018 may have enrolled in ACT in early 2019. There is also a lot of overlap with Choice. Three quarters of those enrolled in ACT were also enrolled in Choice.
Source: Auditor analysis of data supplied by the Multnomah County Mental Health and Addictions Services Division.

For some, ACT may not have been appropriate. Less intensive treatment options may be a better option for some people. ACT would also not be appropriate for people in the State Hospital or in residential care. It would be duplicative, since those facilities already provide treatment. Some clients may also not want ACT treatment.

ACT is an entitled service under Medicaid, which means that anyone on Medicaid who meets medically appropriate criteria, and wants ACT, is entitled to receive it. Of the 900 people who

were civilly committed or held at least four times, from 2016 through 2018, around 600 were enrolled in Health Share (Medicaid) for at least part of the three years, and thus potentially entitled to ACT.

In a sample of the people who were civilly committed but not enrolled in ACT, most were discharged from the hospital with other types of treatment. We also saw that, while people who were homeless prior to a civil commitment were not usually discharged to homelessness, they were often discharged to temporary housing without intensive supports, like ACT could provide.

ACT slots are limited and ACT teams are approaching capacity

ACT space is limited for people without Medicaid and may be restricted even for people with Medicaid. ACT is primarily funded by Medicaid. However, Multnomah County has 24 ACT slots for people not on Medicaid and 10 ACT slots for Choice clients. These slots are constantly full. Other insurance providers, such as Medicare, private insurance, or Veterans Affairs, do not cover ACT.

For those on Medicaid, the current ACT teams in the county are approaching their capacity. Of 351 ACT slots, county staff reported that about eight to ten slots usually have movement among them, providing some availability.

Many people are never referred to ACT or are referred but not enrolled. County program staff told us that people may never get to the referral stage, as social workers or county employees may decide that ACT would not be a good fit before the referral process even starts. Of those who are referred, fewer than half end up enrolling in ACT, according to data from the Oregon Center for Excellence in Assertive Community Treatment. In 2018, at least 100 referrals did not result in enrollment in ACT programs in the county. Individuals were not enrolled either because they were denied services or because they declined to enroll.

People are denied from ACT for a variety of reasons, such as not meeting diagnostic criteria or dangerous behavior. While we did not examine the denials, we can logically conclude that when operating near capacity, providers are not incented to take on higher risk clients. Contracts with ACT providers state that they cannot deny county referrals, though county staff report that they rarely have a situation where they ask providers to take a specific referral.

ACT outcomes

ACT's goal is to provide comprehensive treatment and support services, with expected outcomes including reduced hospital stays and higher quality of life. Many ACT clients did not have negative outcomes, but around a third did. Like Choice, ACT serves people with serious and persistent mental illness, including people with severely active symptoms. Therefore, some level of negative outcomes can be expected. The outcome information that follows should be considered one piece of information, but more work is needed to further understand outcomes.

Over 100 ACT clients experienced negative outcomes while in the program, a reduction for some

Over a third of ACT clients had at least one negative outcome from 2016 through 2018, while enrolled in ACT. A quarter of clients (109 individuals) were put on an involuntary hold at least once, 13% (58) were civilly committed at least once, and 16% (71) were booked into jail at least once. Some people experienced multiple occurrences across multiple categories. With that overlap, overall, 38% of clients (170) experienced at least one of these occurrences.

Outcomes varied by a number of factors. A higher proportion of people of color were involuntarily held than white clients. Higher proportions of young people (25 and under) were booked in jail than other age groups. Outcomes also varied by teams. In alignment with the higher frequency of young people booked in jail, the Outside In ACT team, which serves youth, had the highest proportion of clients booked into jail at least once.

Even though many people experienced negative outcomes while enrolled in ACT, there is also some evidence that the program may help reduce negative outcomes for individuals. Of the roughly 54 ACT clients who enrolled mid-way through our timeframe (allowing us to look at data from both before and after enrollment), nearly all either had reduced occurrences of negative outcomes or had the same number after program enrollment (compared with before). This was true for involuntary holds, civil commitments, and jail bookings.

The division does not actively monitor ACT contracts

The division should examine outcomes of clients in more detail and monitor them regularly. It is not clear that the division is monitoring ACT much at all. Under the Medicaid program, the county holds ACT contracts with providers. However, we had a hard time finding any division employee who was actively managing ACT contracts or providing oversight of ACT providers at the time of our audit fieldwork. This may be in part due to turnover and transitions, as

several key employees left the division at that time. We did speak with some county employees who were involved as gatekeepers for ACT slots.

The contracts with ACT providers include performance measures, mostly focused on activities, including an outcome measure to decrease the rate of readmission to acute care facilities (hospitals). County staff could actively monitor this measure and incorporate more outcome measures.

Additionally, division staff told us that they do not have access to reports that ACT providers send to the state. The Oregon Health Authority requires reporting on a variety of ACT outcome measures. Previously, the county prepared the reports. However, the Oregon Health Authority changed the process and now providers input this information directly in the state computer system, which county employees cannot access. The Oregon Center of Excellence for Assertive Community Treatment, which measures fidelity of ACT programs, does publish some outcomes data on its website. It publishes only some data at a program level, with the rest at the state level.

Systemic risks threaten the sustainability of community mental health programs

Demand for the services and programs highlighted in this report appears to outstrip the supply, and that is unlikely to change. As the urban center for the state, Multnomah County seems to end up with a higher proportion of people needing intensive services. Structures in the system may reinforce that draw. At the same time, capacity constraints are unlikely to abate in the near future. The Oregon Performance Plan is built on the premise that limited access to institutions and increasing use of community-based services will be better for both the individuals in the system and the system itself. In practice, the supply of necessary community-based resources has not been sufficient for the plan to work. It is proving to be very difficult to keep people progressing through the programs. And, with more limited access to institutions, those moving back into the community are reportedly less stable and have greater needs than in past years.

Without significant changes, Multnomah County Choice program will not likely meet need for services

Multnomah County has the highest number of Choice program clients among any county in the state and the highest number of clients per capita among urban counties. Funding from the state has been relatively flat and we do not anticipate a significant increase. Additional funding is

tied to meeting some of the state's goals in the Oregon Performance Plan, but the county did not meet those goals in the last biennium and does not expect to meet them in the near term.

Reducing the number of clients would require reducing demand for program referrals, increasing the rate with which individuals exit the program, or both. Due to a variety of factors within and outside of Multnomah County's control, this appears unlikely.

Demand for Choice services is high and frequently not within the community mental health program's control

Our review of the data illustrated the significant unmet demand for Choice program enrollment – with only about half of individuals who had been civilly committed enrolled in the program. There are also structural issues affecting the county's ability to manage the inflow of clients into the Choice program. The state may transfer financial responsibility for residents of other counties who are in residential treatment within Multnomah County to Multnomah County, without providing any additional funding. Residential treatment facilities are a statewide resource and about a third of all residential treatment programs in the state are in Multnomah County.

The way financial responsibility for serving the population of people who are homeless is determined makes it more likely that financial responsibility for homeless people with persistent mental illness will be assigned to Multnomah County more often than to other metro counties. According to county program managers, if a homeless individual presents or is taken to a hospital in Multnomah County and that person's last known address is more than 60 days old, they are the financial responsibility of Multnomah County. In our sample of people who had been civilly committed in the last three years and were potential candidates for the Choice program, about one quarter were homeless prior to their commitment. Psychiatric acute care capacity also likely has an impact. It is logical that with the largest psychiatric inpatient capacity in the state being in Portland (and Multnomah County) that individuals in psychiatric crisis will end up in these hospitals.

Lack of residential treatment and supported housing as well as housing costs are obstacles to helping clients transition to independent living

The Multnomah County Choice program's ability to help clients transition out of the program is hampered by the fact that so many individuals need ongoing program supports. Reasons for this include the number of individuals who are ineligible for insurance coverage for long-term intensive services, the lack of suitable housing for clients who are ready to leave residential treatment programs, and the cost of housing in the county more generally.

Choice program managers told us that clients stay in the program while in residential treatment and once they are able to leave residential treatment, they stay in the program until they no longer require program supports – such as intensive outpatient services or assistance with housing. Individuals stay in residential treatment if it is the most appropriate place for them, given their condition. Of the 440 Multnomah County Choice clients in residential treatment during our three-year review period, only 9% were able to transition directly into supported housing.

For people who can transition out of residential treatment into less structured care, whether it is supported housing or independent living, they frequently can benefit from intensive outpatient treatment services, such as ACT. ACT services are covered by Health Share (Medicaid), so for these individuals, the cost of the treatment has no bearing on the Choice program. However, a substantial percentage of people who would benefit from Choice and ACT enrollment are not eligible for Health Share and do not have coverage for ACT services. For example, individuals who have Medicare, Department of Veteran's Affairs health insurance, private insurance, or no insurance are generally not covered for ACT. For these individuals who are in Choice, the program must cover the cost. ACT is a long-term treatment, which means these individuals may need to stay in the Choice program for an extended period.

The cost of housing in Multnomah County, whether it is supported or not, is the next barrier to Choice clients being able to move on from the program. Housing supports in the form of rent assistance or housing vouchers make up a significant portion of Choice program budgets throughout the state, but the problem is arguably most severe in and around Multnomah County because of the cost of housing. Options for finding another source of funding to replace Choice housing assistance are limited. For example, individuals transitioning from residential treatment would not qualify for some housing assistance provided by the U.S. Department of Housing and Urban Development because it is reserved for people who are homeless. Even when homelessness is not a criterion, people with persistent mental illness must compete with individuals who have similar priority due to other conditions or situations.

New subsidized supported housing is a focal point of most recent developments in the metro area because it provides both housing that is more affordable and the structural supports that many people in the Choice program need to be able to transition out of the program. New developments show promise, but do not necessarily account for the cost of the associated support services. The cost of these is threatening our existing supported housing capacity and alternatives such as intensive outpatient services may be not be able to fill the gap.

The current supply of supported housing for Choice clients is low – for example, Multnomah County currently has fewer supported housing slots than Marion County, even though our

Choice caseload is more than three times larger. Community mental health program managers told us it is the services, not the physical structure that is the problem – 18 units of supported housing closed within Multnomah County in the last 2 years because the cost of the services was unsustainable. Intensive outpatient services, such as ACT and intensive case management, have the potential to fill the service gap in supported housing. However, increasing the capacity of these treatment options is challenging and is largely out of Multnomah County's control.

Recommendations

We recommend that the Health Department's Mental Health and Addiction Services Division, by December 1, 2020 and then on an ongoing basis:

1. Publicly report to the Board of County Commissioners on Choice program funding prioritization decisions, the status of state funding, and progress in developing new housing resources.
    a. Present at least once during each state biennium in a board briefing or board meeting.
    b. Explain tradeoffs in funding decisions considering possible areas of investment, such as:
        i. Developing new supported transitional housing
        ii. Enrolling more Choice clients (and consequently potentially hiring more Exceptional Needs Care Coordinators)
        iii. Adding peer support services to the Choice program
        iv. Purchasing additional non-Medicaid ACT slots
        v. Contributing to the new Behavioral Health Resource Center

2. In the future, do not underspend state grant funding unless there is a written commitment from the state that the county can keep the funding in future years, and only spend reserved funding on one-time use, not ongoing expenses.

We recommend that the Mental Health and Addiction Services Division of the Health Department, no later than December 1, 2020:

3. Analyze and publicly report on options for addressing ACT accessibility such as:
    a. Advocating with Health Share for additional ACT capacity,
    b. Breaking up ACT services so some can be billed to non-Medicaid insurers,
    c. And/or developing alternatives to ACT services that could provide intensive treatment but be billable to non-Medicaid insurance and with fewer fidelity constraints.
4. Update county Choice policies to ensure that the policy language is aligned with the contract with the state; to clarify Choice enrollment criteria, particularly related to people who are civilly committed but do not go to the State Hospital; and clarify criteria for exiting someone from Choice.
5. Develop a process for regularly monitoring commitment services data, to ensure that those who could be eligible for Choice and ACT are identified.

6. Advocate with the Board of County Commissioners, the Joint Office of Homeless Services, regional partners, and the State of Oregon to increase the number of dedicated supported housing units for people with serious and persistent mental illness.
7. Review data collection processes and make adjustments to improve the availability of information to assess program outcomes for Choice and ACT.
    a. Including changing the "independent living" categories into more categories and conducting satisfaction surveys.
8. Develop a process to capture ACT outcome data that is sent to the state, for monitoring and evaluation purposes.
9. Set up data sharing processes and agreements with other county entities (such as, the Sheriff's Office, the Joint Office of Homeless Services, and the Intellectual and Developmental Disabilities Services Division), to share data for program evaluation purposes.
10. Develop a process to routinely measure outcomes for Choice and ACT, including identifying racial disparities in outcomes.
11. Allocate staff for ACT contract management (as applicable after CCO 2.0).

Objectives, Scope, & Methodology

The objective of this audit was to:

- Determine how well community mental health programs are serving adults with serious and persistent mental illness, particularly regarding access and outcomes.

To accomplish these objectives we:

- Conducted over 50 interviews, including interviews with division staff and management, advocates, providers, state employees, county leadership, and representatives from other Oregon counties.
- Studied applicable laws, administrative rules, contracts, and intergovernmental agreements.
- Analyzed budgets and financial data.
- Analyzed three years of data (2016-18) from the Evolv medical records system; authorization and claims data, from a third party claims administrator and imported to Evolv; and jail booking data from eSwis.
- Examined and analyzed detailed records for a sample of 174 clients.
- Researched best practices, state guidance, relevant literature, and related audit reports.
- Examined a centralized residential waiting list website.

For this audit, we analyzed financial data for the period of FY 2016 - 2018 from SAP, the county's enterprise resource planning system, as of 12/31/2018. Based on the annual review of SAP datasets by the county's external auditor, our office has determined that the data were sufficiently reliable for the purposes of this report.

Additionally, we analyzed data from the Evolv and eSwis information systems. We assessed the data reliability and determined that the data were sufficiently reliable for the purposes of this report. The Evolv data system overall has some limitations, therefore we focused our analysis on the most reliable elements.

We examined three years' worth of data (calendar years 2016, 2017, and 2018), provided by the Mental Health and Addiction Services Division, for Choice, residential, involuntary services (civil commitment), and ACT. County employees input Choice, residential, involuntary services, and ACT data into Evolv. ACT authorization data is imported to Evolv from a third-party claims administrator. The ACT analysis is based primarily on authorizations for coverage, so some clients may have been authorized but not actively engaged with services for the whole authorization period. We also received jail-booking data from the Sheriff's Office from the same period, from the eSwis system.

We used involvement with involuntary services to identify people who might benefit from intensives services. We used this data source as a proxy for a higher level of *acuity*, a measure of how intensely symptomatic someone is, as well as to identify people at-risk of institutionalization. Civil commitment is often the first entry to Choice, and multiple hospitalizations is an indicator for ACT.

We used a cut off of four or more involuntary holds in three years as a proxy for someone at risk of civil commitment. We heard from commitment investigators that some individuals are held frequently without quite meeting the bar of civil commitments. We set the cut off at four or more because there was a natural break in the data at that point. That number also translates to more than once a year.

A benefit of using this data source is that it includes people who are not on Medicaid and otherwise not captured in other county data sources. The community mental health program is responsible for everyone in the community, not just those on Medicaid. We also used involuntary services data, as well as the jail booking data and data on movement through the care continuum, as outcome measures.

We focused the report on Choice and ACT as intensive services. These are not the only intensive services available. However, they are programs that the state, and thus the county, are currently the most invested in. As nearly all clients who are in residential treatment are also in Choice, our references to Choice also include nearly everyone in residential treatment (as well as other Choice clients not in residential treatment). We focused on the civil system and did not include forensic ACT (FACT) or residential placements associated with the justice system, in our analysis.

Additionally, we also reviewed a sample of 174 case files in detail for individuals who were civilly committed during calendar years 2016-18, but did not receive Choice or ACT during the same period.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Audit Staff

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Response Letter

Deborah Kafoury
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November 12, 2019

Jennifer McGuirk, MPA, CIA
Multnomah County Auditor
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Portland, OR 97214

Dear Auditor McGuirk,

The Mental Health and Addiction Services Division (the Division) would like to extend sincere gratitude to the Multnomah County Auditor's Office for their review of the Choice Model Program and associated Assertive Community Treatment (ACT) services. Division Leadership appreciates the thorough and engaging approach that the Auditors utilized during the audit process. In this letter, the Division will provide a high level overview of the Choice Model Program, address the recommendations provided through the audit process, and describe the Division's commitment to respond to the audit findings.

The Choice Model Program is an Oregon Health Authority (OHA) contracted care coordination program that initially began in 2010 as the Adult Mental Health Initiative (AMHI). The impetus for the creation of the program was to improve care coordination services for individuals being discharged from the Oregon State Hospital (OSH) system and/or from structured mental health residential treatment programs. Over the following nine years, the AMHI program expanded and was rebranded as the Choice Model program when it became the main OHA strategy to carry forth the work necessary to address the Oregon Performance Plan (OPP) with the United States Department of Justice (USDOJ). At this point, Choice Model care coordination expanded exponentially to address the USDOJ metrics required of OHA to resolve further litigation.

In addition to providing care coordination to an increased number of eligible participants, Choice Model programs also aimed their efforts on developing local resources. These resources include a spectrum of housing options, specialized and intensive case management, physical care supports and services, guardianship services, peer delivered services, and client assistance for crisis and independent living needs. To manage the increased number of participants and their diverse situations and support needs, alternative care coordination teams within the Division's

Community Mental Health Program (CMHP) and the Medicaid program, worked with individuals who did not require the intensive services and supports of the Choice Model program to engage in their recovery.

Division leadership is invested in providing quality services and is committed to quality improvement efforts to improve service provision to meet the behavioral health needs of the residents of Multnomah County. As noted in the report provided, the locus of control and oversight for the Mental Health system exists at the State level. Barriers persist with the increasing program demands, participant acuity, increasing numbers served, accessible housing, and limited funding. From the recommendations stemming from the audit findings, Division leadership hopes to improve strategic communications, policy and practice, data analytics and evaluation activities, and consumer advocacy efforts. Moving forward, the Division will prioritize operationalizing recommendations based on the audit findings with considerations made to minimize the impact of the barriers described in the Auditor's report, such as the large number of individuals served, residential and supported housing access issues, and flat funding.

Recommendation 1

By December 1, 2020, and then on an ongoing basis, publicly report to the Board of County Commissioners on Choice program funding prioritization decisions, the status of state funding, and progress in developing new housing resources.

1. Present at least once during each state biennium in a board briefing or board meeting.
2. Explain tradeoffs in funding decisions considering possible areas of investment, such as:

    i. Developing new supported transitional housing
    ii. Enrolling more Choice clients (and consequently potentially hiring more Exceptional Needs Care Coordinators)
    iii. Adding peer support services to the Choice program
    iv. Purchasing additional non-Medicaid ACT slots
    v. Contributing to the new Behavioral Health Resource Center

Response:

The Division Director, CMHP Manager and Care Coordination Senior Manager will engage in a Board of County Commissioners (BOCC) briefing annually on Choice Model program funding prioritization decisions, the status of State funding, and progress in developing housing resources. The presentation will specifically include status updates of funding decision considerations related to:

- Housing projects and partnerships, including any new developments
- Choice Model program client enrollment and any barriers faced by the Division to enroll more clients and/or hiring more Exceptional Needs Care Coordinators (ENCCs)
- Inclusion of peer support services
- Case management services for individuals without Medicaid, and
- The Behavioral Health Resource Center

Currently, efforts are underway to address service provision and housing needs. The Division is working to add additional non-Medicaid ACT and Intensive Case Management (ICM) services with certified providers for uninsured Choice Model program participants. The Division is partnering and collaborating with the Joint Office of Homeless Services (JOHS) around three permanent supportive housing projects with awardees of the Portland Housing Bureau's housing development grants.

The housing projects are:

- Central City Concern's Division Street apartments that will include 40 permanent supported housing units;
- The Westwind Apartments on NW 6th Ave, 70 units of permanent supported housing units; and
- The Joyce Hotel on SW 11th Avenue , 69 units of permanent supported housing units.

Additionally, the program continues to coordinate with regional Choice Model programs on developing regional criteria for Choice Model program enrollment and disenrollment from the program.

Recommendation 2

On an ongoing basis, do not underspend state grant funding unless there is a written commitment from the state that the county can keep the funding in future years, and only spend reserved funding on one-time use, not ongoing expenses.

Response:

The program is making every effort to commit the majority of the Choice Model funding from the State to contracted services and supports for participants. Below is a description of state funding allocation for Choice Model and a description of client assistance flexible funding.

Choice Model Funding Breakout:

- Approximately 26% of annual State Choice Model funds are contracted for housing supports that include: rent subsidies, permanent and transitional supported housing, emergency housing, and support services for housing retention and care needs.

- Approximately 19% funds intensive case management services with several community mental health agencies for those who do not have access to Medicaid.

- Approximately 4% is contracted for professional and support services such as guardianship services and transportation services.

- An additional 28% of State funding is utilized for Choice Model program staff positions not funded by Medicaid.

- With the remaining 23% of annual Choice Model funds from the State, the Division provides client assistance flex funding as well as is working on two permanent housing projects.

    - The projects are:

        - Central City Concern's Division Street apartments that will include 40 permanent supported housing units.

        - Cascadia's Centennial Apartments, which will include 72 permanent supported housing units.

- The Division is also working with JOHS on client assisted treatment programming and housing supportive services not already established or met through contracting for two additional housing projects listed below.

    - The Westwind Apartments on NW 6th Ave, 70 units of permanent supported housing units.

    - The Joyce Hotel on SW 11th Avenue , 69 units of permanent supported housing units.

Client Assistance Flexible Funding:

When clients experience a psychiatric crisis or when they are discharged from local acute care and/or emergency departments or from residential treatment facilities, their treatment and care needs must be prioritized. Flexible funding for client assistance must be available to support Choice Model participants when alternative treatment and housing resources are not immediately available in these situations. One Choice Model participant could require 1-3% of

annual Choice Model funds per year to be safely supported in the community until alternative resources are secured. With this in mind, an adequate percentage of Choice Model funds should be available for client assistance, which is a vital “safety net” aspect of the program, allowing the Division to meet overall program goals and metrics.

The Choice Model contract is a stand-alone contract, and not part of the larger Community Mental Health Program (CMHP) contract for statutorily required services of the CMHP as the delegated Local Health Authority. Historically, State Choice Model funds have been allowed to be carried over by the OHA from biennium to biennium. On October 25, 2019 the CMHP Senior Manager currently overseeing the Choice Model program, requested written confirmation from the OHA- Health Systems Division (HSD) Adult Mental Health and Housing Manager that Choice Model funds for the 17-19 biennium would be carried over for use in the 19-21 biennium. This request was acknowledged by the OHA manager who indicated she would need to confirm with her leadership. The CMHP Senior Manager received written confirmation on November 4, 2019 from OHA-HSD Adult Mental Health and Housing Manager, which included the following statements per the OHA-HSD Contracts Manager:

> “Taken in totality, I believe it is reasonable to conclude that Multnomah County can retain any unexpended, Exhibit MHS 37 Choice Model Services funding provided that they do spend it according to the service element description as it appears in their County Direct Agreement, #155525, as amended. If appropriate, continued reporting from the County should be encouraged as long as those excess funds are available and used for Choice services.”

The Division will continue to report to the State, as appropriate, and will not use any reserve funding for any expenditure other than one time only expenses.

Recommendation 3

By December 1, 2020, analyze and publicly report on options for addressing ACT accessibility such as:

1. Advocating with Health Share for additional ACT capacity,
2. Breaking up ACT services so some can be billed to non-Medicaid insurers,
3. And/or developing alternatives to ACT services that could provide intensive treatment but billable to non-Medicaid insurance and with fewer fidelity constraints.

Response:

Care Coordination Organizations (CCO) have a tremendous influence on distribution and coordination of care for individuals served through ACT; thus, it is vital that the Division has a strong voice and role in operationalizing the goals of CCO 2.0. The Division is in planning conversations with both CCOs that will be operating in the tri-county region come 2020. In particular, the Division has been collaborating with Health Share of Oregon (HSO) on the requirements and goals of CCO 2.0, which include the expansion of Intensive Care Coordination (ICC) to ensure that individuals identified as eligible for ACT and ICM services are able to access these services as quickly as possible. There are ongoing monthly discussions with HSO to meet ACT waitlist and caseload requirements set forth by contract requirements. A breakdown of Medicaid and non-Medicaid funded ACT caseloads are determined by ongoing assessment of demand.

The Choice Model program is currently contracting 19% of its annual funds for intensive case management services with several community mental health agencies for those who are not Medicaid eligible. This includes those individuals with Medicare only, which does not fund ACT or ICM services. ACT services account for 9% of these funds and alternative intensive case management services account for the remaining 10%. The CMHP Senior Manager will discuss additional alternative services with treatment providers to explore and identify the feasibility of developing treatment protocols that can mirror elements of ACT services that improve client outcomes, such as collaborative and individualized treatment planning and community based service provision.

Recommendation 4

By December 1, 2020, update county Choice policies to ensure that the policy language is aligned with the contract with the state; to clarify Choice enrollment criteria, particularly related to people who are civilly committed but do not go to the State Hospital; and clarify criteria for exiting someone from Choice.

Response:

The Division's Quality Management unit has already begun the policy review process for the entire Division, which includes all programs. All policies are reviewed every three years and Choice Model is slated to begin their policy work toward the end of 2019. A Quality Management Program Specialist Senior has taken the lead on providing technical assistance to the Choice Model program to update policies. The CMHP Senior Manager and Choice Model Program Supervisor will take the lead on updating the policy itself with assistance from CMHP Program Operations Manager.

Coordination with regional Choice Model programs on developing regional criteria for Choice enrollment and disenrollment from the program began in August of 2019. These efforts will continue to ensure that the Multnomah Choice Model program is aligned with regional stakeholders with the shared goal of providing consistent Choice Model Care coordination services that meet OHA contracting obligations. This criteria will be reflected in the policies noted above.

The Choice Model program participant census has maintained at approximately 650 active participants for the past three years with a high of 766 participants in FY18. The program, on average, exited 60 participants each year for FY17 & FY18. However, in FY19, 130 participants were exited who no longer required Choice Model program support or opted out of the program despite being enrolled. This indicates that Choice Model is regularly enrolling new participants based on practices the program has adopted over the past nine years since inception. The CMHP Senior Manager and Program Supervisor will work with Quality Management to develop protocols and to ensure that program practices align with State contracting requirements and regional Choice Model programs.

Recommendation 5

By December 1, 2020, develop a process for regularly monitoring commitment services data, to ensure that those who could be eligible for Choice and ACT are identified.

Response:

The Senior Manager of the CMHP is planning to lead a work group that includes managers and supervisors from the following teams: Involuntary Commitment program, Post Commitment program, Choice Model program, Crisis Services Program, and Quality Management unit. The work of this group is to determine the data and reporting metrics necessary to monitor commitment and flag individuals who could be eligible for Choice Model and ACT services. This flagging process will ensure that eligible individuals are identified so that program staff can be notified of potential participants. Program staff can then reach out to engage with these individuals and offer services.

Once metrics are determined, the CMHP Operations Manager will work with the Quality Management team members responsible for the Division's Electronic Health Record (EHR) to generate regular reporting mechanisms that identify eligible individuals, and also tracks individuals who have been offered Choice Model and ACT services. The Division will put policies, procedures and training in place that allow for systems planning and monitoring to ensure all designated CMHP staff involved in these processes are offering Choice Model and ACT services to those eligible. ensuring that all designated CMHP staff involved in the process are offering Choice to those eligible will be put into place.

Recommendation 6

By December 1, 2020, advocate with the Board of County Commissioners, the Joint Office of Homeless Services, regional partners, and the State of Oregon to increase the number of dedicated supported housing units for people with serious and persistent mental illness.

Response:

The Division's Senior Leadership will engage in advocacy with the BOCC, JOHS, regional partners and OHA to increase the number of dedicated supported housing units specific to those eligible for Choice Model Program Services. In addition, senior leadership will advocate for continued financial support of existing supported housing programs, and work across partners to identify innovative solutions to meet the needs under current constraints. These programs have had no significant increase in funding for services in the past decade. Stagnant funding has not accounted for cost of living increases and as a result, these programs are in jeopardy of losing their ability to maintain adequate support services for Choice Model participants.

The Division leadership will continue to work with County Government Relations and the Association of Oregon County Mental Health Programs (AOCMHP) to raise these issues up to the legislature as we look to policy priorities in future legislative sessions.

Recommendation 7

By December 1, 2020, review data collection processes and make adjustments to improve the availability of information to assess program outcomes for Choice Model and ACT.

1. Including changing the "independent living" categories into more categories and conducting satisfaction surveys.

Response:

The program is committed to improving data collection methods, including data dimensions and report accessibility. Consumer-driven and outcomes-based programming are Division values and satisfaction surveys are a useful tool to align practices with these values. Over the next year, the CMHP Senior Manager will prioritize resources to develop a survey that will assist program in better understanding the participants' experience. This will provide opportunities to adjust and improve where needed and to better understand program impact on client recovery.

The program recognized the inadequacies of using "independent living" to describe multiple living situations. The Senior Manager and Program Supervisor have worked with the EHR system (Evolv) and reporting teams to update categories to be more reflective of various living situations. Methods of collecting this information, reviewing the data, and reviewing reports generated from the system are being altered to accurately capture data. Assessments of our

systems, processes and accessibility are ongoing and adapt to emerging program needs to ensure that the Division has sufficient and accurate client and program data for evaluation purposes.

Recommendation 8

By December 1, 2020, develop a process to capture ACT outcome data that is sent to the state, for monitoring and evaluation purposes.

Response:

According to the contract that the Division holds with the State, providers should be completing the report template that is online and emailing the information to the State. Staff allocated for ACT contract management, (e.g. Program Specialists), will work with contracted providers to receive copies of the reports that are sent to the State.The data in the reports will be reviewed for trends, themes and evaluation purposes. By the Division receiving this data and information, program staff working with ACT contracted providers will be able to monitor access, retention and outcomes.

Recommendation 9

By December 1, 2020, set up data sharing processes and agreements with other county entities (such as, the Sheriff's Office, the Joint Office of Homeless Services, and the Intellectual and Developmental Disabilities Services Division), to share data for program evaluation purposes.

Response:

The Division has been active in a project aimed at incorporating data sharing systems to improve collaboration and communication on clients who engage with multiple County systems. The initial focus for the Division in moving this recommendation forward will be to identify an evaluation plan that clearly outlines data points that will be incorporated in the evaluation activities. The Division will then explore what data is gathered and available internally to our Division and what data will need to be obtained from outside sources- both other County programs and provider sources. One example of a data sharing system that has been piloted in some County programs that could potentially provide access to data to inform evaluations is the Service Coordination Portal Engine (SCoPE). SCoPE allows for Multnomah County providers to identify shared clients across County systems.

Once the specific data need is identified, the Senior Manager and the Quality Manager will meet with other county entities and Senior Assistant County Attorney and Chief Privacy Officer, Cindy Hahn, to talk about options for data sharing. None of these identified entities are HIPAA Covered Entities which makes data sharing more complicated and less permissive. Although data available through SCoPE is limited, SCoPE may still be used to access or assess engagement

across the County programs. Consideration can be given to utilize aggregate data for a more complete evaluation. To fully address this audit recommendation, however, it will require a significant cross-entity collaboration and participant consent, which will take time in order to actualize the benefits.

Recommendation 10

By December 1, 2020, develop a process to routinely measure outcomes for Choice and ACT, including identifying racial disparities in outcomes.

Response:

The Division currently collects data on race and ethnicity from clients enrolled in programs. Program Senior Manager, Program Supervisor, Quality Management team and Reporting team will work together to identify measurable outputs and outcomes for Choice Model and ACT. Program Supervisor will collaborate with Quality Management and Reporting teams to develop visualizations and analytic tools to assess enrollment and retention data in addition to outcomes, specifically looking at disaggregated data to assess racial disparities. Program will review trends, themes and disparities, and make adjustments to program based on the data reviewed in the reports. Trends and themes will be reviewed for general access to services, and data will be disaggregated by race for enrollment, retention and outcomes. Once the reporting tools are built, review of data will occur on a quarterly basis.

Recommendation 11

By December 1, 2020, allocate staff for ACT contract management (as applicable after CCO 2.0).

Response:

With CCO 2.0 on the horizon, the Division has begun to determine how to align staff in a structure that supports the goals of CCOs in our region. Planning for the shift has begun, and Division Senior Leadership will have a plan for allocating ACT contract management as needed by February 2020. From March - November 2020, Division leadership will assess needs based on changes due to CCO 2.0 implementation, and will determine applicability of allocating staff for ACT contract management for Choice Model at that point.

Sincerely,

Deborah Kafoury
Multnomah County Chair

Patricia Charles-Heathers, Ph.D.
Multnomah County Health Department Director