U.S. Department of Justice
S. Amanda Marshall
United States Attorney
District of Oregon
1000 SW Third Avenue, Ste. 600 *(503) 727-1000*
Portland, OR 97204-2902 *Fax:(503) 727-1117*

November 9, 2012

John Dunbar
Attorney in Charge, Special Litigation Unit
Oregon Department of Justice
1515 S.W. Fifth Avenue, Suite 400
Portland, OR 97201

Re: Agreement regarding United States' Investigation of Oregon's Mental Health System, DJ#168-61-30

Dear Mr. Dunbar:

This letter will memorialize the agreement between the State of Oregon ("State") and the United States Department of Justice ("Department") to implement a process which upon full implementation as described below, will resolve the Department's investigation of the State's compliance with the integration mandate of Title II of the Americans with Disabilities Act ("ADA") and *Olmstead v. L.C.*, 527 U.S. 581 (1999) for persons with serious and persistent mental illness.

The State is currently in the midst of transforming its health care system. The transformation includes integration of the systems delivering physical and mental health care, expand coverage under the Oregon Health Plan, and ensure improved quality of services through an outcome-driven system. This health transformation process provides a unique opportunity for the State and the Department to work together to address the Department's concerns in this particular investigation by embedding reform in the design of the State's health care system. We have agreed that it is the State's intent to use this health reform process to better provide individuals with serious and persistent mental illness with the critical community services necessary to help them live in the most integrated setting appropriate to their needs and achieve positive outcomes. We agreed that these measures cannot be implemented all at once, but that the process must be staged over the next few years as outlined below.

First, in year one of this agreement, the State will collect statewide system data on the services currently being provided and the people being served as provided in the attached agreed upon matrix. This matrix contains both "System Development Measures" and "Program Outcome Measures" which outlines the information the state will collect throughout this process to identify not only what services are available throughout the state, but also to assess what gaps need to be filled during the State's healthcare transformation. Three of the terms used in the matrix – Serious and Persistent Mental Illness (SPMI), Supported Housing, and Supportive Housing -- are defined in the attachments to the matrix. The State also agreed to include community integration and data collection requirements in provider contracts, regulations

promulgated to implement Oregon's transformation process, and other guidance issued to the Community Care Organizations (CCOs) and Counties. The data collected will be shared with the Department at periodic intervals as the State collects it. More specifically, the State will provide data to the Department as shown in the attached matrix. It is anticipated that it will take about a year to collect data that covers the entire system. Therefore, the State will share final system wide data with the Department no later than October 15, 2013, except as shown in the matrix. During year one of the agreement, the State and the Department will meet periodically to discuss gaps revealed by the data. In conjunction with this investigation, the Department also has conducted an investigation of the Oregon State Hospital, which is not yet complete. The parties are hopeful that the work described in this agreement will aid Oregon in providing treatment in the setting that is most integrated and appropriate.

Second, in year two of this agreement, the State and the Department will resume discussions shortly after the system wide data has been shared with the Department. It is anticipated that these discussions will resume in early November, 2013. These discussions will focus on identifying gaps in the community service system that are impeding serving individuals in the most integrated setting appropriate to their needs. These discussions will also include whether the data collected should be broadened to include crisis services access by those with serious mental illness as well as those with SPMI as defined herein. If gaps in the system are agreed upon, the State has agreed to include further requirements in its plan documents, regulatory materials, and provider contracts with the CCOs and Counties to ensure that an adequate array of community services is available throughout the State to help individuals live successfully in the community and prevent their unnecessary institutionalization. If the State and the Department cannot agree upon gaps in the system, the Department reserves the right to continue its investigation. The State will continue to collect the data listed in the matrix, or other data that may be agreed to at that time, in order to fill the gaps and discern if gaps are being filled throughout the year.

Third, in year three of the agreement, the State and the Department will develop outcome measures that will be included in plan documents, contracts and regulatory materials. It is anticipated that these discussions will occur in early November, 2014. Throughout this year, the State will provide the data it collects on the measures in the matrix, to the Department.

Fourth, in year four of the agreement, the State and the Department will meet to discuss whether positive outcomes are being achieved on the agreed-upon outcome measures. If adjustments need to be made to the outcome measures, the State and the Department agree to engage in discussions about making those adjustments. It is anticipated that these discussions will occur in early November, 2015.

This agreement is without any admission of liability by the State, and it shall not be received or construed as an admission on any issue. Both parties reserve their rights in the event that they fail to reach agreement in the future on issues described in this agreement.

The State and the Department are optimistic that this iterative process will improve the lives of thousands of Oregonians with severe and persistent mental illness. It is contemplated that this process will successfully resolve the Department's investigation once an array of adequate community services is in place and positive outcomes are being achieved on agreed-upon outcome measures.

Enclosure (as noted)

Agreed to by the State:	Agreed to by the United States:
ELLEN F. ROSENBLUM Attorney General of the State of Oregon By: John Dunbar John J. Dunbar Attorney In Charge, Special Litigation Unit Oregon Department of Justice	S. AMANDA MARSHALL United States Attorney District of Oregon Jonathan M. Smith Chief Special Litigation Section Civil Rights Division

Oregon Health Authority – Addictions and Mental Health Division
United States Department of Justice (USDOJ) matrix

System Development Measures	Date Reported
1. # of CCOs that operate a single 24/7 behavioral crisis hotline.	April 1, 2013 October 15, 2013 Biennially thereafter
2. # of subcontractors with each CCO and the number of subcontractors with each County who offer each of the following behavioral health services: • Crisis hotline • Mobile crisis teams • Walk-in/drop-off crisis centers • Crisis apartments/respite • Short-term crisis stabilization units • Inpatient hospitals • Agreed-upon alternatives to above crisis services in frontier • Assertive Community Treatment (ACT) • Intensive case management (out of office) • Peer support • Supported employment • Psych-education and living skills training • Supported housing services, using definition provided by USDOJ for supported housing • Supportive housing services, using SAMSHA definition for supportive housing (or subset of SAMSHA definition such as single site housing) • Assessment (initial and review) • EASA	April 1, 2013 October 15, 2013 Biennially thereafter
3. # of adults with SPMI who utilized/received: • Crisis hotline • Mobile crisis teams • Walk-in/drop-off crisis centers • Crisis apartments/respite • Short-term crisis stabilization units • Inpatient hospitals • State Hospital	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

System Development Measures	Date Reported
• Agreed-upon alternatives to above crisis services in frontier • Assertive Community Treatment (ACT) • Intensive case management (out of office) • Peer support • Supported employment • Psych-education and living skills training • Supported housing services, using definition provided by USDOJ • Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition) • Non Title XIX supported housing services (subject to agreement on definition) Assessment (initial and review)	
4. # of service units per adult with SPMI per month for each of the following behavioral health services: • Case management • Peer support • Supported employment • Psych-ed and living skills training • Supported housing services, using USDOJ definition • Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition)	CCO: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter County: October 15, 2013 Quarterly thereafter
5. Housing: • # of available independent supported housing units for adults with SPMI, using USDOJ supported housing definition. • # of available supportive housing units for adults with SPMI, using SAMSHA supportive housing definition (or subset of SAMSHA definition)	April 1, 2013 October 15, 2013 Biennially thereafter
6. # adults with SPMI who reside in each of the following settings: • Own house • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition)	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

System Development Measures	Date Reported
• Adult foster home (AFH) • Residential treatment homes (RTH) • Residential treatment facilities (RTF) • Secure residential treatment facilities (SRTF) • State hospitals	
7. # of adults with SPMI: Moved from the state hospital, inpatient hospital, or residential care setting into an independent supported housing setting.	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
8. % of funding for community services spent for adults with SPMI living in supported housing for each of the following: • ACT • Intensive case management (out of office) • Peer support • Supported employment • Psych-Ed and living skills training • Assessment (initial and review)	CCO: April 1, 2013 October 15, 2013 Biennially thereafter Counties: October 15, 2013 Biennially thereafter
9. % of all service dollars spent for adults with SPMI that are used for care provided in: • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition) • AFH • RTH • RTF • SRTF • Inpatient hospital • State hospitals	CCO: April 1, 2013 October 15, 2013 Biennially thereafter Counties: October 15, 2013 Biennially thereafter

9.1. Amount of funds spent for EASA	April 1, 2013 October 15, 2013
10. % of adults with an identified SPMI who: • Have had a PCP visit within the past 12 months • Have a current care plan (e.g., has been reviewed and updated within the past XX months) • Have a current bio-psycho-social assessment • Have had a level of care assessment within the past 12 months	First Bullet: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Other Bullets: October 15, 2013 Annually thereafter
11. % of care plans for adults with SPMI that include a current crisis intervention plan.	October 15, 2013 Annually thereafter
12. # of behavioral health screen (e.g., depression, substance abuse) conducted by PCPs during initial health screens for newly enrolled adults (all adults enrolled in a CCO, not just adults with SPMI).	October 15, 2013 Annually thereafter
13. % of adults with SPMI who had a follow-up after hospitalization for mental illness within 7 days and within 30 days.	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
14. Conduct assessment of current Quality Assessment and Performance Improvement (QAPI) program and develop a plan for establishment of a QAPI program that integrates behavioral health and physical health at the state and individual CCO level. For the CCOs this includes development of contractual requirements related to QAPI.	October 15, 2013

15. Establishment of integrated QAPI structure (committee, staff) at state and individual CCO that includes expertise in the delivery of care to adults with SPMI.	April 1, 2013
16. Development and implementation of comprehensive data system (data warehouse) that allows for analysis of encounter/claims and client demographic/clinical data and monitoring of care delivered to adults with SPMI at level of individual client, individual provider, individual CCO and overall system of care.	October 15, 2013
17. Development of management reports and dashboards that monitor system performance for adults with SPMI.	April 1, 2013
18. Identification of Performance Improvement Projects (PIPs) that seek improvement in at least one of the identified areas of poor performance in the behavioral health system for adults with SPMI.	October 15, 2013 Annually thereafter
19. Identification of gaps, barriers, and needs of behavioral health as collected by CCOs and Counties. NOTE: CCOs are required to do a Community Health Assessment that identifies gaps and barriers and the counties are responsible for conducting a behavioral health community assessment. Both require plans to address gaps and needs. AMH has agreed to provide copies of those county plans in April 2013. OHA has taken significant steps in the past to increase outreach for Medicaid enrollment. OHA can provide a report of such actions and the outcomes of those efforts.	April 30, 2013 (copies of County plans)
SYSTEM DEVELOPMENT MEASURE (for third-year contract by OHA)	
1. # of CCOs that have formal agreements with law enforcement agencies or clear policies and procedures for coordination with and/or training of law enforcement.	3rd year of CCO contracts

Program Outcome Measures	Date Reported
1. Ability to effectively manage behavioral health crises in a community setting as measured by: a. # of emergency room visits for adults with SPMI in crisis b. # of inpatient hospital admits for adults with SPMI that are the results of a behavioral health crisis c. # of 30 and 180 day readmission rates for inpatient psychiatric care for adults with SPMI d. # of adults with SPMI who are referred/moved to the state hospitals e. # of adults with SPMI who are referred/moved to a SRTF, RTF, RTH and AFH from a less intensive setting f. Behavioral health crisis hotline call standards, e.g., 24/7 coverage, response rates of 5 rings/30 seconds, abandonment rate g. % of adults with SPMI (and or their family) that report positively about the system response to a behavioral health crisis event h. % of adults with SPMI show have a behavioral health crisis event who also had a crisis intervention plan	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Note: g. will be provided by November 30, 2013, based on current survey results.
2. Ability to provide access to behavioral health services in a community setting as measured by: # of service units per adult with SPMI per month for each of the following behavioral health services: o Case management o Peer support o Supported employment o Psych-ed and living skills training o Supported housing services, using USDOJ definition o Supportive housing services, using SAMSHA definition (or subset of SAMSHA definition)	CCO: April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter Counties: October 15, 2013 Quarterly thereafter

Program Outcome Measures	Date Reported
3. Ability to provide access to adequate housing as measured by: • % of adults with SPMI living in supported housing, using DOJ definition (90 consecutive days in supported housing) • % of adults with SPMI living in supportive housing, using SAMSHA definition or subset (90 consecutive days in supportive housing) • % of adults with SPMI who are living in a setting that is at the appropriate level of care	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
4. # of adults with identified SPMI who reside in each of the following settings: • Supported housing, using USDOJ definition • Supportive housing, using SAMSHA definition (or subset of SAMSHA definition) • AFH • RTH • RTF • SRTF • State hospital	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
5. The average length of stay, admission rate, and readmission rate for adults with SPMI in each of the following settings: • State hospitals • Inpatient hospital setting • SRTF • RTF • RTH • AFH	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
6. % of adults with an identified SPMI who: • Received their first routine services with XX days of their initial assessment • Have had a PCP visit within the past 12 months • Are employed	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter

Program Outcome Measures	Date Reported
• Have abstained from drug/alcohol use • Had a criminal justice event (jail, arrest, other interactions with law enforcement, etc.) • Had a homeless event	
7. % of adults with SPMI reporting positively about: • Their living environment • Their opportunity to improve their housing situation (e.g., supported housing) • Ability to access community-based behavioral health services • Outcomes (i.e., perception of care) • Improved level of functioning • Service quality and appropriateness • Social connectedness	November 15, 2012 (Current survey results) October 15, 2013 (next year's survey) Annually thereafter
8. % of adults receiving mental health services who filed complaints related to: • Quality of care (substantiated and unsubstantiated) • Access and availability to services • Effectiveness/appropriateness of services	April 1, 2013 July 1, 2013 October 15, 2013 Quarterly thereafter
9. QAPI programs at the state and CCO level: • Are successfully implemented and meet contractual requirements • Are able to demonstrate the operation of an effective system for continuous quality improvement (identification of areas for improvement, implementation of interventions, and improved outcomes)	October 15, 2013
10. The statewide comprehensive data system: • Includes accurate and timely encounter/claims/and client demographic/clinical data for adults with SPMI • Generates key management reports, including dashboards with program outcome scores (statewide and at individual CCO level).	October 15, 2013

Program Outcome Measures	Date Reported
11. The individual CCOs have methods that are able to: • Identify adults with SPMI who are high-risk (high need) and would benefit from intensive services • Generate key QAPI-related management reports, including those that are submitted to the State	October 15, 2013
12. Ability to provide access to behavioral health services in a community setting as measured by: • Time from enrollment to first encounter for adults receiving mental health services • % of primary care providers who report no difficulty obtaining behavioral health services for members	April 1, 2013 (first bullet) Quarterly thereafter October 15, 2013 (second bullet)

Serious and Persistent Mental Illness Definition

Addictions and Mental Health Division

AMH previously submitted a definition of Serious and Persistent Mental Illness (SPMI) based on defining this for the Medicaid population. The definition takes into account both the diagnosis and functioning. To define SPMI beyond the Medicaid population is more challenging due to the limits of CPMS, the current data system. CPMS only collects diagnostic impression which only captures broad diagnostic categories. For example, the data will indicate that someone has a Mood Disorder but will not distinguish between Major Depression and Depressive Disorder, NOS. This distinction is necessary to determine if the person has a SPMI. The new system COMPASS we will capture specific diagnoses that will enable us to select individuals, 18 or older based on the diagnoses listed below:

- Schizophrenia and other psychotic disorder: 295xx; 297.3; 298.8; 298.9
- Major Depression and Bi-Polar Disorder 296xx
- Anxiety Disorders: 300.3; 309.81 (PTSD and OCD)
- Personality Disorders: 301.22; 301.83 (schizotypal and borderline)

OR

Has one or more mental illnesses recognized by the current edition of the Diagnostic and Statistical Manual, excluding substance abuse and addiction disorders, and a GAF score of 40 or less that result from such illnesses.
This definition incorporates diagnosis and functional impairment and the elements in this definition will be captured in Compass.

Therefore, if the decision is to collect information on individuals that are enrolled in Medicaid **and** those that are not enrolled in Medicaid, then AMH will be able to collect data on individuals with SPMI after the implementation of COMPASS.

Supported Housing

United States Department of Justice

Supported housing is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

Supported housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.

Supported housing is scattered site supported housing, with no more than 20% of the units in any building to be occupied by individuals with a disability known to the State.

Supported housing has no more than two people in a given apartment or house, with a private bedroom for each person. If two people are living together in an apartment or house, the individuals must be able to select their own roommates.

Supported housing providers cannot reject individuals for placement due to medical needs or substance abuse history.

Supportive Housing Definition

Addictions and Mental *Health Division*

The Addictions and Mental Health Division will collect data for supportive housing based on the Substance Abuse and Mental Health Services Administration definition

Permanent Supportive Housing is the following:

Permanent. Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent;
Supportive. Tenants have access to the support services that they need and want to retain housing; and
Housing. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities [and can be] single-site housing, in which tenants who receive support services live together in a single building or complex of buildings with or without onsite support services; or scattered-site housing in which tenants who receive support services live throughout the community in housing that be agency-owned or privately owned."

"key elements" of supportive housing are:

- *"Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction."*
- *"Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability."*
- *"Participation in services is voluntary and tenants cannot be evicted for rejecting services."*
- *"House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community."*
- *"Housing is not time-limited, and the lease is renewable at the tenants' and owners' option."*
- *"Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market."*

- *"Housing is affordable, with tenants paying no more that 30 percent of their income toward rent and utilities, with the balance available for discretionary spending."*
- *"Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities."*
- *"Tenants have choices in the support services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences."*
- *"As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes."*
- *"Support services promote recovery and are designed to help tenants choose, get, and keep housing."*
- *"The provision of housing and the provision of support services are distinct."*

Source: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Evidence Based Practices Kit