Oklahoma Department of Mental Health And Substance Abuse Services

Regional Performance Management Report

Report for Third Quarter of FY2003

Reported September 2003
By
ODMHSAS Decision Support Services

Table of Contents

List of Figures and Tables

Regional Performance Management Report
For 3rd Quarter of FY2003

INTRODUCTION

The initial RPMR report was published in May 2003 for the period of October through December 2002. This current effort encompasses data for January through March 2003.

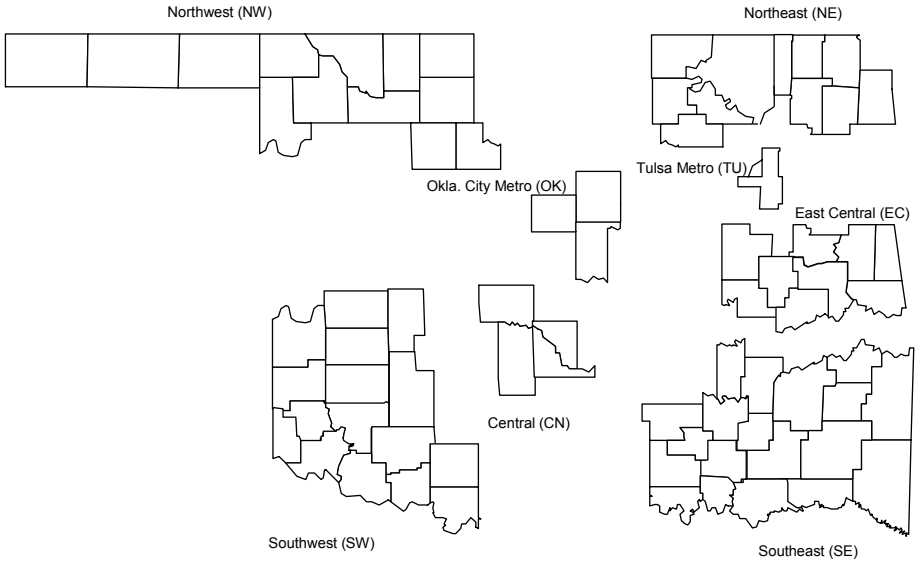
Background. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Regional Performance Management Report (RPMR) was developed with support from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for technical assistance from Howard Dichter, MD, who had helped establish a similar system in Pennsylvania and other states. A primary aim of the RPMR is to provide up-to-date information to guide system performance improvement efforts. That aim is achieved by timely (quarterly) production of reports that give feedback to providers, consumers, Department administrators and other stakeholders on key indicators of performance for substance abuse and mental health treatment providers funded in whole or in part by ODMHSAS.

A draft set of indicators was defined based on the experience of the technical consultant, the data sources available to the Department, performance and outcomes measurement work the Department had already done under grants from the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS), and ODMHSAS administrative needs for information for decision support (see a list of draft indicators and their operational definitions in Appendix 1). For example, indicators were calculated based on specific target populations and for innovative or evidence-based treatment programs.

The Department has produced an annual 'report card' for the past few years based on a set of indicators developed through input from the Mental Health Statistics Improvement Program, the National Association of State Mental Health Program Directors, the National Association of State Alcohol and Drug Abuse Directors, CSAT, CMHS and state stakeholders. However, the annual reporting cycle of those indicators, while providing useful information for some decision-making, did not help providers address identified performance problems in a timely manner. The quarterly RPMR reports will permit faster identification of, and response to, performance that is outside a prescribed or desired range.

Another difference between the report card the Department has been producing and the RPMR indicators is the level of aggregation of the data. While the report card provides information on every provider of services being evaluated for a given indicator, the RPMR indicators focus on each of the eight ODMHSAS planning regions of the State (see map below, a more detailed map is provided in Appendix 2).

Regional Advisory Boards



By compiling data at the regional level, regional variances in the availability of services and the level of performance of those services can be evaluated. At the same time, the Department is preparing to produce monthly RPMR data summaries for each provider. Using that information, performance improvement coordinators, administrators and clinicians can make decisions about whether and what changes need to be made within an individual agency, then monitor the impact of those changes before the next quarterly report is published. This kind of timely data access should make the performance improvement process more efficient and effective.

Performance Measure Reporting. Many of the RPMR indicators are expressed in terms of utilization of a service or set of services (e.g., outpatient services) by members of a selected group (e.g., persons with a substance abuse diagnosis). A region has high service utilization if services in the region are provided to clients at a rate *more than* one standard deviation*[1] above the state's average (mean*) for the prior two years (the eight quarters covered by each quarterly report), and low service utilization* if services are provided to clients in the region at a rate *more than* one standard deviation below the mean for the prior two years. The standard deviation is calculated for each measure based on the results from the eight regions in the eight quarters studied and is indicated by the dashed lines on the graphs. The upper dashed line represents one standard deviation above the mean and the lower dashed line represents one standard deviation below the mean. A region *trends toward* a high rate of utilization if it has high service utilization for two or more of the most recent quarters. A region *trends toward* a low rate of utilization if it has low service utilization for two or more of the most recent quarters. Service utilization in the most recent quarter can sometimes appear low because some services are reported after the cut-off date for preparing the report.

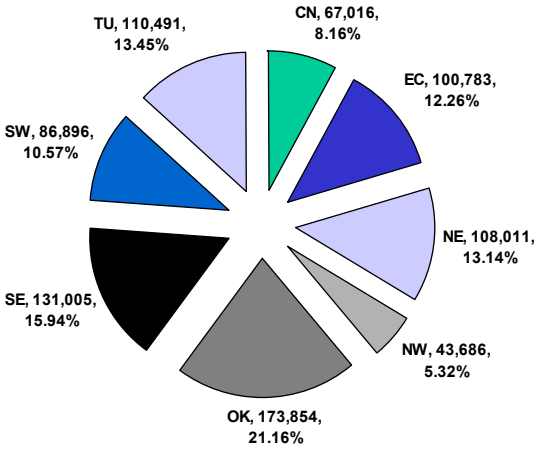
[1] Population groups, statistics and terms used in the RPMR rates and analyses are noted with an asterisk (*) in the text and their definitions are provided in a glossary in Appendix 3.

Future Development. System stakeholders were involved in previous indicator development processes, and as stakeholders express their perspectives regarding the utility of the selected RPMR indicators, or as system improvements make monitoring an indicator less important, it is likely other indicators will emerge to include in the RPMR. The continuing RPMR development process is being monitored with a work plan that identifies each task associated with an indicator, comments about progress, and actions to be taken. If you have questions about the project or this report, please contact John Hudgens (405-522-3849, jhudgens@odmhsas.org) or Steve Davis (405-522-3813, or sdavis@odmhsas.org).

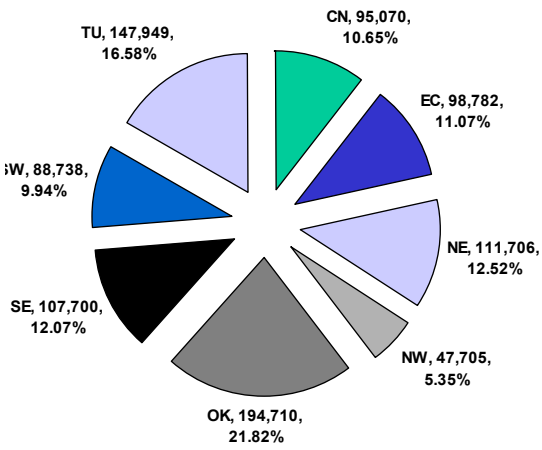
PERFORMANCE MEASURES -- MENTAL HEALTH

Background: A household income below the 200% of poverty threshold* has been established as an eligibility requirement for receipt of most ODMHSAS services to adults (hereinafter referred to as 'in poverty'). Some adult measures were population-adjusted* for each region, based upon U.S. Census estimates of Oklahoma's adult population up to 200% of poverty, to ensure differences in population distributions among regions do not affect region-to-region comparisons. The charts below present U.S. Census estimates of the regional distributions of adults and children eligible for ODMHSAS services that were used for indicator calculations in this report.

Persons Eligible for ODMHSAS Services in the General Population



Adults below 200% poverty level
Total: 821,742

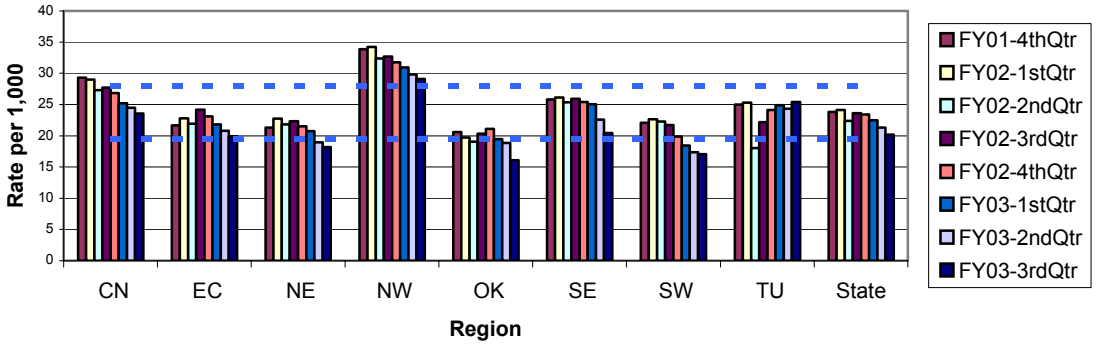


Children (all income levels) 0 – 17
Total: 892,360

There were an estimated 821,742 adults residing in Oklahoma with incomes up to 200% of poverty in 2000. Children are eligible to receive ODMHSAS-funded services without regard to family income; their estimated number is 892,360. The measures in this report are a monitor of services received by members of these groups.

Measure 1: Adults Receiving Any ODMHSAS-funded Mental Health Service

Figure 1: Adults Receiving Any ODMHSAS-Funded Mental Health Service in the Quarter Rate per 1,000 Adults with Household Income Below 200% Poverty Level

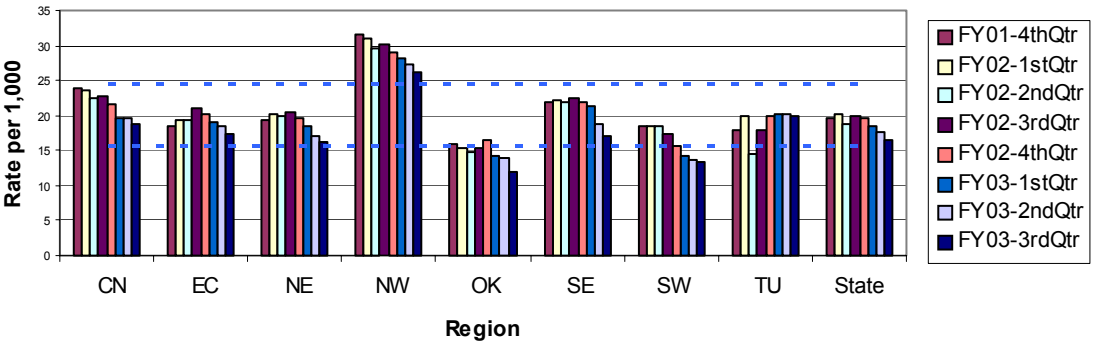


As shown in Figure 1, statewide, 20 of every 1,000 adults in poverty received an ODMHSAS-funded mental health service in the 3rd Quarter of FY03 (the focus of this report). This is less than the range of 24 to 21 adults per 1,000 in poverty that received a service in the prior seven quarters.

Adults in the NE, OK and SW regions trended toward low utilization of mental health services. In the most recent quarter, 18, 17 and 16 adults, respectively, per 1,000 in poverty in each region received a mental health service. Statewide, and for seven regions, there were declines in the rate of services provided for at least the last three quarters. The TU region is the only area to experience an increase.

Measure 2: Adult Mental Health Core Outpatient Services

Figure 2: Persons Receiving Any Core Mental Health Service in the Quarter Rate per 1,000 Adults with Household Income Below 200% Poverty Level

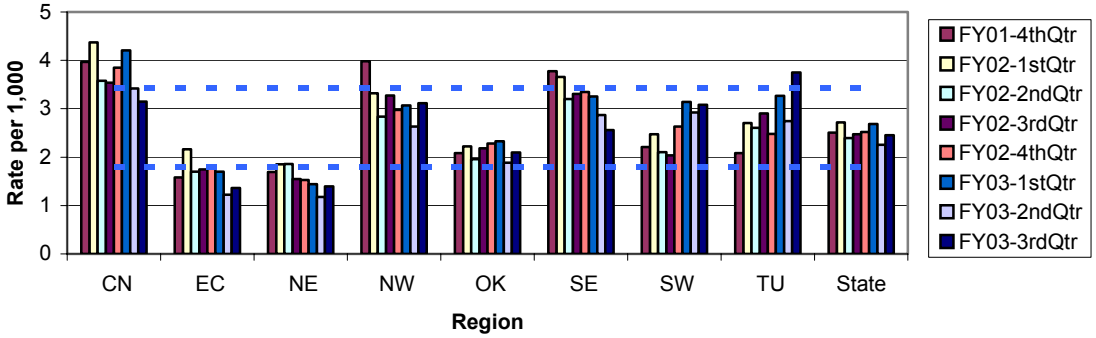


Outpatient services are the most frequently provided, so "Any ODMHSAS-funded" and "Core Outpatient" services follow the same general pattern of utilization. Statewide, about 17 of every 1,000 adults in poverty received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 3rd Quarter of FY03 (Figure 2). This is less than the range of 18 to 20 persons per 1,000 statewide that received services in each of the prior seven quarters.

Adults in both the OK and SW regions trended toward low utilization of core outpatient mental health services with about 12 to 13 persons per 1,000 of the general population in poverty receiving outpatient services in those regions in the last two quarters. As with any service, adults in the NW region had a high utilization of core outpatient mental health services in all eight quarters measured. With the exception of the TU region, there was an overall downward trend in core outpatient services provided in the state over the past three quarters.

Measure 3: Adult Inpatient Services

Figure 3: Persons Receiving Inpatient Mental Health Service in the Quarter
Rate per 1,000 Adults with Household Income Below 200% Poverty Level

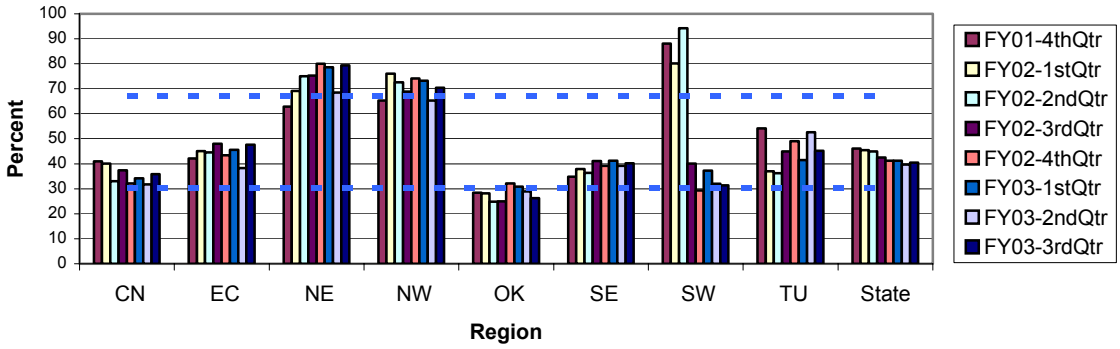


Statewide, 2.5 of every 1,000 adults (25 of every 10,000) in poverty received an inpatient mental health service (in a state hospital or community-based inpatient unit) in the 3rd Quarter of FY03 (Figure 3). The range for the prior seven quarters was between 2.3 and 2.7 per 1,000.

The TU region had the highest utilization of inpatient services with 3.7 adults per 1,000 in poverty receiving an inpatient service in the 3rd Quarter of FY03, followed by the CN and NW regions with a utilization rate of 3.1 adults per 1,000 in poverty. The EC and NE regions tended to have low rates of utilization at 1.4 per 1,000 adults in poverty. Seven of eight quarters in the EC region were one standard deviation or more below the statewide mean and all quarters reported from the NE region were at least one standard deviation below the mean.

Measure 4: Adult Inpatient Follow-up in Outpatient Care within 7 Days after Discharge

Figure 4: Percent of Adults Discharged from Inpatient Care in the Quarter with Follow-up Outpatient Care within 7 Days



Statewide, 41% of adults discharged from an inpatient psychiatric setting received an outpatient visit within seven days of discharge during the 3rd Quarter of FY03 (Figure 4). The percent of adults in inpatient treatment seen after seven days slightly increased after falling across the previous seven quarters measured.

The percent of adults discharged from an inpatient psychiatric setting who received an outpatient visit within seven days was the highest in the NE region at 79% in the 3rd Quarter of FY03 and was at least one standard deviation above the mean for the previous six quarters. The inpatient follow-up rates in both the NE and NW regions were well above the state average for all eight quarters. Adult inpatient follow-up trended low in the OK region with 26% of the inpatients being seen in outpatient care within seven days in the 3rd Quarter of FY03.

Steps Taken: In May, the Deputy Commissioner for Mental Health dispatched Community-Based Services Division staff to conduct on-site reviews at each CMHC to observe screening, assessment, referral, and treatment initiation processes, subsequent to the implementation of new uniform guidelines requiring a Core Service Plan for the Department's priority population (see Appendix 3: Glossary of Terms for definition of the Core Service Plan). Findings from those reviews are being summarized. In general, it was observed that Centers which previously had assertive outreach and aftercare initiatives in place that were developed when civil beds at Eastern State Hospital were closed were more likely to meet the expectations outlined in the Core Service Plan guidelines. Improved access to care and more immediate screening and assessing of new clients were not as evident at sites which had limited past experience with this approach.

Following the 2nd Quarter FY03 report, treatment providers suggested explanations for several of the findings. ODMHSAS staff conducted the following analyses to determine whether:

1. clients admitted under involuntary statuses were less likely to engage in follow-up treatment and, therefore, have a lower follow-up rate;
2. clients with a dual diagnosis of substance abuse and mental illness would be more likely to engage in follow-up services;
3. the number of clients with dual mental health and substance abuse diagnoses has been increasing in the last two years.

1. Do clients admitted under an involuntary status have a lower follow-up rate?

Table 4a: Follow-up Rate by Legal Status

Voluntary	3,574	1,643	46.0
*Involuntary			
Court Committed	3,137	1,187	37.8
clients previously seen in DMHSAS system follow-up rate			39.3
clients previously not seen in DMHSAS system follow-up rate			34.4
Emergency Detention	6,984	2,939	42.1
clients previously seen in DMHSAS system follow-up rate			45.0
clients previously not seen in DMHSAS system follow-up rate			38.6
Order of Detention	148	82	55.4
Subtotal	10,269	4,208	41.0
Total	13,843	5,851	42.3

** Involuntary statuses are defined in the Appendix 3: Glossary of Terms.*

The percent of clients involuntarily admitted to treatment that received a follow-up service within seven days of discharge was 41.0%, compared to 46% of clients admitted voluntarily (Table 4a). Court committed clients had the lowest follow-up rate at 37.8%, followed by clients under emergency detention with a rate of 42.1%. Clients admitted under an order of detention had a follow-up rate of 55.4%, which is higher than the rate for voluntary clients.

For clients who were court committed to treatment, those who had not previously been seen within the ODMHSAS system had a lower rate of follow-up (34.4%) than those who had previously been seen within the system (39.3%). The same was true for clients under an emergency order of detention: clients not previously seen within the system had a lower rate of follow-up (38.6%) than clients previously seen (45%).

Conclusion: Involuntary patients, in general, were less likely to have follow-up than voluntary clients. Those clients under an Order of Detention, were an exception to the above and had a higher rate of follow-up. Additional dialogue regarding this finding will be pursued with providers.

2. Are clients with dual diagnoses (mental health and substance abuse diagnosis) less likely to receive follow-up services?

The percentage of dual diagnosed patients discharged from inpatient care who received a follow-up service between 3rd Quarter FY01 and the 3rd Quarter FY03 was 45.2%, which was higher than the mean of 42.7% for all clients.

Conclusion: Having a dual substance abuse and mental health diagnosis did not negatively impact follow-up contact.

3. Has the number of dual diagnosed clients been increasing in the last two years?

The number of inpatients with dual diagnosis did not trend higher between the 3rd Quarter FY01 and the 3rd Quarter FY03, as shown in the Table 4b.

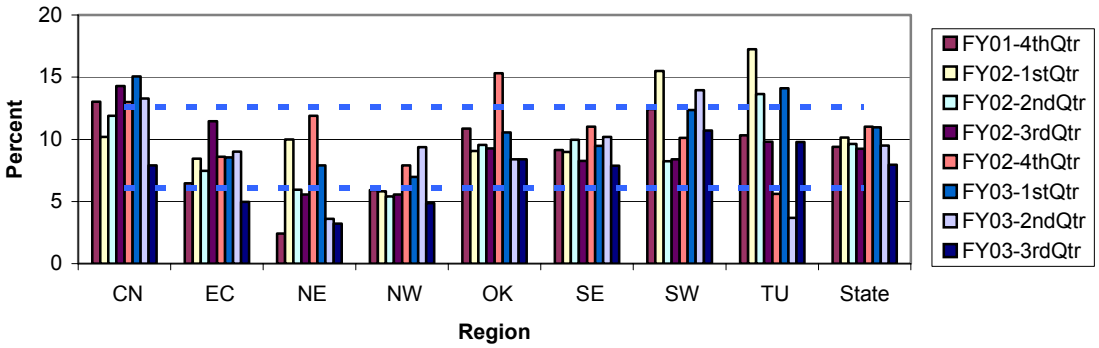
Table 4b: Discharge Rate for Clients with Dual Diagnoses

	FY01-4thQtr	FY02-1stQtr	FY02-2ndQtr	FY02-3rdQtr	FY02-4thQtr	FY03-1stQtr	FY03-2ndQtr	FY03-3rdQtr
Dual-Diagnosis Discharges	325	366	317	302	337	377	360	303
Total Number of Discharges	1,734	1,844	1,795	1,600	1,744	1,995	1,665	1,535
% of All Discharges	18.7	19.8	17.7	18.9	19.3	18.9	21.6	19.7

Conclusion: The number of clients hospitalized with dual diagnoses remained about the same across the eight quarters. This did not contribute to lower rates of follow-up services.

Measure 5: Adult Inpatient Re-admissions within 30 Days After Discharge

Figure 5a: Adults Discharged from Inpatient Care in the Quarter
Percent Readmitted within 30 Days



The adult inpatient re-admissions indicator measures the percentage of adults discharged from inpatient care in the quarter who were re-admitted within 30 days following their discharge. Inpatient re-admissions displayed some variability within regions across time (Figure 5a). Most variable was the TU region, which reflects the numerous significant organizational changes that have occurred in that region over the past two years: TU had the highest, and close to the lowest, reported number of 30-day inpatient re-admissions over the past eight quarters. Statewide re-admissions ranged between 8% and 11% of discharged inpatient adults. Substantial decreases in re-admissions were noted for the CN, EC, NW, SE and SW areas from the 2nd to the 3rd Quarter in FY03. The NE region trended low the last two quarters and the re-admission rate in the 3rd quarter was 3%.

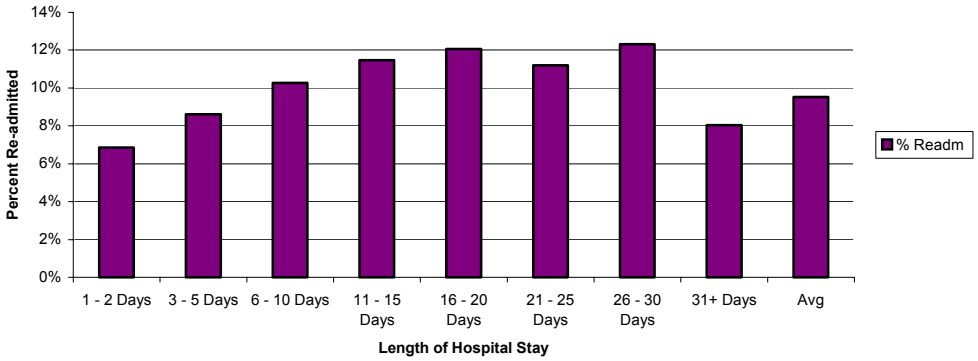
Steps Taken: In response to provider comments regarding inpatient re-admission trends, ODMHSAS conducted data analyses to determine whether:

1. clients with short lengths of hospital stay were more likely to be re-admitted within 30 days of discharge;
2. clients with dual diagnoses were more likely to be re-admitted to inpatient within 30 days;
3. clients admitted involuntarily were more likely to be re-admitted within 30 days.

1. Were clients with short lengths of hospital stay more likely to be re-admitted within 30 days of discharge?

Clients with short inpatient stays (1 to 2 days and 3 to 5 days) were less likely to be re-admitted within 30 days than the average client (Figure 5b). The percent of clients who were re-admitted within 30 days increased as length of inpatient stay increased, up to 21 days, although there was not a large difference between the lowest (7%) and highest (12%) readmission rates.

Figure 5b: Percent of Adults Re-admitted within 30 Days
FY01-Q4 through FY03-Q3



Conclusion: The percentage of clients re-admitted was not higher for clients with a short length of hospital stay.

2. **Were clients with dual diagnoses more likely to be re-admitted to inpatient care within 30 days of discharge?**

The percentage of dual diagnosed patients re-admitted between 3rd Quarter FY01 and 3rd Quarter FY03 was 11.8%, which was slightly higher than the mean of 9.5% for all clients.

Conclusion: Dual diagnosed clients were more likely to be re-admitted within 30 days of discharge. However, the number of clients hospitalized with dual diagnoses remained about the same across the eight quarters (average=336).

3. **Were clients who were admitted involuntarily more likely to be re-admitted within 30 days?**

Table 5: Readmission Rate by Legal Status

Admission Status	# of Discharges	# of Re-admissions	Percent
Voluntary	3,574	360	10.1
*Involuntary	10,269	989	9.6
Court Committed	3,137	318	10.1
clients previously seen in DMHSAS system re-admission rate			11.4
clients not seen in DMHSAS system re-admission rate			7.1
Emergency Detention	6,984	656	9.4
clients previously seen in DMHSAS system re-admission rate			12.8
clients not seen in DMHSAS system re-admission rate			5.3
Order of Detention	148	15	10.1
Subtotal	10,269	989	9.6
Total	13,843	1,349	9.7

** Involuntary statuses are defined in the Appendix 3: Glossary of Terms.*

As shown in Table 5, patients under a court commitment or order of detention were re-admitted at the same rate (10.1%) as voluntary clients (10.1%). However, emergency detention clients (9.4) were slightly less likely to be re-admitted than voluntary clients (10.1%).

For clients under court commitments or emergency detentions, clients previously seen within the ODMHSAS system had a higher re-admission rate than those clients not previously seen.

Conclusion: The percentage of voluntary clients re-admitted (10.1%) was slightly higher than involuntary clients (9.6%).

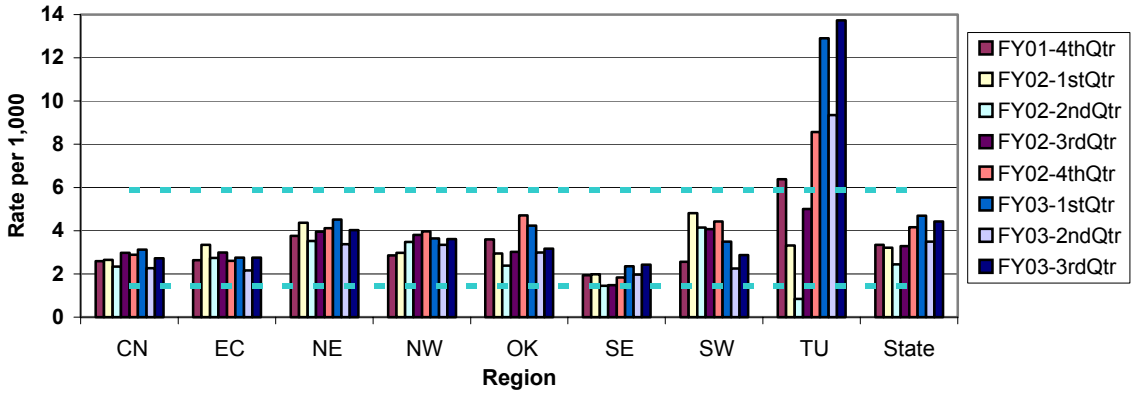
In response to the initial RPMR report and other developments, one provider has chosen to monitor recidivism as a primary performance improvement/total quality management project for this year. That provider reports data indicate substance use

(including methamphetamine) was a factor in a significant portion of re-admissions. Follow-up and assertive aftercare was complicated for these types of repeat admissions. Interim action taken by the provider includes using treatment consultation from the ODMHSAS designated specialist for co-occurring disorders. They have also identified a need to develop strategies to improve relationships with law enforcement. A more formal report will be prepared at the conclusion of the PI/TQM project.

Carl Albert Community Mental Health Center (CACMHC) and Mental Health Services of Southern Oklahoma (MHSSO), both in the SE region, noted that 30-day inpatient readmissions declined in the Southeast Region compared to the prior quarter. They report that a new PACT program at CACMHC continued to enroll additional high users each month, with success in preventing re-admissions to inpatient care. In addition, CACMHC analyzed the characteristics of individuals who had rapid readmissions. Their analysis indicated a high number of these consumers either had co-occurring (dual diagnosis) disorders or primary substance abuse disorders (admitted for psychosis secondary to substance use). These findings are consistent with the above conclusion that dual diagnosed clients were more likely to be readmitted within 30 days of discharge. In addition, MHSSO reports an increased emphasis on assertive outreach and continuity of care planning for persons being discharged from inpatient settings at Arbuckle Memorial Hospital and Griffin Memorial Hospital may have had the greatest influence in the decline in 30-day readmissions.

Measure 6: Adult Mental Health Face-to-Face Crisis

Figure 6: Adult Face-to-Face Crisis Events during the Quarter
Rate per 1,000 Adults under the 200% Poverty Level



The Adult Mental Health Face-to-Face Crisis indicator measures the rate per 1,000 adults in poverty in each region who received a crisis service in the quarter. Since practice patterns for emergency services vary among the regions, this measure will help bring focus to changes within regions and throughout the state over time.

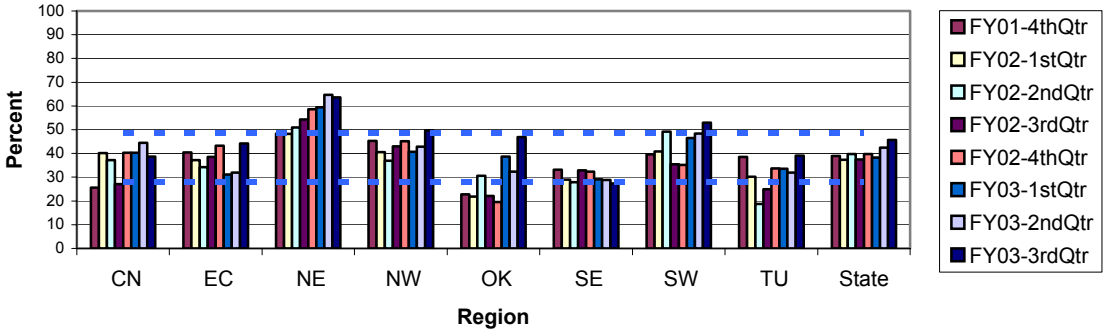
The number of adults with face-to-face mental health crisis services during the 3rd Quarter of FY03 for the state was 4.4 per 1, 000 of the adult population below 200% of

the poverty level (Figure 6). This rate was toward the high end of the range of 2.4 to 4.6 per 1,000 for the eight quarters studied. The TU region's rate of face-to-face crisis services trended towards high and was at its highest level (13.7 per 1,000) for the two-year time period. One reason for the high utilization of crisis services in the TU region may be a mobile crisis intervention program called Community Outreach Psychiatric Emergency Services (COPES) provided in that area. This program, available 7 days a week, 24 hours a day, responds to persons in crisis in Tulsa County. While the program does not open outpatient cases, nor do staff provide traditional outpatient services, services usually include several crisis follow-up visits throughout the crisis episode and people are linked with outpatient services as part of the plan for safety or stability.

Measure 7: Adult Crisis Follow-up in Outpatient Care within 7 Days

For the 3rd quarter of FY03, 46% of all adults with a face-to-face mental health crisis service in the state were seen for a non-crisis outpatient service within seven days, the highest percentage in the eight quarters measured (Figure 7). During the prior seven quarters, the percentage of adults that were seen within seven days ranged from 37% to 42%.

Figure 7: Adult Mental Health Face-to-Face Crisis Events during the Quarter
Percent Receiving Outpatient Follow-up within 7 Days



The adults in the NE region had a high rate of adult mental health face-to-face crisis follow-up (one standard deviation or more above the state mean) for all eight quarters measured and may represent a best practice (see Appendix 3: Glossary of Terms for discussion of the Core Service Plan). The SW region also had a high rate of follow-up with 53% of adult crisis services being followed-up within seven days in the 3rd Quarter of FY03. The SE region was the only area to have a rate of follow-up one standard deviation below the mean at 27% for the 3rd Quarter of FY03.

Carl Albert Community Mental Health Center (CACMHC) and Mental Health Services of Southern Oklahoma (MHSSO) noted that the SE region showed a slight decrease from the previous quarter and remained at one standard deviation below the mean.

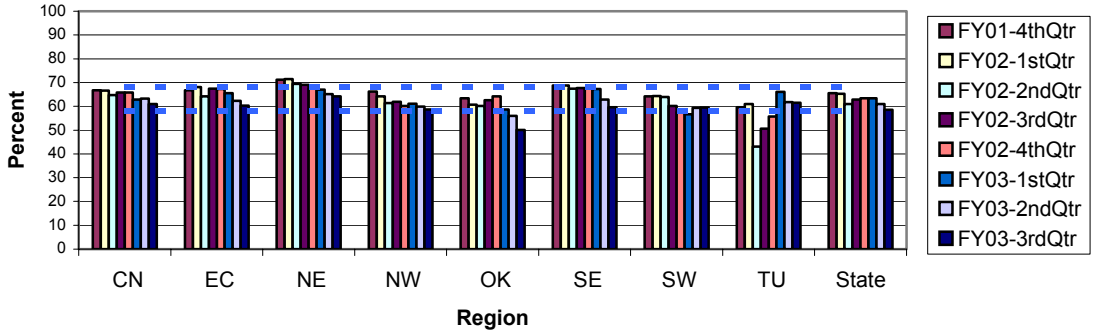
Previous similar measures measured follow-up at 14 days. In prior studies, 88% of CACMHC clients received an outpatient service after a crisis visit, the highest percentage among all CMHCs. Sixty-four percent of MSSHO clients received an outpatient visit within 14 days. MHSSO did not emphasize follow-up after crisis with direct service staff, but will do so going forward. The CMHCs suggested that setting a clear timeframe for crisis follow-up would be helpful.

ADULTS WITH MAJOR MENTAL ILLNESS (MMI)

Background: To more clearly define a category of clients with more serious disorders that could be identified in data also collected by the Oklahoma Health Care Authority (OHCA), criteria for Major Mental Illness (MMI) were selected (refer to Appendix 3 for a description of MMMI). This population is similar to the group of adults designated by providers as having a Serious Mental Illness (SMI), without considering level of functioning (which is not collected by OHCA). The tables in this report contain only data from the Integrated Client Information System (ICIS), which is the ODMHSAS statewide data system. ICIS includes Medicaid fee-for-service clients for which ODMHSAS pays the state match. For future analyses, it is planned to combine and/or compare similar data from OHCA and ICIS, including data on OHCA-funded clients from the three urban areas of the state where Medicaid managed care has been implemented.

Measure 8: Adults with MMI Receiving Any ODMHSAS-Funded Mental Health Service

Figure 8: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received Any Mental Health Service in the Quarter



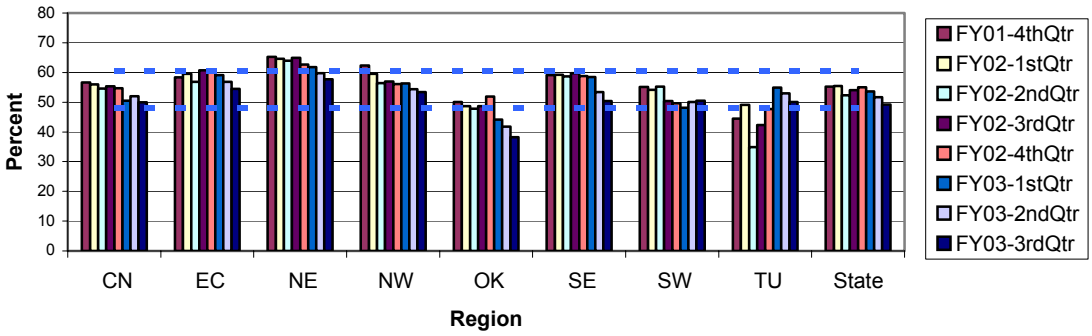
Among ODMHSAS-funded adult clients, about 59 percent of those diagnosed with a major mental illness in the past year were seen for a mental health service in the 3rd Quarter of FY03 (Figure 8). This is a decline from 61% seen in the 2nd Quarter FY03 report, which was also a decline from previous quarters.

The OK region trended toward a low percentage of adults with MMI utilizing mental health services, decreasing from 59% to 50% in the first three quarters of FY03. All areas but the TU and SW regions experienced a downward trend in providing services to adults with MMI.

Measure 9: Adults with MMI Core Outpatient Mental Health Services

About 49 percent of adults with MMI received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 3rd Quarter of FY03 (Figure 9). This is lower than the range between 52% and 55% that received services in the seven prior quarters.

Figure 9: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received a Core Mental Health Service in the Quarter

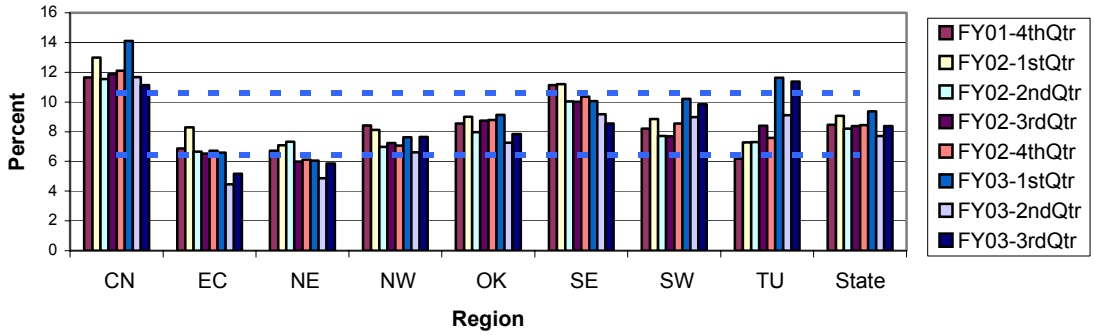


While utilization is decreasing in the NE region, it still had the highest rate of utilization for core outpatient mental health services for all eight quarters, with 58% of adults with MMI receiving a core outpatient visit in the 3rd Quarter of FY03. The OK region trended toward a low percentage of adults with MMI receiving core outpatient services with 44%, 41%, and 38% receiving a service in the three most recent quarters. Statewide, and in six of the eight regions, the rate of adults with MMI receiving core outpatient services has fallen in at least two of the most recent quarters.

Measure 10: Adults with MMI Inpatient Services

About 8% of all adults with MMI, statewide, were hospitalized in the 3rd Quarter of FY03 (Figure 10). The range of adults with MMI hospitalized in the prior seven quarters was between 7% and 9%.

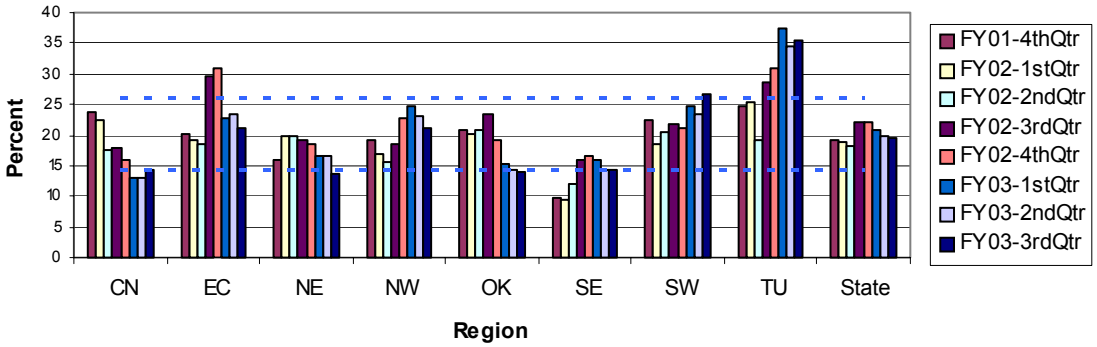
Figure 10: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received an Inpatient Mental Health Service in the Quarter



Both CN and TU regions had a rate of 11% in the 3rd Quarter of FY03, with the CN region demonstrating a high rate of adults with MMI hospitalization in all eight quarters. The adults with MMI in the EC and NE regions trended toward a low rate of inpatient hospitalization with utilization rates of 5% and 6%, respectively, in the 3rd Quarter of FY03.

Measure 11: Adults with MMI Case Management

Figure 11: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received a Case Management Service in the Quarter



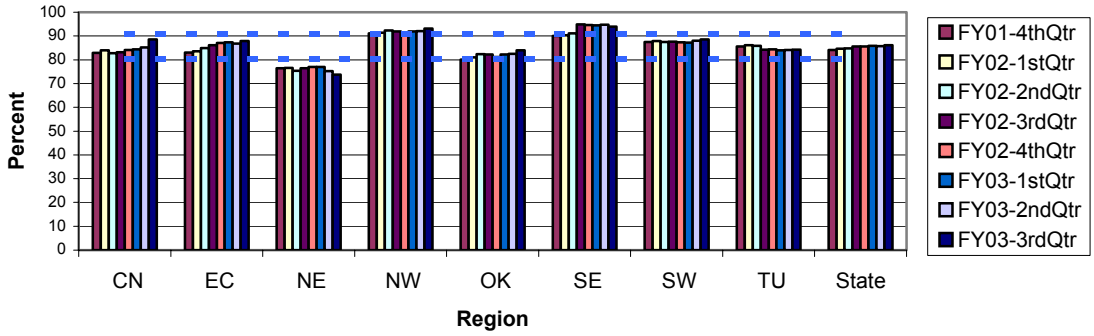
As in the previous quarter, about 20 percent of adults with MMI in the state received case management services in the 3rd Quarter of FY03, with a range of 18% to 23% in the prior seven quarters (Figure 11).

The CN, NE, OK and SE regions had low percentages of adults with MMI utilizing case management services; however, of these, the CN region experienced an increase from the prior quarter. The SW and TU regions were one standard deviation above the state mean in case management utilization for adults with MMI, with the TU region having a high utilization rate for the last five quarters.

Measure 12: Adults with MMI Independent Housing

Independent housing is an important quality of life issue for consumers. To obtain an indicator of independent housing, the 'Current Residence' reported to ICIS is used. Persons whose current residence is reported as 'Private Residence' or 'Supported Living' are considered living in independent housing for this report.

Figure 12: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Living in Independent Housing in the Quarter



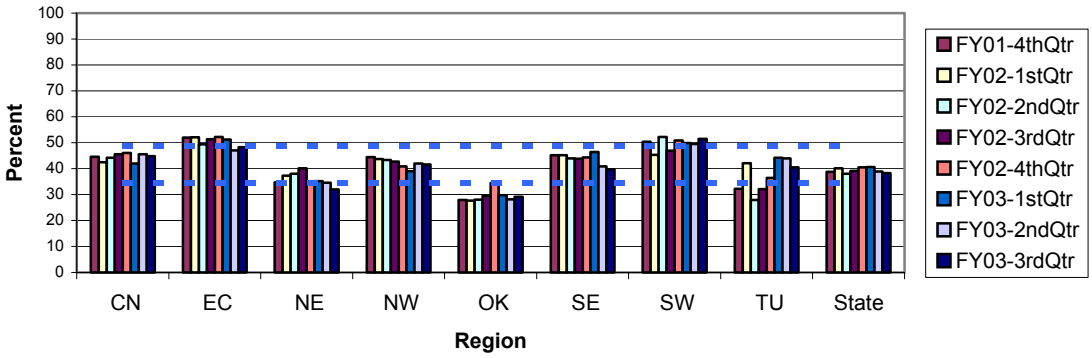
Statewide, 86% of adults with MMI lived in independent housing during the 3rd Quarter of FY03 (Figure 12). The statewide percentages continued to increase from 84% to 86% over the eight quarters studied. The adults with MMI in the NE region had a low percentage of independent housing for all eight quarters, while the adults with MMI in the NW and SE regions had high percentages of independent living for all eight quarters. The variation in independent housing across the regions may reflect the differences in available housing for this population, including a higher number of residential care facilities in the NE region compared to the rest of the state.

ADULT SELECT PRIORITY GROUP (SPG)

Adult clients with severe mental illness comprise the Select Priority Group (SPG), which was defined to evaluate access to medication services (refer to Appendix 3 for a definition of SPG).

Measure 13: Adult Select Priority Group Medication Visits

Figure 13: Adults with a Select Priority Group (SPG) Diagnosis in the Past Year
Percent Who Received a Medication Service in the Quarter



The measure is based on the assumption that the majority of clients with these diagnoses could benefit from a medication service each quarter. This measure represents the percentage of adults in the SPG that received a medication service in a quarter.

Statewide, 38% of all adults in the SPG received a medication service in the 3rd Quarter of FY03 (Figure 13). The range in the prior seven quarters was between 38% and 41%. The EC and SW regions had overall trends toward high rates of medication visits, 48% and 50%, respectively; and in all but two quarters had reported medication visit rates at least one standard deviation above the mean. Studying practices in these regions may identify activities that could be emulated elsewhere. The OK region had a low percentage of adults with SPG receiving a medication visit in all eight quarters measured; with 29% receiving a medication visit in the 3rd Quarter of FY03.

Steps Taken: Providers offered possible explanations for the low percentage of select priority group quarterly medication visits.

1. Stable clients may receive services less often than quarterly.
2. Medication services may not be recorded in the ODMHSAS database. Veterans or American Indians may receive case management services paid by ODMHSAS, but medication services from Veterans Administration clinics or the Indian Health Service. These services would not be recorded in the ODMHSAS database.
3. Clients with Medicaid may also receive medication services that are not recorded in the ODMHSAS database, but are available from the Oklahoma Health Care Authority (OHCA), the state Medicaid agency.

1. Do stable clients receive medication services less often than quarterly?

By expanding the timeframe for medication services from 90 days (quarterly) to 120 days, the rate of clients receiving medication visits only increased 4% (41% and 45%,

respectively), as shown in Table 13a. In doubling the timeframe to 180 days, only 5% more clients received medication visits.

Table 13a: Percent of Clients in SPG Receiving Medication Visits within the Following Time Periods

90 Days	41%
120 Days	45%
180 Days	50%

Conclusion: Expanding the timeframe did not substantially increase the number of clients in the SPG who received medication services.

2. Do veteran or American Indian clients receive medication services that may not be recorded in the ODMHSAS database?

When determining whether American Indians or veterans had lower rates of medication visits due to reporting the event to other pay sources, it was found that 40% of American Indians and 36.7% of veterans received medication visits in the most recent quarter studied compared to 39.5% of all clients in the SPG (Table 13b).

Table 13b: Percent of American Indian and Veteran Clients Receiving Medication Visits

	% of SPG population	Med visit in quarter	Med visit in year
All clients in SPG	100%	39.5%	61%
American Indian	8.3%	40.0%	62%
Veteran	5.8%	36.7%	60%

Given the small number of veterans (5.8%) and American Indians (8.3%) reported to the ODMHSAS database, these two groups have a very small impact on the overall rate of clients in the SPG who received medication visits. In fact, when American Indians and veterans are removed from the analysis, the rate changes from 39.5% to 39.6%.

Conclusion: American Indian and Veteran subpopulations in the SPG population do not appreciably affect the findings of the SPG Medication Visits indicator.

3. Do clients with Medicaid receive medication services that may not be recorded in the ODMHSAS database but may be available from the OHCA?

ODMHSAS staff reviewed the 2nd Quarter findings with Medicaid staff related to Medication Access for persons in the SPG. At that meeting, staff determined additional methods by which some available Medicaid data could be utilized to more completely calculate the extent to which persons in the SPG group were seen for medication appointments. This analysis will be performed for a future report.

In addition, ODMHSAS will assess the percentage of SPG clients receiving medication services within four- and six-month time periods to determine what percentage of clients receive medication visits less frequently than quarterly. This analysis will assist

ODMHSAS to determine factors impacting the utilization of quarterly medication services by the SPG population.

Conclusion: Analyses using additional Medicaid data are needed and will be reflected in the 4th Quarter of FY03 report.

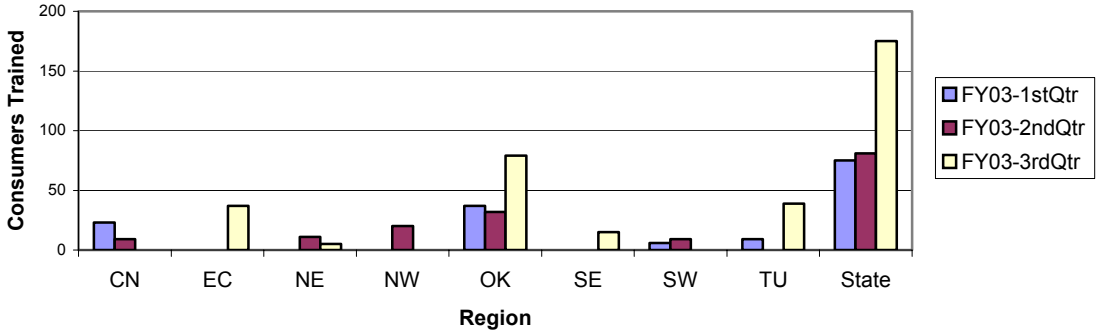
Edwin Fair CMHC: This CMHC in the NE region is actively addressing the issue of ensuring that Priority Clients One and Two, as designated by the Core Service Plan, receive timely medication. Staff meetings in Stillwater and Ponca City focused on this issue. The staff is being educated and med clinic staffing forms are being revised to better ensure that Priority One and Two groups have access to medications on a timely basis. More clients are expected to receive services and medication. Edwin Fair CMHC has applied for additional funds to help cover the expected impact of these changes on their medication budget.

EVIDENCE-BASED PRACTICES

Measure 14: Illness Self- Management

The illness self-management indicator measures the number of unique individuals that participated in a Wellness and Recovery Action Plan (WRAP) illness self-management education program each quarter for each region and the state. The WRAP training is an evidence-based practice implemented by the Oklahoma Mental Health Consumer Council under a contract with ODMHSAS. WRAP training is curriculum-based and specifically equips consumers with tools to understand their mental illness and develop strategies to be advocates for themselves as they continue their recovery. The ODMHSAS goal is for WRAP to be available in all regions in each quarter. Data reported to ODMHSAS for WRAP training does not include participant or client identifiers. Data are currently available for only the last three quarters.

Figure 14: Clients Receiving Illness Self-Management Training
Unduplicated Count by Quarter

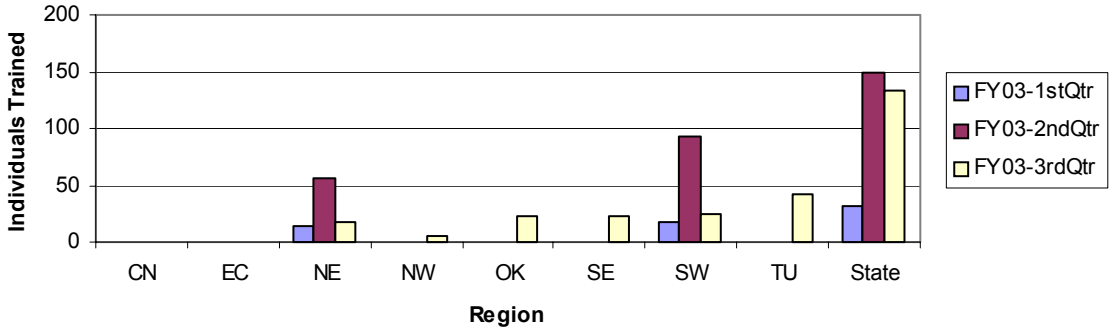


Illness self-management education services were made available for the first time in the EC and SE regions during the 3rd Quarter of FY03, allowing clients statewide the opportunity to attend within the past three quarters. This service was also available in the NE, OK, and TU regions, for a total of 175 consumers receiving training in the 3rd Quarter of FY03 (Figure 14). This represents an increase from 81 consumers who received training in the 2nd Quarter of FY03.

Measure 15: Family-To-Family Training

The Family-to-Family indicator measures the unique number of family members that participated in a psycho-educational training program presented by NAMI-OK under contract with ODMHSAS. Family-to-Family is also curriculum-based training in which, over the course of several sessions, family members learn about mental illnesses, effective treatment, and ways to support their relatives in treatment and recovery. Data reported to ODMHSAS for Family-to-Family training does not include participant or client identifiers. Currently data are available for only the last two quarters.

Figure 15: Family Members Receiving Family-to-Family Training
Unduplicated Count by Quarter



A total of 134 individuals received training in the 3rd Quarter of FY03, a slight decrease from 149 individuals trained in the prior quarter (Figure 15). Training sessions were held in the NE, NW, OK, SE, SW and TU regions during the 3rd Quarter of FY03. The trainings were offered for the first time in the NW, OK, SE and TU regions, increasing the number of regions in which the training was offered from three in the prior two quarters to six.

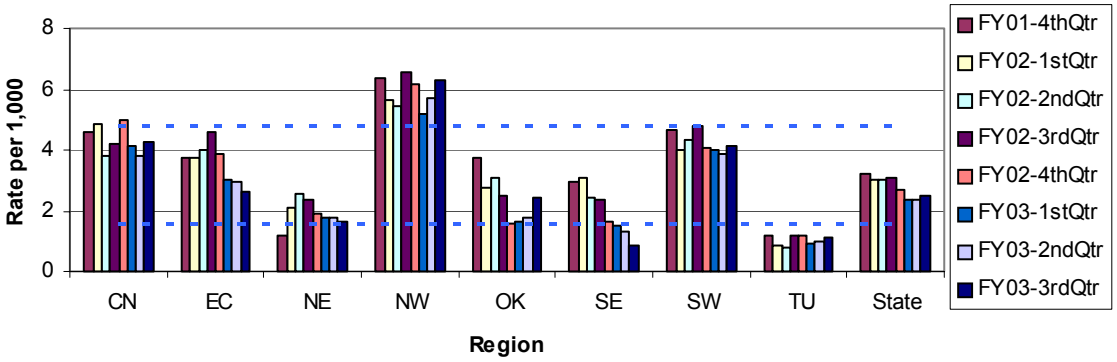
CHILDREN'S SERVICES

Background: Mental health services to children ages six through 17 years of age were measured. Children less than six years old were excluded because they are less likely than the older group to be the focus of services. The children's measures are based on the estimated numbers of children in each region reported by the U.S. Census for Oklahoma. The majority of publicly-funded services to children in this population are

paid through Medicaid (including the state match). As a result, they are not reported to ICIS and are not currently included in the RPMR.

Measure 16: Children with Any ODMHSAS-Funded Mental Health Service

Figure 16: Children Receiving Any ODMHSAS-Funded Mental Health Service Rate per 1,000 Children



Statewide about 2.5 children per 1,000 between the ages of 6 through 17 received ODMHSAS-funded mental health services in the 3rd Quarter of FY03 (Figure 16). The range was between two and three per 1,000 children in the seven preceding quarters. Based on the data reported to ICIS, children in the NW region had a high rate of service utilization, which ranged from 5.2 to 6.5 per 1,000 children for the eight measured quarters, with a rate of 6.3 per 1,000 children for the 3rd Quarter of FY03. The children in the TU region had a low reported rate of utilization in all eight quarters measured, which ranged from 0.8 to 1.2 per 1,000, and a rate of 1.1 per 1,000 children for the 3rd Quarter of FY03. The number of children receiving services in the SE region trended low with a rate of 0.8 per 1,000 children in the 3rd Quarter of FY03. The population-adjusted number of children in the SE region using ODMHSAS-funded services has been on a decline for six quarters. In addition, during the Third Quarter FY03, the number that received services was about a third of the mean for the state and was the least reported number of children served in any region during the last eight quarters.

PERFORMANCE MEASURES - SUBSTANCE ABUSE

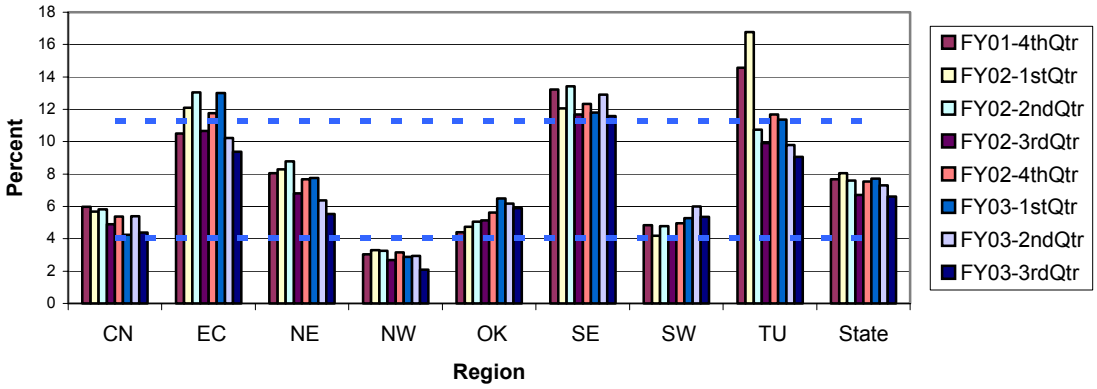
The indicators of substance abuse treatment performance used in this report are based on work funded by the federal Center for Substance Abuse Treatment (CSAT) and produced by a multidisciplinary group of providers, researchers, managed care representatives and public policy-makers. The Washington Circle, as the group is titled, agreed that promoting quality "is best accomplished through adopting a *process of care* model and defining a set of measures for each domain within that model." They note that "early recognition and intervention can positively affect the course of an individual's problem with alcohol and other drugs." Thus, the indicators they propose measure the extent to which persons in need are identified, initiated into treatment and engaged to stay in treatment.

Measure 17: Identification

Clients were considered "identified" (as substance abusers in need of treatment) if they received a substance abuse service in the quarter. There were 3,334 clients identified as in treatment during the 3 rd Quarter of FY03. Between 3,079 and 3,674 clients were identified in each of the seven prior quarters. The patients were identified by the first substance abuse services they used:

Outpatient – 1,290 clients (43%)
Detoxification – 954 clients (31%)
Residential – 676 clients (22%)
Community living – 112 clients (4%)

Figure 17: Adults in Poverty Estimated to Need Treatment
Percent "Identified" by ReceivingTreatment



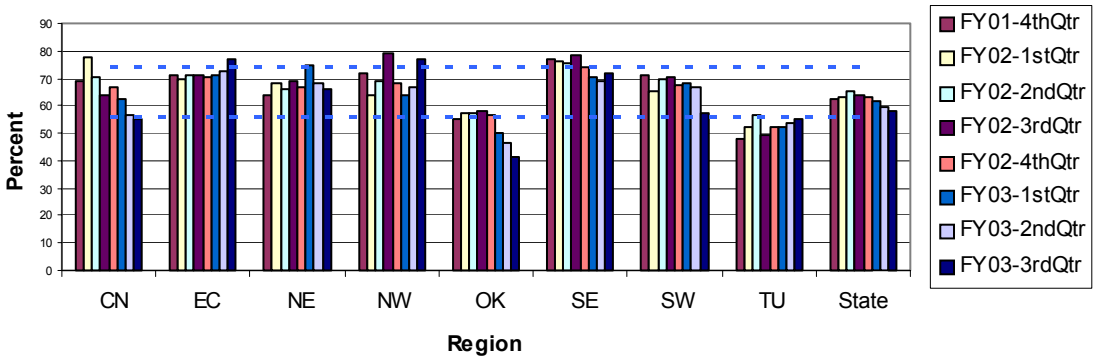
Statewide, seven percent of the adults with estimated needs for substance abuse treatment received a substance abuse service in the 3rd Quarter of FY03 (Figure 17). Between 7% and 8% of estimated adults with substance abuse problems received substance abuse services in the eight quarters measured.

A higher percentage of adults with substance abuse problems in the SE region (between 12% and 15%) received a substance abuse service in all eight quarters measured. A low percentage of adults with substance abuse problems in the NW region received a substance abuse service in all eight quarters measured, dropping from 3% to 2%.

Measure 18: Initiation

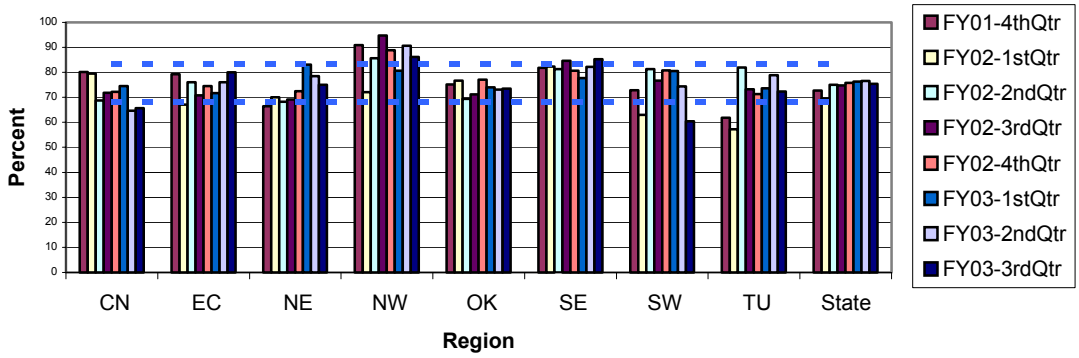
Among those clients who received a first (index) substance abuse service in the quarter (with no services in the past 60 days), initiation rates were calculated based on the level of care in which the clients were first served. Statewide, 58% of clients with a first substance abuse service (as described above) initiated treatment in the 3rd Quarter of FY03 (Figure 18a). This was below the range of 59% to 65% of clients that initiated treatment in the seven prior quarters.

Figure 18a: Initiation of Substance Abuse Treatment Following a First Service at Any Level of Care



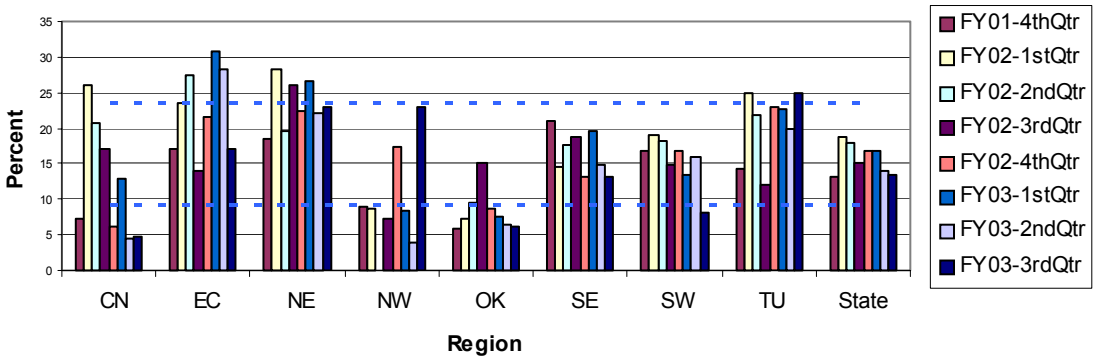
Initiation for residential and community living services were not included in the graph because nearly all clients initiated residential and community living treatment (as defined by the Washington Circle Group) by remaining in treatment a second day. The Initiation indicator was trended by outpatient and detoxification services separately because of the variation in the percent of clients initiating treatment among the two levels of care.

Figure 18b: Initiation of Substance Abuse Treatment Following a First Outpatient Service



As shown in Figure 18b, statewide, 75% of adults with first treatment episodes who started treatment in outpatient care initiated treatment (had a second service within 14 days). While the 3rd Quarter rate was slightly down from the previous quarter, the rate has remained fairly constant for the past six quarters. The CN and SW regions had low initiation rates at 66% and 60%, respectively, while the NW and SE regions had high rates at 86% and 85%, respectively.

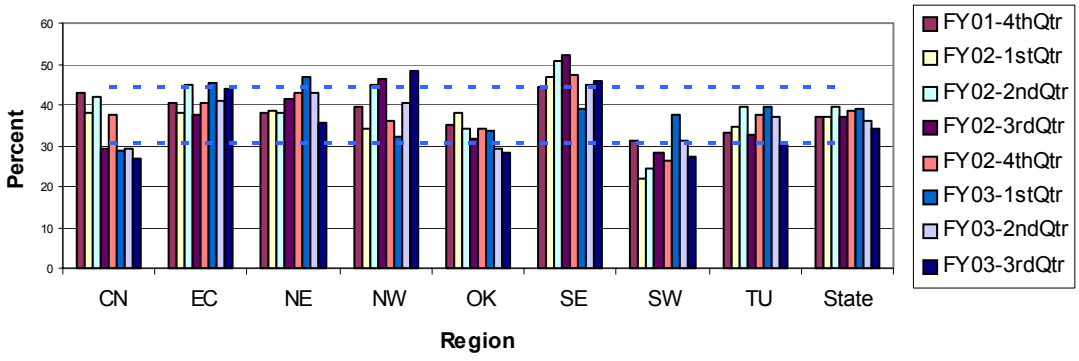
Figure 18c: Initiation of Substance Abuse Treatment Following a First Detoxification Service



Of all adults statewide with a treatment episode that started with a detoxification service, 13.5% initiated treatment (had a service within 14 days of discharge from detoxification treatment, refer to Figure 18c). This was less than the range in the prior six quarters. Both the CN and OK regions trended low on treatment initiation at 4.9% and 6.3%, respectively; however, there is much more variability in the CN region rate while OK has been declining for four quarters. The SW region experienced a substantial drop in the 3rd Quarter of FY03 from the previous seven quarters.

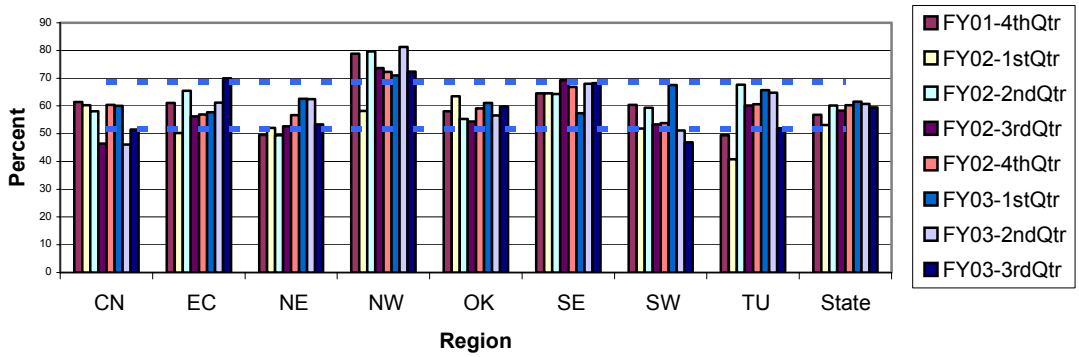
Measure 19: Engagement

Figure 19a: Engagement in Substance Abuse Treatment Following a First Service at Any Level of Care



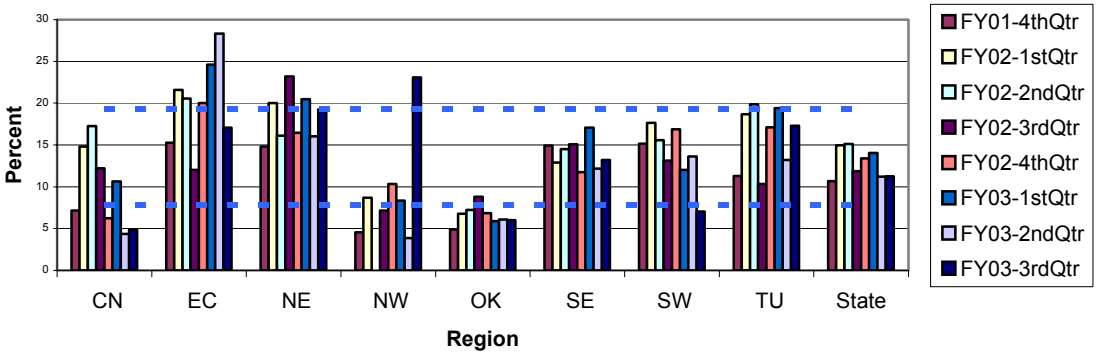
Statewide, 34% of clients with a new substance abuse treatment engaged in treatment during the 3rd Quarter of FY03 (Figure 19a). This was below the range of 36% to 40% of clients that engaged in treatment in the prior seven quarters.

Figure 19b: Engagement of Substance Abuse Treatment Following a First Outpatient Service



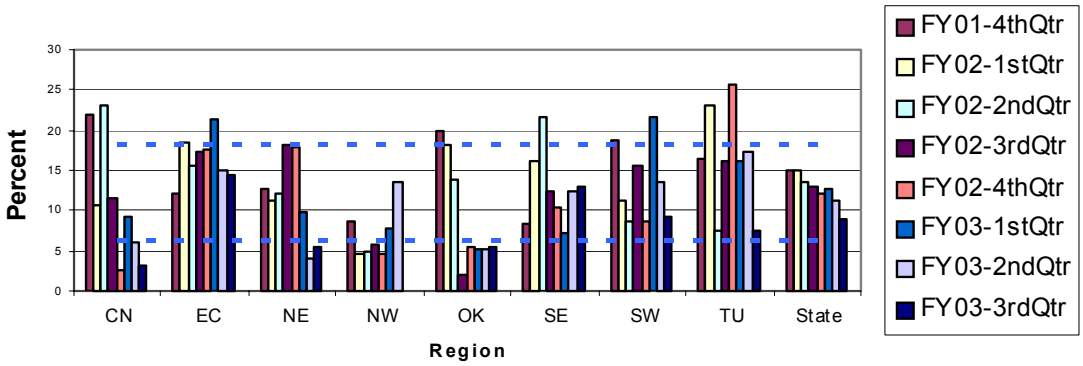
During the 3rd Quarter of FY03, 60% of clients who started treatment in outpatient care engaged in treatment (initiated treatment within 14 days after an initial outpatient service and had two more services within 30 days following initiation, refer to Figure 19b). This was within the range of 53% to 62% that engaged in treatment during the seven prior quarters.

Figure 19c: Engagement of Substance Abuse Treatment Following a First Detoxification Service



Eleven percent of clients who started treatment with detoxification services engaged in treatment (had one service within 14 days of discharge from detoxification services and two additional services within 30 days of the first post-discharge service). This was within the range of 11% to 15% in the prior seven quarters (Figure 19c). On engagement after detoxification services, both the CN and OK regions trended low, at 4.9% and 6%, respectively.

Figure 19d: Engagement of Substance Abuse Treatment Following a First Residential Treatment Service



As shown in Figure 19d, 9% of clients who started treatment with residential services engaged in treatment (had two substance abuse services within 30 days after discharge from residential treatment). This fell below the range of 11% to 15% in the prior seven quarters. The CN, NE and OK regions trended low for engagement in substance abuse treatment after discharge from residential treatment, with the CN region having a rate of 3.2%, and both the NE and the OK regions having a rate of 5.4%. In the 3rd quarter, the NW region had a rate of 0%, although this may be due to low numbers of clients being discharged from residential treatment.

MEASURES PLANNED FOR FUTURE RPMR REPORTS:

Consumer Complaints – currently complaints from service recipients are received through two official channels, the Patient Advocate and the office of Constituent Affairs (formerly part of the Patient Advocacy Office). The Patient Advocate Office has a database of complaints and incidents from which de-identified complaint information will be compiled to provide a summary of the types of issues that the Patient Advocate's office has addressed. The aim is to identify patterns or other information that would provide opportunities to develop and implement performance improvement plans. The Office of Consumers Affairs is being re-designed within the Mental Health Division and efforts will be made to compile similar information from that source. NAMI-OK and the Consumer Council also collect information that, in the future, may be useful to more effectively track complaints.

Stakeholder Feedback – proposed policies for Provider Certification will establish a Quality Council to review issues of service quality and performance improvement. It is proposed that this body be a primary source of stakeholder feedback. In addition, it is planned that RPMR reports will be made available to service recipient and advocate groups to provide them an opportunity to have input into the performance improvement process. Feedback from these groups can be incorporated in future reports.

The Mental Health Planning Council was offered the opportunity to learn more about the RPMR with the potential of incorporating the RPMR process into is ongoing monitoring

and planning activities. The Council requested a presentation on RPMR at a July meeting. The Directors of the Decision Support Services and Community Based Services Divisions will determine next steps for involving the Council in RPMR reviews, based on the Council's direction following the July presentation. Some of the RPMR measures are similar to indicators previously selected by the Council for inclusion in the State's Mental Health Block Grant Plan for FFY2002-2004.

Presentations are also being offered to the ODMHSAS Regional Advisory Boards (RAB). ODMHSAS staff presented the RPMR findings in June to the Tulsa RAB and have plans to meet with the East Central and OKC RABs in the coming months.

Provider Opinions – in Pennsylvania, Louisiana and other states, a survey of provider opinions has been established as a formal mechanism to allow providers to identify environmental, funding, policy, infrastructure and other issues that affect their ability to provide efficient and effective services. A similar instrument will be prepared to solicit feedback from ODMHSAS-funded service providers. ODMHSAS will rely on stakeholder feedback to develop provider opinion measures that will be meaningful and track useful data over time and between regions.

Program of Assertive Community Treatment (PACT) – PACT is a service-delivery model for providing comprehensive community-based treatment to persons with serious mental illness. The multi-disciplinary staff provides intensive treatment, rehabilitation and support services to clients in their homes, on the job and in social settings to enable clients to successfully reside in the community. To ensure this evidence-based practice is enrolling clients at the rate prescribed by the model, the number of quarterly enrollments and the number of clients served will be monitored. This measure will be reported beginning in the fourth quarter of fiscal year 2003.

Children's System of Care (SOC) – SOC is a best practice which assists communities in building fully inclusive organized systems of care for children who are experiencing a serious emotional disturbance and their families. Like PACT, it is important that the five project sites grow in an effective manner to ensure access to children and their families. Beginning in the fourth quarter of fiscal year 2003, the number of quarterly enrollments and the number of clients served will be monitored.

Appendix 1: RPMR Indicator Definitions

Mental Health Measures:
For all Mental Health measures, clients had to be admitted to a ODMHSAS-funded agency and be six years of age or older. Further, treatment services had to be paid from a mental health funding source or received at a ODMHSAS hospital or community mental health center. (ICIS contract source = 00, 01, 25, 39, 42, 43, 36, 50, 51 or 52.)

Measure 1: Adults receiving any ODMHSAS-funded Mental Health Service – The rate of people, 18 years or older, who received any mental health service from a ODMHSAS-funded agency per one thousand adults living at or below 200 percent of the poverty level in the state.

Numerator: Adult clients who received a service during the quarter being examined X 1000.

Denominator: Adults in the Oklahoma general population at or below 200% of the federal poverty guideline.

Measure 2: Adult Mental Health Core Outpatient Services – The rate of clients, 18 years or older, who received a mental health core outpatient service per one thousand adults living at or below 200 percent of the poverty level in the state. "Mental Health Core Outpatient Services" consists of one of the following services: individual counseling, group counseling, family/marital counseling, individual rehabilitation, group rehabilitation, case management, pharmacological management, medical review, home-based services, assertive community treatment, intensive case management, or psychosocial rehab program (ICIS service codes: 135, 136, 137, 216, 217, 225, 304, 305, 207, 214, 226 or 431).

Numerator: Adult clients who received a core outpatient service during the quarter X 1000.

Denominator: Adults in the Oklahoma general population at or below 200% of the federal poverty guideline.

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Measure 3: Adult Inpatient Services – The rate of clients, 18 years or older, who received either an acute or intermediate inpatient service per 1,000 adults in poverty. The inpatient services could be provided at either a hospital or a community-based inpatient unit (ICIS service codes = 001D or 001A).

Numerator: Adult clients who received an inpatient service during the quarter X 100.

Denominator: Adults in the Oklahoma general population at or below 200% of the federal poverty guideline.

Measure 4: Adult Inpatient Follow-up in Outpatient Care within Seven Days after Discharge – The percent of clients, 18 years or older, who received an outpatient service within seven days of being discharged from inpatient.

Numerator: Adult clients who received an outpatient service within seven days of being discharged from inpatient services during the quarter X 1000.

Denominator: Adult clients discharged from inpatient services during the quarter.

Measure 5: Adult Inpatient Re-admissions within 30 Days – The percent of clients, 18 years or older, who were discharged from inpatient care within the quarter and were re-hospitalized within 30 days of discharge. The re-admission may occur at the same facility or at a different from the original inpatient admission site. The accounting period for this indicator is shifted 30 days so the follow-up period is the last 30 days of the most recent quarter studied.

Numerator: Adult clients re-admitted to an inpatient unit within 30 days of a discharge from an inpatient unit during the quarter X 100.

Denominator: Adult clients discharged from an inpatient unit during the quarter.

Measure 6: Face-to-Face Mental Health Crisis Service - The rate of clients, 18 years or older, who received a face-to-face mental health crisis per 1,000 adults in poverty.

Numerator: Adult clients who received a face-to-face mental health crisis service in the quarter X 1000.

Denominator: Adult in the Oklahoma general population at or below 200% of the federal poverty guideline.

Measure 7: Mental Health Crisis Follow-up – The percent of clients, 18 years or older, who received an hourly, face-to-face crisis service and received another service, other than a crisis service, within seven days. To allow a seven-day follow-up period, only crisis events that occurred seven days before the end of the quarter were included.

Numerator: Adult clients receiving a non-crisis outpatient service within 7 days of receiving an hourly face-to-face crisis service X 100.

Denominator: Adult clients who received a face-to-face mental health crisis service in the quarter.

Adults with Major Mental illness (MMI):

Clients, 18 years or older, with a diagnosis of schizophrenia (except schizophreniform disorder), schizoaffective disorder, major depression/bipolar disorder - severe, mood disorder not otherwise specified (NOS), psychotic disorder, post traumatic stress disorder, obsessive/compulsive disorder, anti-social personality, paranoid personality disorder, borderline personality disorder, depression NOS, or bipolar NOS. This set of clients was identified as a group with serious mental illnesses that could also be identified from data collected by OHCA for Medicaid clients to permit combined and

cross-agency comparisons. The diagnosis Schizophreniform was omitted because, by definition, persons with this disorder have symptoms from one to six months and are not chronically ill. The Adults with MMI measure is intended to reflect persons with mental illnesses that are chronic and persist for longer terms.

Measure 8: Any ODMHSAS-Funded Mental Health Service for Adults with MMI – The rate of people with MMI, 18 years or older, who received any mental health service from a ODMHSAS-funded agency per 1,000 adults living at or below 200 percent of the poverty level in the state.

Numerator: MMI clients who received a service during the quarter X 1000.

Denominator: All clients identified as having MMI in the past year.

Measure 9: Core Outpatient Mental Health Service for Adults with MMI -- The rate of clients, 18 years or older, who received a mental health core outpatient service per 1,000 adults living at or below 200 percent of the poverty level in the state. "Mental Health Core Outpatient Services" consists of one of the following services: individual counseling, group counseling, family/marital counseling, individual rehabilitation, group rehabilitation, case management, pharmacological management, medical review, home-based services, assertive community treatment, intensive case management, or psychosocial rehab program (ICIS service codes: 135, 136, 137, 216, 217, 225, 304, 305, 207, 214, 226 or 431).

Numerator: MMI clients who received a core outpatient service during the quarter X 1000.

Denominator: All clients identified as having MMI in the past year.

Measure 10: Inpatient Services for Adults with MMI – The percent of MMI clients who had an inpatient service during in the quarter.

Numerator: MMI clients who received an inpatient service during the quarter X100.

Denominator: All clients identified as having MMI in the past year.

Measure 11: Case Management Services for Adults with MMI – MMI clients who received a case management service (ICIS service codes = 204, 225, or 226) in the quarter.

Numerator: MMI clients receiving a case management service during the quarter X100.

Denominator: All clients identified as having MMI in the past year.

Measure 12: Independent Housing for Adults with MMI – The percent of MMI clients who lived in independent housing during the quarter. Independent housing is defined as a private residence or a supported living residence (ICIS current residence code = 1 or 7).

Numerator: MMI clients who live in independent housing X 100.

Denominator: All clients identified as having MMI in the past year.

Adult Select Priority Group (SPG):
Clients, 18 years or older, with a diagnosis of schizophrenia (except schizophreniform disorder), schizoaffective disorder, major depression/bipolar disorder - severe, or psychotic disorder. This set of clients was identified as the group to most likely need regular treatment with newer generation anti-psychotic medications.

Measure 13: SPG Medication Visits – The percent of SPG clients who received a medication visit (ICIS service codes = 301, 304, 305, or 308).

Numerator: SPG clients who received a medication visit during the quarter X100.

Denominator: All SPG clients receiving any service during the quarter.

Measure 14: Illness Self-Management Training – The count of clients who received the WRAP training by region by quarter as reported by the Oklahoma Mental Health Consumer Council.

Measure 15: Family-to-Family Training - The count of clients who received the Family-to-Family training by region by quarter as reported by NAMI-OK.

Children's Services:
For all Mental Health measures of children's services, clients had to be admitted to an ODMHSAS-funded agency and be six to 17 years of age. Further, treatment services had to be paid from a mental health funding source or received at an ODMHSAS hospital or community mental health center (ICIS contract source = 00, 01, 25, 39, 42, 43, 36, 50, 51 or 52). Household income is not a constraint on providing mental health services to children. The majority of publicly-funded children's services are funded through the Medicaid agency and are not currently represented in the RPMR measures.

Measure 16: Children with Any ODMHSAS-Funded Mental Health Service -- The rate of children who received any mental health service from an ODMHSAS-funded agency per 1,000 children in the general population, by region and quarter.

Numerator: Children who received any mental health service in the quarter X 1000.

Denominator: US Census count of children ages 6-17 in the general population.

Substance Abuse Clients:
For all substance abuse measures, clients had to be admitted to a ODMHSAS-funded agency and be 18 years of age. Further, treatment services had to be paid from a mental health funding source other than inmate services and the presenting problem could not be co-dependence (ICIS contract source = 02, 17, 18, 19, 20, 21, 23, 27, 29, 37 and presenting problem not equal 745, 746, 747, 748, 749, 750).

Measure 17: Identification – The rate of clients, 18 years or older, who received any substance abuse service during the quarter per 1,000 people in the general population, 18 years or older, at or below 200 percent of the poverty level, who are estimated to be in need of treatment (as determined by the Substance Abuse Needs Assessment Study).

Numerator: Adult clients who received any substance abuse services during the quarter X 1000.

Denominator: Adults in the general population, at or below 200 percent of the poverty level, who are in need of treatment.

Measure 18b: Initiation (Outpatient) – The percent of clients, 18 years or older, who were admitted to an outpatient level of care with no other service in the previous 60 days and received a second substance abuse service (other than detox or crisis) within 14 days after a first service that identified the person as a substance abuse client (refer to diagram below).

Numerator: Adult clients admitted to outpatient care during the quarter who had received no other substance abuse service in the previous 60 days and received a second service within 14 days after a first service that identified the person as a substance abuse client.

Denominator: Adult clients admitted to outpatient care during the quarter who had received no other substance abuse service in the previous 60 days.

Measure 18c: Initiation (Detox) – The percent of clients, 18 years or older, who were admitted to a detoxification level of care with no other service in the previous 60 days and received another substance abuse service (other than detox, crisis, or inpatient) within 14 days of discharge from detox (refer to diagram below).

Numerator: Adult clients admitted to detox during the quarter who had not received any other substance abuse service in the previous 60 days and did receive another service within 14 days of discharge from detox.

Denominator: Adult clients admitted to detox during the quarter who had not received any other substance abuse service in the previous 60 days.

Measure 19b: Engagement (Outpatient) – Of the clients, 18 years or older, who had a 2nd service within 14 days after an initial outpatient service, the percent of those clients who had two more services (other than detox, crisis, community living, residential or inpatient) within 30 days following the 2nd service (refer to diagram below).

Numerator: Clients who received two or more services within 30 days of service initiation during the quarter.

Denominator: Clients who met the service initiation criteria during the quarter.

Measure 19c: Engagement (Detox) – Of the clients, 18 years or older, discharged from detox who initiated service within 14 days of discharge, the percent who had two more services (other than detox, crisis, or inpatient) within 30 days (refer to diagram below).

Numerator: Adult clients who initiated service after discharge from detox service during the quarter who received two more services within 30 days of service initiation.

Denominator: Adult clients who initiated service following discharge from detox service during the quarter.

Measure 19d: Engagement (Residential) – Of the clients, 18 years or older, who had a 2nd service within 14 days of their 1st service in residential treatment, the percent of those clients who had two more services (other than detox, crisis, residential or inpatient) within 30 days of *discharge* (refer to diagram below).

Numerator: Adult clients who initiated treatment following residential treatment discharge during the quarter who received two more services within 30 days of initiating treatment.

Denominator: Adult clients who initiated treatment following residential treatment discharge during the quarter.

Figure 20: Substance Abuse Treatment - Outpatient Diagram

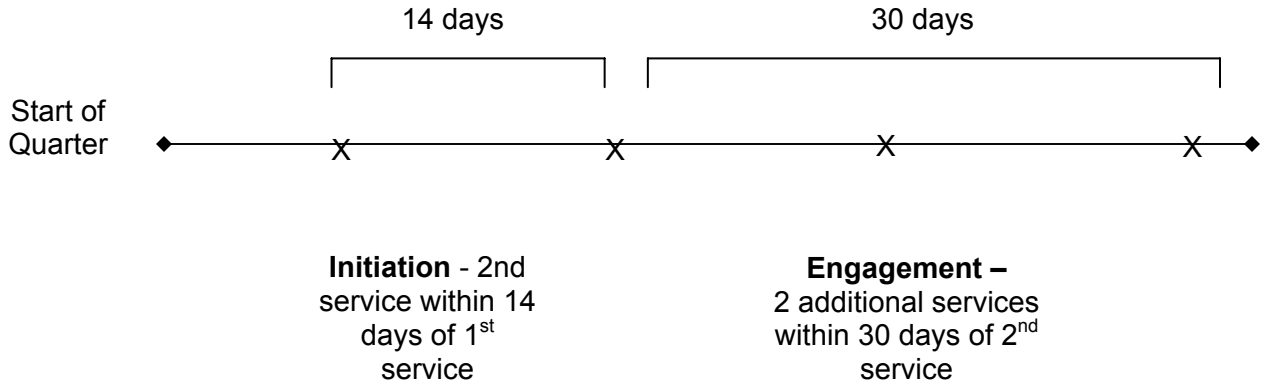


Figure 21: Substance Abuse Treatment - Detox Diagram

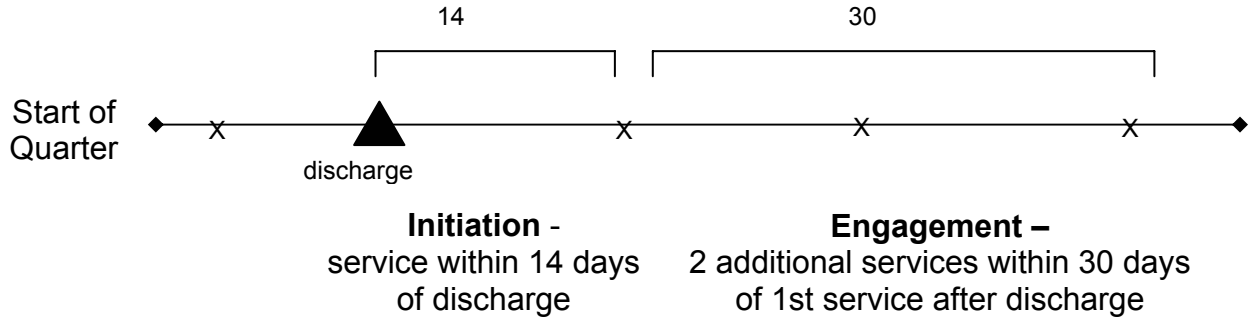
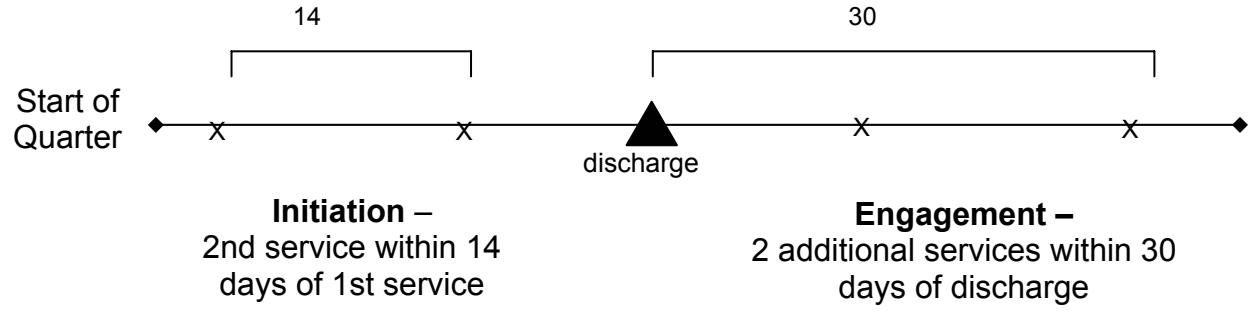
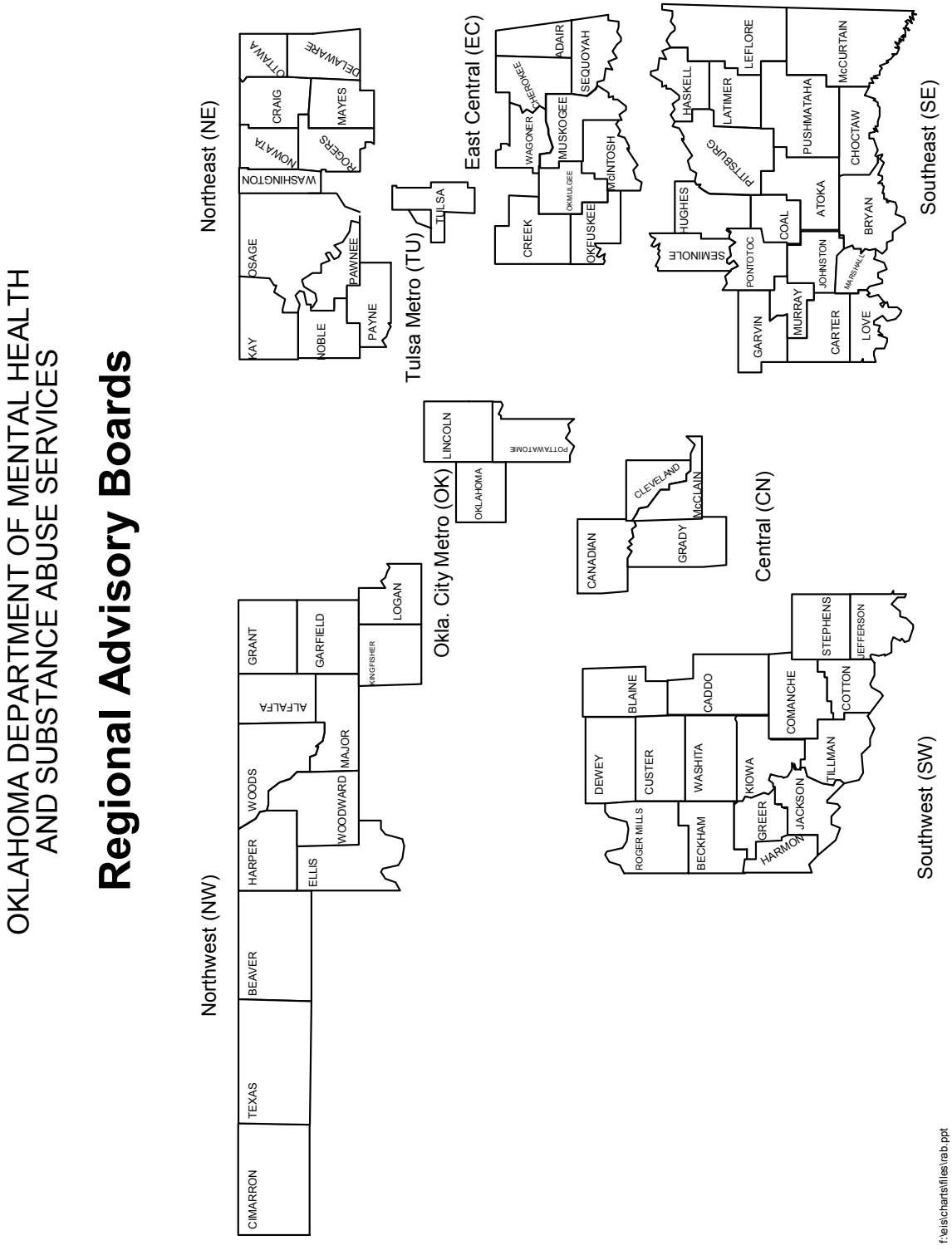


Figure 22: Substance Abuse Treatment – Residential Treatment Diagram



Appendix 2: Map of ODMHSAS Planning Regions



Appendix 3: Glossary of Terms

Core Service Plan – The Department requires that each CMHC must provide specific services to priority individuals within specified time frames, as clinically indicated. Required services include crisis intervention, emergency examinations, face-to-face clinical assessment for newly referred individuals, timely access to medications, involvement of family members (as permitted by the consumer) in service planning, strengths-based case management, group psychiatric rehabilitation, continuity of care planning with inpatient and stabilization facilities, and assertive outreach for persons discharged from inpatient or stabilization settings. The target population subject to the Core Service Plan are adults with serious mental illnesses who: (1) Are a danger to self or others as a result of mental illness; (2) Require long-term treatment for serious mental illness; (3) Have psychotic or major mood disorders; or (4) Are completing stabilization or inpatient treatment for mental illness. The Core Service Plan was initiated January 1, 2003.

Court Commitment – A court order under the Mental Health Code requires the individual to receive services involuntarily from the agency (Mental Health Law Title 43A).

Emergency Detention – Patient arrival at a detention facility from a point of emergency examination with three (3) required forms: a) Petition; b) Licensed Mental Health Professional's statement; c) Peace Officer's Affidavit (Mental Health Law Title 43A).

High rate of service utilization – This occurs when the percent of clients receiving services in the region is at a rate more than one standard deviation *above* the state's average (or mean) for the prior two years (eight quarters).

Low service utilization - This occurs when the percent of clients receiving services in the region is at a rate more than one standard deviation *below* the state's average (or mean) for the prior two years.

Major mental illness -- Adults with Major Mental Illness are persons 18 years of age or older who, at their last visit in the prior year, were diagnosed with one of the following disorders: schizophrenia, schizoaffective disorder, major depression–severe, bipolar–severe, mood disorder NOS, psychotic disorder NOS, panic disorder with or without agoraphobia, post traumatic stress disorder, dissociative identity disorder, obsessive compulsive disorder, anti-social personality, borderline personality or paranoid personality.

Mean - the average of a set of numbers, i.e., the sum of a set of numbers divided by the number in the set; used to represent the 'central tendency' of a set of numbers.

Order of Detention – Court orders an individual to be detained in a detention facility for no longer than 72 hours, excluding weekends and holidays, pending court hearing (Mental Health Law Title 43A).

Population adjusted - a statistical transformation of one set of population data in relation to another, to take into account differences in the distributions of population characteristics in the two datasets, e.g., age, race and sex distributions, so rates calculated on one dataset can be more accurately compared to rates in the other dataset. For example, a population with younger members would be age adjusted before comparing death rates with a population that included many more older members.

Poverty threshold (or poverty level) - poverty level is based upon federal Department of Health and Human Services estimates, and is a function of number of people in the household and total household income. ODMHSAS uses 200% of this poverty level as a criterion for eligibility for all but emergency and children's services. In this report, 'in poverty' refers to persons at or below the 200% of poverty set by ODMHSAS as the threshold for service eligibility.

Select Priority Group - The Select Priority Group (SPG) includes persons 18 years of age or older who were diagnosed in their last visit within the prior year with one of the following diagnoses: schizophrenia, schizoaffective disorder, psychotic disorder NOS, major depression–recurrent and severe, and bipolar disorder.

Standard deviation - a statistic that represents how far a number is from the average (or mean) of a set of numbers. Approximately, sixty-eight percent of a set of numbers lies within one standard deviation above and below the average of a set of numbers. A number from the set that is more than one standard deviation above or below the mean is, thus, a relatively rare occurrence. Therefore, closer inspection may be needed for those regions falling one standard deviation above or below the mean.

Trends toward a high rate of utilization - This denotes high service utilization (one standard deviation above the mean) for two or more of the most recent quarters.

Trends toward a low rate of utilization - This denotes low service utilization (one standard deviation below the mean) for two or more of the most recent quarters.

Appendix 4: List of Acronyms Used

CMHS – Center for Mental Health Services
CN – Central Oklahoma Region
CSAT – Center for Substance Abuse Treatment
EC – East Central Region
FY – fiscal year
ICIS – Integrated Client Information System
MMI – Major Mental Illness
NE - Northeast Region
NW - Northwest Region
ODMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services
OHCA – Oklahoma Health Care Authority
OK – Oklahoma Metro Region
PACT – Program of Assertive Community Treatment
RAB – regional advisory board
RPMR – Regional Performance Management Report
SAMHSA – Substance Abuse and Mental Health Services Administration
SE - Southeast Region
SOC – Children Systems of Care
SPG – Select Priority Group
SW – Southeast Region
TU - Tulsa Region
WRAP – Wellness and Recovery Action Plan