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February 5, 2019

Ms. Sarah Radcliffe, Managing Attorney
Mental Health Rights Project
Disability Rights Oregon
511 SW 10th Avenue, Suite 200
Portland, OR 97205

<Sent via mail and electronic delivery>

Dear Ms. Radcliffe:

Thank you for your December 3, 2018, letter. We understand and share your concerns regarding individuals' rights to due process and supportive, planned transitions from secure residential facilities. We agree that the issues you described in your letter are deeply concerning and do not reflect OHA's values or responsibility to the Oregonians we serve. I appreciate this opportunity to share with you the findings of our internal assessments and the steps we are taking to resolve them and prevent them from recurring.

Approximately a year ago, Oregon Health Authority leadership first became aware of the significant number of denials issued for continued stay in adult mental health (MH) secure residential treatment facilities (SRTF). We have been addressing that issue with the primary focus on ensuring that individuals' care and safety are not disrupted and that we don't cause unnecessary stress and confusion. We extended prior authorizations for individuals while seeking systemic changes.

As we dug deeper, we discovered multiple issues:

- The notices of action lacked crucial details regarding their denials and did not inform individuals of their rights to due process. In some cases, the notices were not being sent to guardians.
- Oversight of transition planning for those who were deemed ready to move into more integrated care settings was inadequate. This caused avoidable confusion and disruptions in care for some individuals.
- Limited community resources, and particularly the housing crisis, continue to threaten the progress individuals make while working toward greater independence.
- Our contract with KePro needed clarification and updates in order to improve processes and produce better outcomes for individuals with serious and persistent mental illness.
- We were also not adequately analyzing the health outcomes of individuals, which kept us from seeing the gaps in our systems.

We believe the above issues were the root cause of many of the concerns you outlined in your letter. Below, I will describe our actions and plans regarding each issue.

Notices of action

Ensuring that guardians receive notices of action requires coordination with the Oregon Judicial Department guardianship records and the Medicaid Management Information System (MMIS).

We are taking steps to obtain regular, accurate data from the Oregon Judicial Department's statewide guardianship records. Internal MMIS staff are meeting with our contractor to determine the best way to store this information in the system.

We have also revised the notices sent in the case of denials or reductions of services to include more details about the determination when the decision is effective and their rights to a hearing.

Transition planning

When a transition is appropriate for an individual, it is critical that the process is well planned, coordinated and causes as little disruption as possible. The following are changes we implemented to provide greater oversight on the process.

- We are now connecting individuals with their Choice provider when they receive a notice of denial or reduction of services. We expect that this will identify and connect residents to services and supports to facilitate transition. We are also working with our Choice providers to follow up and assist, as necessary, those that have not successfully transitioned.
- We also are hiring a staff member who will monitor all individuals who step down to a lower level of care. This will be a full-time staff member of OHA who will be dedicated to reviewing every transition from a licensed residential setting and will monitor to ensure that the Choice contractor is actively involved. This staff member will also review the data regarding outcomes after a transition to identify trends and opportunities for improvement.
- We are also improving the way we track outcomes for individuals transitioning from and among residential facilities. In reviewing your comments, we saw that although OHA retains data, we had not aggregated it sufficiently to report the outcomes. To correct this issue, we are developing a regular "dashboard" to monitor utilization and outcomes associated with these services. We expect this to be available for use this spring. We believe that this improved tracking will give a better understanding of how we are doing or where we can continue to improve. Please see the attached data dashboard for more details.

Strengthening the continuum of care

You also expressed concerns that investments in lower levels of care were insufficient. We agree that the full continuum of care needs to be strong for individuals with chronic mental illness to receive the care they need, when they need it, at the most appropriate setting. Since 2014, with support from the Legislature, OHA has invested tens of millions of dollars in building community services to support individuals to live in the most independent setting possible. Here are the activities ongoing at the state to strengthen community resources.

- Since 2014, Assertive Community Treatment has expanded from four high fidelity teams to 35 teams.

- With the 2018 legislative investment, mobile crisis services are now available in all Oregon counties.
- Also in 2014, we implemented a rental assistance program for adults with a serious and persistent mental illness. As of June 30, 2018, there were 1,036 individuals in that program. We have wanted to expand this, but we acknowledge that this has been challenging due to the dramatic increase in rents across Oregon. To address the supply issue, OHA has awarded $5 million to housing developers to build additional supported housing and worked in partnership with Oregon Housing and Community Services (OHCS) to award $20 million in supported housing expansion.
- We continue to partner with OHCS to plan for the expenditures to expand supported housing outlined in the Governor's budget. CCO 2.0 has a focus on social determinants of health with a special focus on housing which will increase CCOs' role in partnering with housing providers to provide support services for residents.

KePro contract amendments

As you know, KePro is OHA's third-party vendor that performs medical necessity reviews and creates person-centered service plans for individuals in residential care. We heard feedback from many individuals, families, providers, and advocates like DRO that led us to critically reassess our contract language. We dedicated a new team of staff to a) administer and enforce the existing contract and b) work on amendments.

OHA amended the KePro contract, effective Jan. 22, 2019. Below is a summary of the changes that we made.

- First, we removed the incentive payment tied to denials of continued stay in an SRTF.
- Another significant amendment to the KePro contract addresses increased OHA oversight of the stability of residents in adult foster homes, residential treatment facilities and residential treatment homes, which are all the same level of community-based setting under federal Home and Community-Based Services settings regulations. As of January 7, 2019, pursuant to a stop work order, KePro ceased conducting frequent medical appropriateness reviews for the HCBS settings. The medical appropriateness review schedule is now annual, in most cases. We expect that this will have the effect of giving people more time to stabilize and remain in their setting of choice.
- It is very important to OHA to offer services and treatment in the least restrictive setting possible. Therefore, KePro will continue to conduct the medical appropriateness reviews for individuals residing in SRTFs. OHA clinicians will review any determinations that an individual does not meet medical necessity to remain in the SRTF. If KePro's determination is upheld, then OHA will issue an informative notice of action with hearing rights to the individual and their representative, if any. OHA staff will also connect the individual directly with a Choice contractor to work with the individual to facilitate a supportive transition. We believe that these additional levels of oversight will decrease disruption in care and provide a supportive transition with the appropriate supports and services.
- Furthermore, contract amendments include more explicit direction on the person-centered planning process. OHA staff are having ongoing dialogue with KePro about what person-

- centered planning entails, who should be involved in the process, and what information is required to be included in the person-centered service plan developed by KePro. Additionally, KePro has been provided with links to the Oregon Training and Consultation's (OTAC) webpage so that they may view the person-centered service plan and materials used by the Department of Human Services' Office of Developmental Disabilities Services program for its person-centered service planning.

We certainly appreciate the complexities of balancing our responsibility to protect individuals' rights to live in the community, with the responsibility to assure that individuals are provided services that minimize risk of destabilization. In striking this balance, we embrace the concept of the "dignity of risk" which incorporates the idea that the right to take reasonable risks is a part of dignity and independence and should not be limited by an overly cautious treatment system. We are working to achieve this balance as we improve the process of utilization review.

OHA's contract with KePro expires June 30, 2019. We are preparing for a new procurement to be effective July 1, 2019. We will keep you apprised of updates in this process.

I want to thank you again for sharing your questions and concerns. We value your input and will continue to seek your perspective as we build toward a care system that better serves individuals with chronic mental illness. I look forward to our continued dialogue.

Sincerely,

Patrick M. Allen
Director

Data Dashboard

Below are the outcomes we will start tracking and sharing on an ongoing basis. This dashboard includes utilization and outcome information for individuals transferring from adult mental health residential settings. The data attached to this letter is for all individuals transitioned from residential settings which may or may not be related to a KePro determination. This broad set of data explains outcomes for individuals receiving or who have received MH residential services. This data aligns closely with your original request.

Please note that these outcomes data are calculated based on the individual fitting into any one of these categories at any point during a six-month period following discharge, so the same individual might be counted in multiple categories. Information provided in earlier reports described a different number of deaths. The differences are the results of different goals. The earlier reports focused on certifications that were made by KePro with specific focus on denials. The attached information looks at all discharges and is not tied to KePro utilization review activities. In addition, all outcomes in the attached must have occurred within six months of a discharge. It is not clear if that was the case for the information provided earlier. Finally, earlier information focused solely on SRTF whereas the attached information includes RTH, RTF and AFH. We will update this data regarding individuals transitioning from residential services quarterly.

This data reflects people who were discharged from secure residential treatment facilities, residential treatment homes/facilities, and adult foster homes (MH clients—not DD) from July 2017 through June 2018 (FY17/18). For each of those individuals we tracked outcomes for a six-month time period from the point of their discharge.

For the 224 people discharged from a secure residential treatment facility, at some point during the six months following their discharge:

* 9 (4%) were homeless

* 26 (12%) visited an acute care hospital within 7 days

* 51 (23%) visited an acute care hospital within 180 days

* 22 (10%) were admitted into OSH and 68% of those admission were civil commitments

* 4 (2%) visited an emergency department for MH reasons

* 78 (35%) visited an emergency department for non-MH reasons

* 5 (2%) were arrested according to self report

* 3 (1%) died, based on reasons for leaving Medicaid

* 91 (41%) went to another residential setting

* 109 (49%) received community MH services[1]

* 122 (55%) received some community medical services other than MH

For the 591 people discharged from a residential treatment home or facility, at some point during the six months following their discharge:

* 30 (5%) were homeless

* 47 (8%) visited an acute care hospital within 7 days

* 77 (11%) visited an acute care hospital within 180 days

* 50 (9%) were admitted into OSH and 54% of those admission were civil commitments

* 19 (3%) visited an emergency department for MH reasons

* 217 (37%) visited an emergency department for non-MH reasons

* 21 (4%) were arrested according to self-report

* 23 (4%) died, based on reasons for leaving Medicaid

* 159 (27%) went to another residential setting

* 421 (71%) received community MH services[1]

* 412 (70%) received some community medical services other than MH

For the 364 people discharged from an adult foster home, at some point during the six months following their discharge:

* 24 (7%) were homeless

* 17 (5%) visited an acute care hospital within 7 days

* 45 (12%) visited an acute care hospital within 180 days

* 15 (4%) were admitted into OSH and 60% of those admission were civil commitments

* 11 (3%) visited an emergency department for MH reasons

* 142 (39%) visited an emergency department for non-MH reasons

* 9 (3%) were arrested according to self-report

* 19 (5%) died, based on reasons for leaving Medicaid

* 89 (25%) went to another residential setting

* 330 (91%) received community MH services[1]

* 279 (77%) received some community medical services other than MH

[1]Community mental health services provided in a residential facility by the facility program are not reflected in these numbers. In general, community MH services include all MH services supported by the Oregon Health Plan with the exception of hospital based services and residential services.