Oklahoma Department of Mental Health And Substance Abuse Services

Regional Performance Management Report

Report for Fourth Quarter of FY2003

Reported November 2003 By ODMHSAS Decision Support Services

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Regional Performance Management Report
For 4th Quarter of FY2003

INTRODUCTION

The initial RPM report was published in May 2003 for the period of October through December 2002. This current report reviews activities for the final quarter of FY 2003, i.e., April through June 2003.

Background. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Regional Performance Management (RPM) Report was initiated with support from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for technical assistance from Howard Dichter, MD. The project continues with technical assistance from Dr. Dichter, a consultant with expertise with rapid monitoring of state health programs. In addition, technical assistance is provided by Linda Graver, Kay Miller, and Dan Whalen as staff with The MEDSTAT Group, a healthcare information company that provides services for managing the cost and quality of healthcare, supported by a contract with SAMHSA. Additional information about the selection and definition of indicators is provided in Appendices 1 and 2.

Performance Improvement Cycle. As noted in the introduction to previous reports, the primary aim of the RPM report is to provide up-to-date information to guide system performance improvement efforts. Production of the report itself follows the Plan-Do-Check-Act (PCDA) cycle promoted as a model for performance improvement activities. The indicators for the report were "planned" with federally-funded technical assistance. To "do" the report, staff members of ODMHSAS Decision Support Services compile data for the quarterly report, from which the narrative is produced with input from Jennifer Glover, Substance Abuse Services, John Hudgens, Mental Health Services, and Performance Improvement Coordinator for the Department, Jan Savage. Following compilation of the draft report, it is circulated among ODMHSAS Central Office staff members to get their 'first take' comments. Any changes they recommend are incorporated into the draft, which is then distributed to all substance abuse and mental health providers for their input. This "checking" step of the process has begun to stimulate an informative exchange of ideas to explain regional differences. Finally, the process has also spurred follow-up "actions": DSS staff have performed additional analyses to evaluate proposed explanations of findings (see the 'Provider Feedback' and the section on 'Supplemental MMI Analysis' paragraphs for several indicators). In addition, some providers have begun to use report results as the basis for initiating system improvement activities.

A map of regions for which data are summarized is provided in Appendix 3 and a glossary of terms and list of acronyms are presented in Appendices 4 and 5. The continuing RPM report 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 Jennifer Glover (405-522-2347, jglover@odmhsas.org) or Jan Savage (405-522-5379, jsavage@odmhsas.org).

Overview of the 4th Quarter of FY03. Statewide there was a six-quarter trend of fewer persons seen for any and core outpatient services each quarter. However, the Regional Performance Management (RPM) indicators for adult with MMI, which is similar to the adult SMI population, show evidence the system is stabilizing. In the reported quarter (4th Quarter of FY03), the percentage of adults with MMI receiving any service, core outpatient and case management services were higher than the prior quarter. This reversed the downward trends over the prior three quarters. The percentage of people with MMI who live in independent housing was similar to the rate of the prior quarter and slightly higher than the percentage in the prior seven quarters.

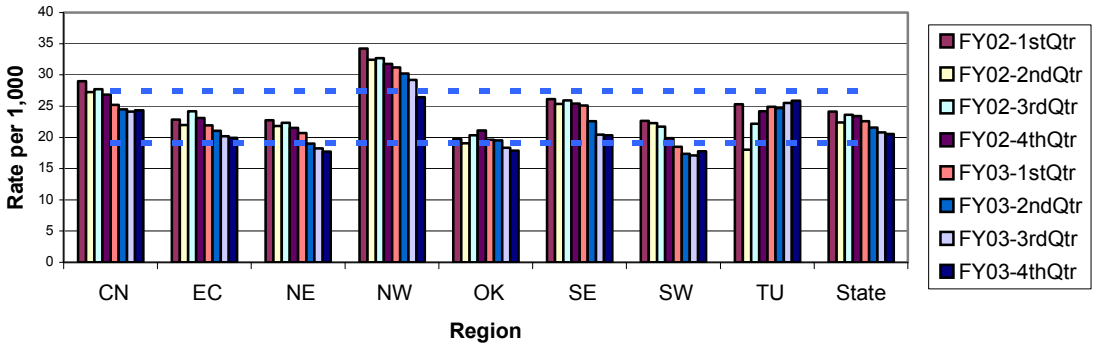
The RPM results are consistent with providers, statewide, maintaining the quality of services at the levels prior to budget restrictions. Adult inpatient admissions were stable in the 4th Quarter of FY03compared to the prior seven quarters. The rate of hospitalization in 4th Quarter of FY03 was the second lowest rate in the prior seven quarters. Measures of continuity of care also showed evidence of system stability. During the last two quarters, a slightly higher percentage of adult inpatients received a follow-up within seven days of discharge as compared to the prior quarter. This reversed the trend over the seven prior quarters where, each quarter, lower percentages of inpatients received a follow-up. During the 4th Quarter of FY03, the percentage of re-admissions within 30 days was within the range of the prior seven quarters. The percentage of adults with a crisis service seen for an outpatient service within seven days of the crisis was also within the range of the prior seven quarters.

The RPM measures indicate that services to severely ill adult clients are stabilizing. In addition, RPM measures of quality indicate that the quality of services in the last quarter was similar to the quality prior to budget restrictions.

PERFORMANCE MEASURES -- MENTAL HEALTH

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



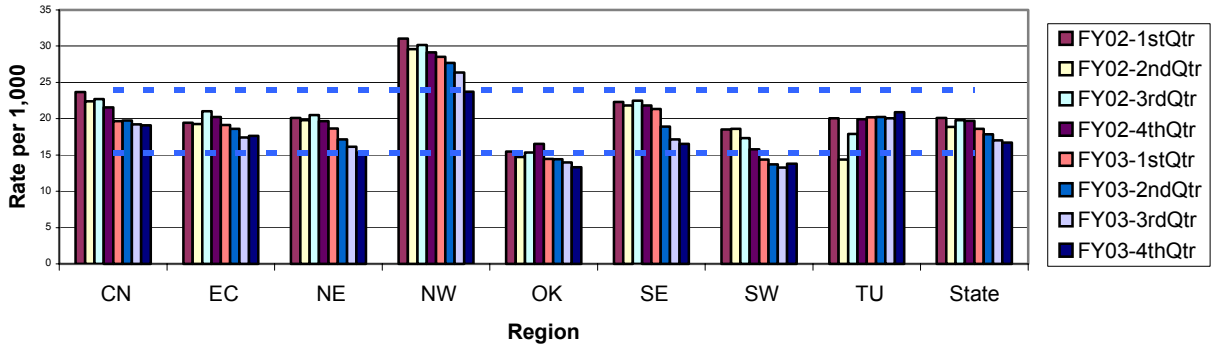
As shown in Figure 1, statewide, 21 of every 1,000 adults in poverty received an ODMHSAS-funded mental health service in the 4th Quarter of FY03 (the focus of this report). The range of adults per 1,000 in poverty that received a service in the prior seven quarters is 21 to 24. Statewide, the number of persons that received any service declined by 15% over the past eight 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 18 adults, respectively, per 1,000 in poverty in each region received a mental health service. Statewide, and for five regions (EC, NE, NW, OK, SE), there were declines in the rate of services provided for at least the past year. Although still within one standard deviation above the mean, services in the Tulsa region have trended counter to the rest of the state and have increased over the past seven quarters.

Provider Feedback:
For both Measures 1 and 2, HOPE Community Services Inc. (OK region) reported that the decline in ODMHSAS-funded mental health services reflected funding cuts and implementation of the more restrictive priority I and II criteria. These changes did not affect people with MMI as drastically because they are more likely to meet priority I and II criteria, but caused a reduction in services to individuals who do not meet the MMI definition.

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

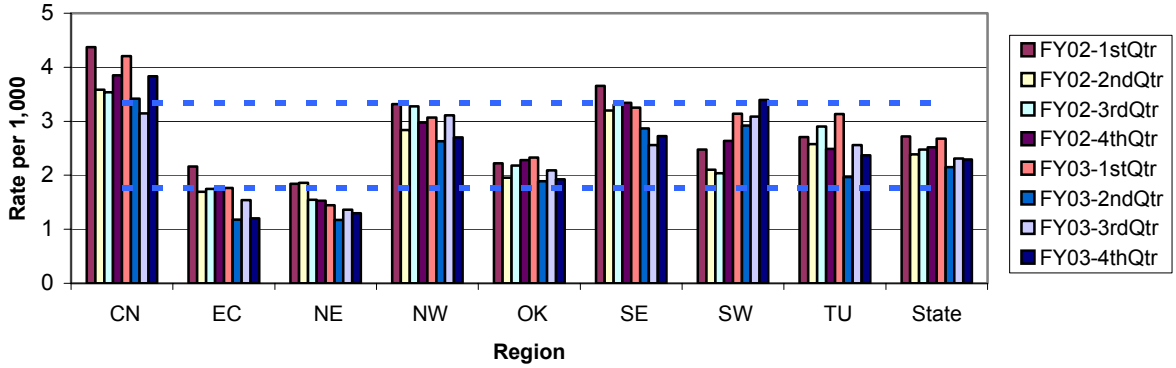


Outpatient services are the most frequently provided, so "Any ODMHSAS-funded" and "Core Outpatient" services follow the same general pattern of utilization. Statewide, about 17 of every 1,000 adults in poverty received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 4th Quarter of FY03 (Figure 2). The range of persons per 1,000 statewide that received services in each of the prior seven quarters is 17 to 20. Statewide, the number of persons that received a core outpatient service declined 17% over the past eight quarters.

The OK and SW regions were one standard deviation below the state average for the past year although the SW region showed an increase in the 4th quarter of FY03. As with the “Any Service” indicator, adults in the NW region had a high utilization of core outpatient mental health services in all eight quarters measured, although the rate has been decreasing for the past five quarters. The state and five regions (CN, NE, NW, OK, and SE) showed a downward trend in core outpatient services provided in the state. Though the increase is not as marked as for “Any Service,” Tulsa core outpatient services have trended slightly upward overall, while the rest of the state has trended downward.

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

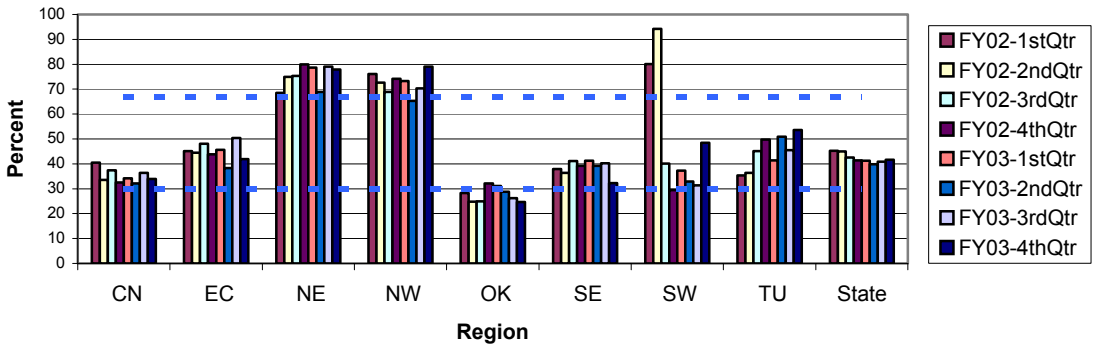


Statewide, 2.3 of every 1,000 adults (23 of every 10,000) in poverty received an inpatient mental health service (in a state hospital or community-based inpatient unit) in the 4th Quarter of FY03 (Figure 3). The range for the prior seven quarters was between 2.1 and 2.7 per 1,000.

The CN region had the highest utilization of inpatient services with 3.8 adults per 1,000 in poverty receiving an inpatient service in the 4th Quarter of FY03, followed by the SW region with a utilization rate of 3.4 adults per 1,000 in poverty. The EC and NE regions tended to have low rates of utilization at 1.2 and 1.3, respectively, per 1,000 adults in poverty. The NE was more than one standard deviation below the mean for six quarters and EC for five of the eight quarters.

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

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

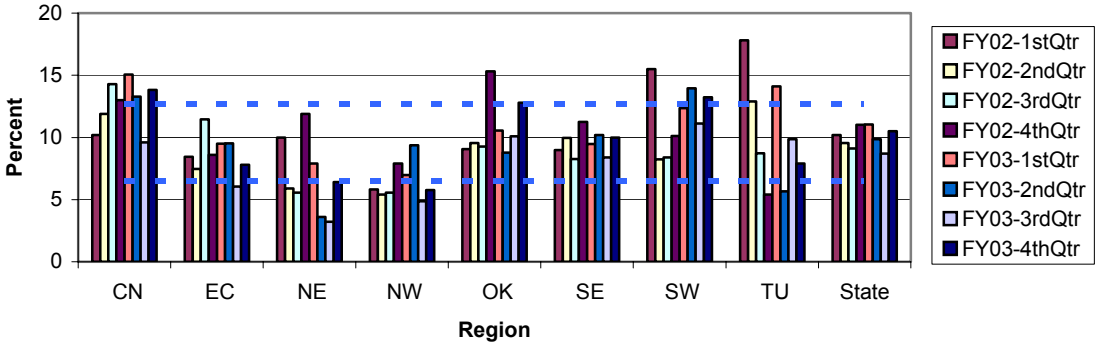


Statewide, 41% of adults discharged from an inpatient psychiatric setting received an outpatient visit within seven days of discharge during the 4th Quarter of FY03 (Figure 4). While trending down in the first six quarters, the percent of adults in inpatient treatment seen after seven days has risen slightly in the two most recent quarters statewide, due to improvements in follow-up in the NW, SW and TU regions.

The percent of adults discharged from an inpatient psychiatric setting who received an outpatient visit within seven days was the highest in the NW region at 79% in the 4th Quarter of FY03, followed by the NE region at 78%. 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 25% of the inpatients being seen in outpatient care within seven days in the 4th Quarter of FY03.

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

Figure 5: 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. Statewide re-admissions ranged between 9% and 11% of discharged inpatient adults. Statewide and for regions except the TU region, readmissions rose from the 3rd to the 4th quarter of FY03. The CN, OK and SW regions experienced re-admission rates at or above one standard deviation from the mean.

As demonstrated in the 3rd Quarter FY03 report, clients with co-occurring illnesses were more likely to be readmitted within 30 days than clients with only one identified diagnosis. This finding stresses the need for stringent screening and assessment to identify clients with co-occurring illnesses, and the need for inclusive discharge planning to ensure they are referred and connected to the appropriate services in the community upon discharge.

Provider Feedback:
Carl Albert CMHC (SE region) had a high rate of 30-day re-admissions compared to other CMHCs in the state and national rates using the Joint Commission on

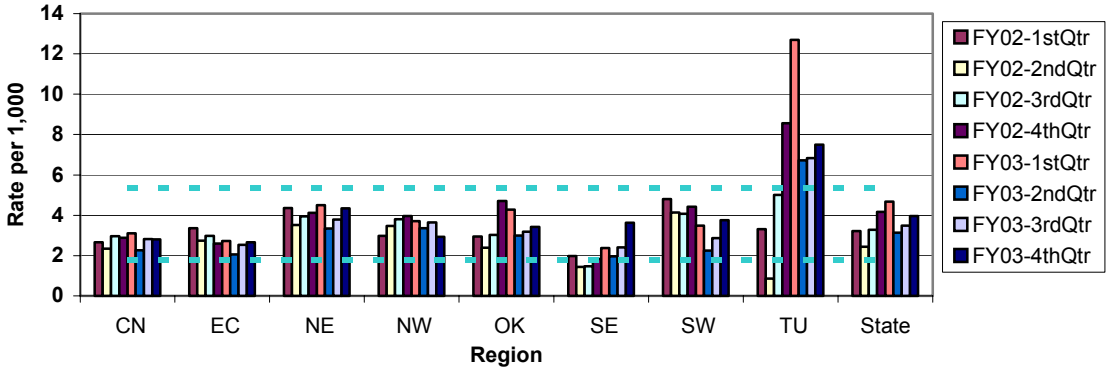
Accreditation of Healthcare Organizations performance measurement system. Carl Albert CMHC initiated a formal six-step problem-solving process to address the issue.

They assembled a team including the Medical Director, Psychiatrist, Inpatient Unit Manager, Social Work, Psychological Services, Inpatient RNs, Patient Care Assistants and Outpatient Supervisor. The team felt the following factors contributed to inpatient re-admissions: co-occurring mental health and substance abuse disorders, the lack of consequences for substances users with substance induced psychiatric crisis, fragmented post-discharge treatment resources and the lack of local resources.

Carl Albert CMHC staff initiated a number of actions to impact inpatient re-admissions. Discharge plans were strengthened. Inpatient stays were extended to ensure the most appropriate referral was established. Referrals to their PACT team increased. Staff monitored inpatient census characteristics. The ODMHSAS Substance Abuse Services staff was used for case consultation, referral and treatment ideas. The agreement with a local provider of ODMHSAS-funded substance abuse services was re-established. Other ideas include identifying best practices for this population, and working with law enforcement on appropriate referrals. Evaluation of the impact of the changes on inpatient re-admissions is ongoing.

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

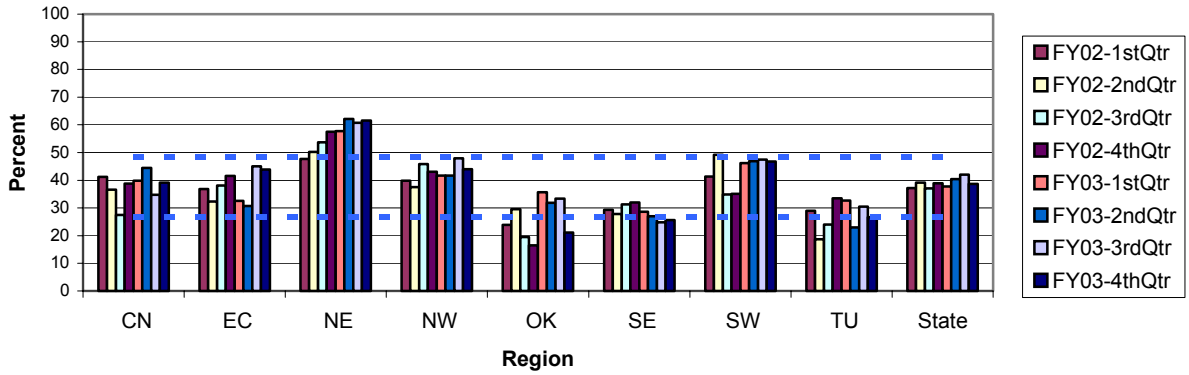


The Adult Mental Health Face-to-Face Crisis indicator measures the rate per 1,000 adults in poverty in each region who received a crisis service in the quarter. A comparison of this table with previous reports will show significant differences. A re-evaluation of coding practices related to selected services reported in the TU region was performed in response to previous RPM reports. As a result of that analysis, some services were re-coded and the result is a significantly different picture of activity in the region.

The number of adults with face-to-face mental health crisis services during the 4th Quarter of FY03 for the state was 4 per 1,000 of the adult population below 200% of the poverty level (Figure 6). While the rate is trending up from the previous two quarters, it falls within the two-year range of 2.7 to 4.3 per 1,000 of the adult population below 200% of the poverty level. Even after the service code adjustment, the TU region's rate of face-to-face crisis services continues to be high at a rate of 7.5 for the most recent quarter and has been at least one standard deviation above the average for the previous four quarters. The remaining regions fell within one standard deviation of the state mean, ranging from 2.7 to 4.3 per 1,000 of the adult population below 200% of the poverty level.

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

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



For the 4th quarter of FY03, 39% 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, (Figure 7). During the prior seven quarters, the percentage of adults that were seen within seven days ranged from 37% to 42%.

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. The SW region also had a high rate of follow-up with 47% of adult crisis services being followed-up within seven days in the 4th Quarter of FY03. The OK, SE and TU regions have rates of follow-up one standard deviation or more below the mean at 21%, 26% and 27%, respectively, for the 4th Quarter of FY03.

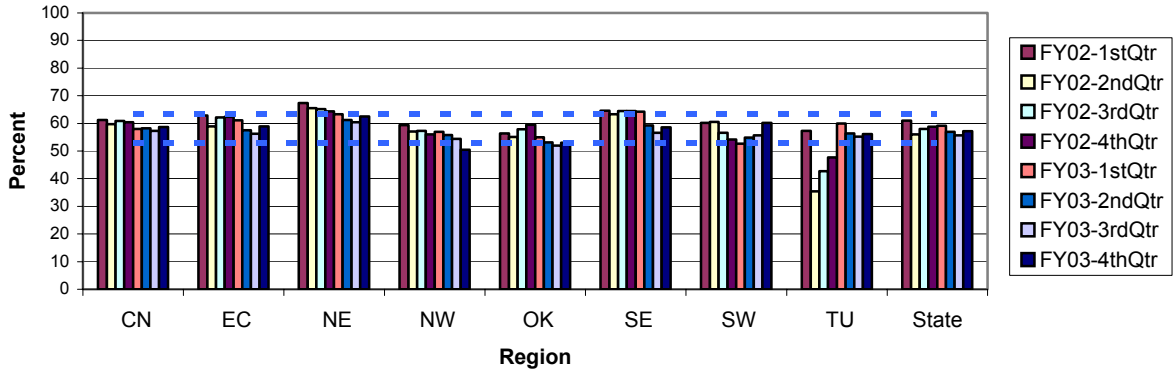
ADULTS WITH MAJOR MENTAL ILLNESS (MMI)

Background: Criteria for Major Mental Illness (MMI) were selected 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), (refer to Appendix 3 for a description of MMI and see the section below on "Supplemental MMI Analysis"). 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). Rand Baker, Deputy Commissioner for Mental Health, has requested that the MMI definition be reviewed in light of the Core Service Plan (refer to Appendix 4 for explanation of the Core Service Plan) eligibility criteria, which may be more limited than the initial MMI definition. This analysis will be done prior to the 1st Quarter FY04 report and a decision will be made about changing criteria for inclusion in the MMI group.

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

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



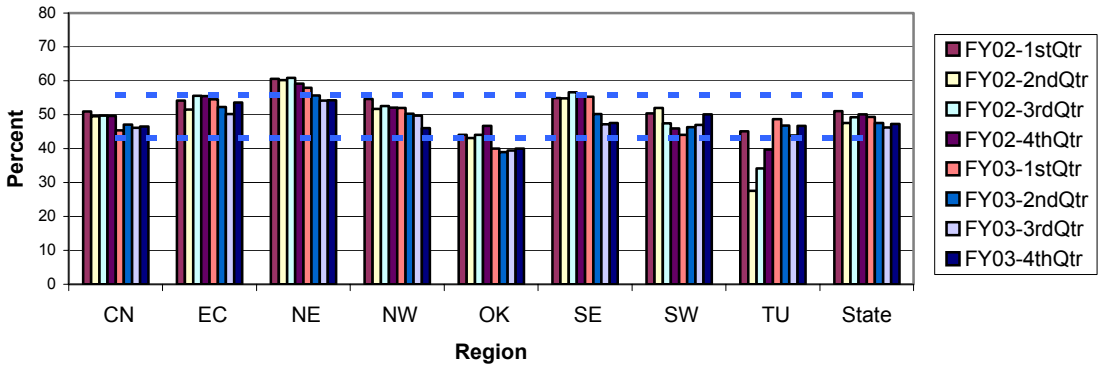
Among adult clients receiving ODMHSAS-funded services, about 57% of those diagnosed with a major mental illness in the past year were seen for a mental health service in the 4th Quarter of FY03 (Figure 8). There has been little variation over the last eight quarters, with a range of 56% to 61%.

The NW region trended toward a low percentage of adults with MMI utilizing mental health services, decreasing from 60% in the 1st Quarter of FY02 to 51% in the 4th Quarter of FY03. All areas but the NW region experienced a slight increase in the percent of adults with MMI receiving a mental health service from the 3rd to the 4th Quarter of FY03.

Measure 9: Adults with MMI Receiving Core Mental Health Outpatient Services

About 47 percent of adults with MMI received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 4th Quarter of FY03 (Figure 9). This is within the range of 46% to 51% 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 Outpatient Service in the Quarter

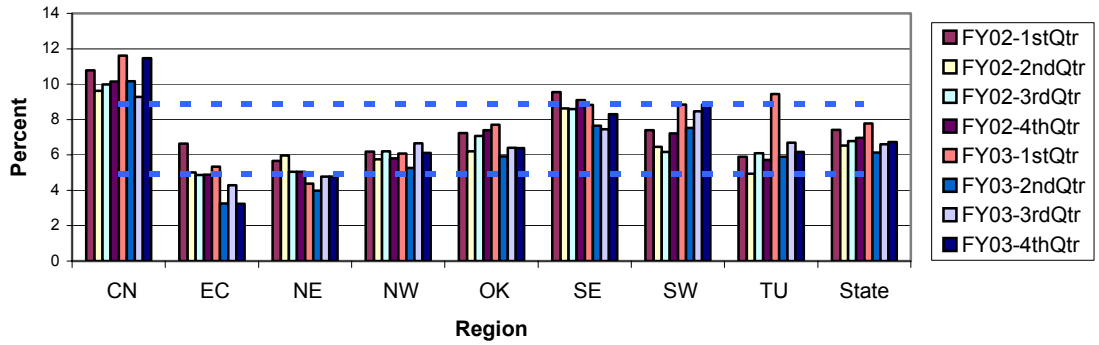


While utilization is decreasing in the NE region, it still had the highest rate of utilization for core outpatient mental health services for all eight quarters, with 54% of adults with MMI receiving a core outpatient visit in the 4th Quarter of FY03. The OK region has experienced a low percentage of adults with MMI receiving core outpatient services, ranging from 39% to 40% in FY03. The NW region was the only area not to show an increase from the 3rd to 4th Quarter of FY03; however, the percent of clients with MMI receiving core outpatient services in the NW region remains within one standard deviation of the mean.

Measure 10: Adults with MMI Receiving Inpatient Services

About 7% of all adults with MMI, statewide, were hospitalized in the 4th Quarter of FY03 (Figure 10). The range of adults with MMI hospitalized in the prior seven quarters was between 6% and 8%.

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



The CN region had a rate of 11% in the 4th Quarter of FY03, demonstrating a high rate of adults with MMI hospitalization in all eight quarters. The adults with MMI in the EC and NE regions show a low rate of inpatient hospitalization with utilization rates of 3% and 5%, respectively, in the 4th Quarter of FY03.

Provider Feedback:
The providers noted a number of factors, which may have been associated with lower hospitalization, including PACT and other specialized teams that work with clients at risk for hospitalization, as well as quick access to services.

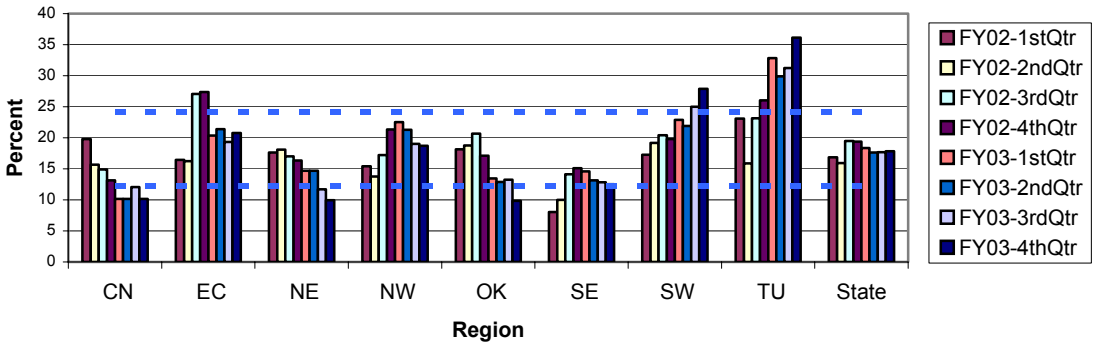
Edwin Fair CMHC (NE region) reported that the reduction of inpatient hospitalizations might have been related to case management teams that focus on the SMI population and hospitalizations, as well as their assertive outreach, which has been in place for some time. Red Rock reported the presence of their PACT team in the Tulsa region was associated with dropping rates of hospitalization. They indicate that the presence of a PACT team in the Southwest Region may help reduce the region's hospitalization as well.

Red Rock also noted the fact that the OK Region is consistently below the state average and commented that the coordination between the CMHC and staff at the Oklahoma County Crisis Intervention Center and Griffin Memorial Hospital was very good, enhancing quick access.

Jim Taliaferro CMHC (SW region) reported that 81% of all adult inpatient consumers were admitted with an emergency detention legal status. The CMHC noted that inpatient admissions had risen from 6% in the third quarter to 9% in the fourth quarter but was unaware any actions that may have cause the increase.

Measure 11: Adults with MMI Receiving 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 18% of adults with MMI in the state received case management services in the 4th Quarter of FY03, with a range of 16% to 19% in the prior seven quarters (Figure 11).

The CN, NE and OK regions were more than one standard deviation below the average and each experienced a decline from the previous quarter. The SW and TU regions were more than 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.

Provider Feedback:
The providers offered a number of reasons to explain the low percentage of adults receiving Case Management, including the reporting provision of Individual Rehabilitation services in lieu of case management, staffing issues, provider focus on a smaller group of more ill consumers and coding misinterpretation.

Hope Community Services Inc. (OK region) reported that recently case management issues were more often addressed as part of psychosocial rehabilitation, and therefore coded as psychosocial rehabilitation rather than Case Management.

Red Rock (OK region) reported that from FY03 to FY04, Individual Rehabilitation services increased 41%, as compared to a 6% increase in Case Management services. Red Rock reported that Case Management in the Central region dropped in the last quarter and was among the lowest in the state. Red Rock is planning office and staff reorganizations in the next few months to address this issue.

Case Management in the Tulsa region was the highest in the state. Red Rock (TU region) attributes this to their PACT service team.

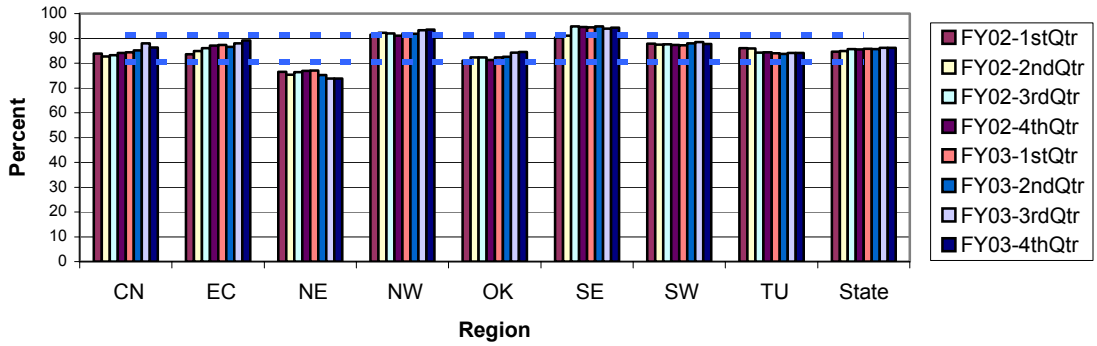
Jim Taliaferro CMHC, which serves the SW region, reported an increase in the percentage of people with MMI receiving case management from 17% in Quarter 1, FY02 to 27% in Quarter 4, FY03, which is more than one standard deviation above the state norm. The agency reached full staffing in the past six months. They reported that low salaries contribute to a high turnover rate for case management staff working with MMI consumers.

Edwin Fair CMHC (NE region) reported difficulty in filling two case management positions in the past year, which may be associated with the low percentage of MMI receiving case management. Edwin Fair CMHC reported that the lower percentage of people with MMI receiving case management was associated with their focus on the more severe segment of the SMI population. Since MMI and SMI criteria are similar except for the additional functioning criteria of SMI, an analysis of the impact of functional criteria may be useful.

Carl Albert's CMHC (SE region) reported misinterpretation of services billable under the Case Management Code. Proper coding was clarified with staff. The agency is awaiting the results of this intervention.

Measure 12: Adults with MMI Receiving Independent Housing

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



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.

Statewide, 86% of adults with MMI lived in independent housing during the 4th Quarter of FY03 (Figure 12). The statewide percentages remain fairy constant ranging from 85% to 86% over the years 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.

Supplemental MMI Analysis:

Not all persons with MMI in the past year were active in the current quarter and not all active MMI received treatment in the quarter. To better understand active and inactive status, as well as treatment services for those with MMI, ODMHSAS looked at a variety of aspects of the MMI population including regional variation of active status and variations associated with the types of service received.

The MMI category includes clients with a variety of diagnoses. Clients with some illnesses may have more need for services than clients with other illnesses. ODMHSAS examined active status for clients diagnosed with Schizophrenia, because these clients were very likely to need ongoing services. In addition, case management for people with MMI was reviewed for each diagnosis included in the MMI definition. Finally, ODMHSAS looked for explanations for the subgroup of persons with MMI that received no core outpatient services in the quarter.

MMI Regional Variations:

Region	Active in current quarter
CN	75%
EC	70%
NE	68%
NW	65%
OK	72%
SE	66%
SW	68%
TU	69%
All	**71%**

Finding: A significant portion of people identified with MMI in the past year were not receiving services in the current quarter: a range of 25% to 35% and 29% statewide. The percentage of people identified with MMI in the past year who received services in the current quarter varied from 65% in the NW region to 75% in the CN region.

MMI Service Type:

Service Location	Active in current Quarter
CMHC	72%
Hospital	35%
Crisis	28%

Finding: As a group, people with MMI were less than half as likely to have a service in the quarter if they had received services in a crisis or hospital setting.

Diagnosis of Schizophrenia:
The diagnosis of Schizophrenia was chosen to monitor from among all MMI diagnoses because it is a chronic condition that is likely to benefit from active treatment in every quarter. Seventy-eight percent of the population diagnosed with Schizophrenia were active in quarter 4, FY03, as compared to 71% of all MMI.

Finding: Four out of five persons diagnosed with Schizophrenia and active in the state treatment system in the past year, were active during the last quarter reported.

Case Management Services by Diagnosis

The ODMHSAS reviewed the percentage of adults with MMI that received case management services in the current quarter by their diagnosis to determine the association of diagnosis and case management utilization. The category of people with

MMI was constructed to include most clients designated as seriously mentally ill, which comprises a wide range of diagnoses. Clients with specific diagnoses may require more frequent case management services than clients with other diagnoses, although other factors are also influential. The distribution of primary diagnoses for those with MMI are listed below.

Case Management by Diagnosis in the current quarter:

Diagnosis	Received Case Management
Schizoaffective Disorder	17%
Schizophrenia	22%
Depression NOS	11%
Psychotic Disorders NOS	11%
PTDS	15%
Mood Disorder NOS	10%
Bipolar NOS	17%
Borderline Personality Disorder	14%
Panic Disorder	17%
Anti-social Personality Disorder	10%
Obsessive-Compulsive Disorder (OCD)	20%
Paranoid	13%
Dissociative Identity Disorder	8%
All	**16%**

Finding: Adults with the diagnosis of Schizophrenia; OCD; Schizoaffective; panic disorder; and Bipolar Disorder, NOS who were active in the prior year were somewhat more likely to receive case management services in the quarter than all persons designated as MMI. However, the differences were small.

Please note that the diagnoses were placed in descending order by number of clients with a diagnosis. The diagnoses of Schizoaffective Disorder; Schizophrenia; Depression, NOS; PTSD; Mood Disorder, NOS; and Bipolar, NOS were identified in over 90% of the people in the MMI population. The remaining diagnoses were reported present in less than 10% of the people with MMI population.

People with MMI who did not receive a core service

Some clients not served in the quarter may have benefited from treatment, given the severity and chronic nature of disorders among people with MMI. The ODMHSAS reviewed factors associated with clients with MMI who did not receive core services in the quarter.

Factor	Percent of MMI population
Discharged prior to the quarter	31%
No services	8%
Crisis and/or Inpatient services only	10%

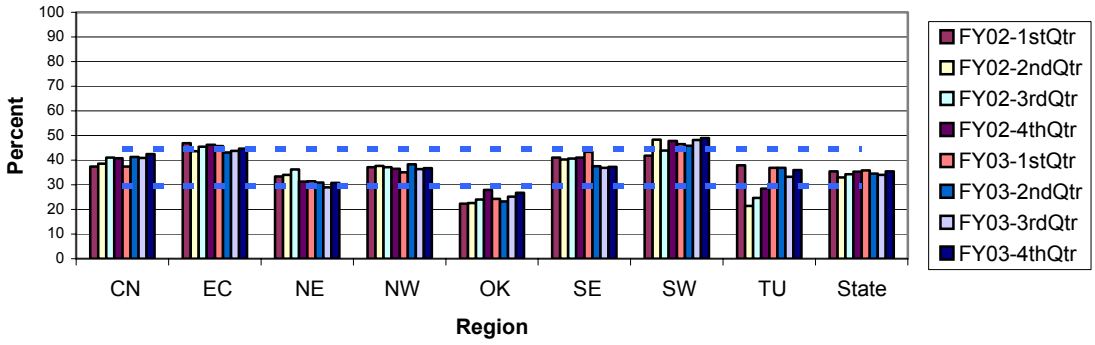
Findings: Nearly a third of the people with MMI who had been served in the past year were discharged from treatment prior to the quarter. Eighteen percent either had no services or received only crisis and/or inpatient services during the quarter. Further evaluation of people with MMI who did not receive core services in the quarter may assist the state to identify additional clients that would benefit from treatment.

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 Visit in the Quarter



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

Statewide, 36% of all adults in the SPG received a medication visit in the 4th Quarter of FY03 (Figure 13). The rate has remained fairly consistent with a range of 33% to 36% in the prior seven quarters. The EC and SW regions had overall trends toward high rates of medication visits, 45% and 49%, respectively; and with the exception of one quarter 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 27% receiving a medication visit in the 4th Quarter of FY03.

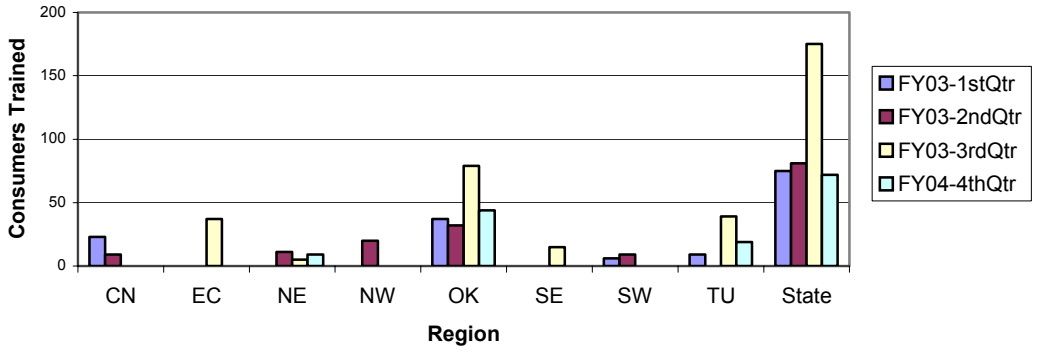
In earlier reports, providers suggested that clients with Medicaid may also receive medication services that are not recorded in the ODMHSAS database, but are available from the Oklahoma Health Care Authority (OHCA), the state Medicaid agency. ODMHSAS staff has reviewed with Medicaid staff the RPM report findings 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.

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 four quarters.

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

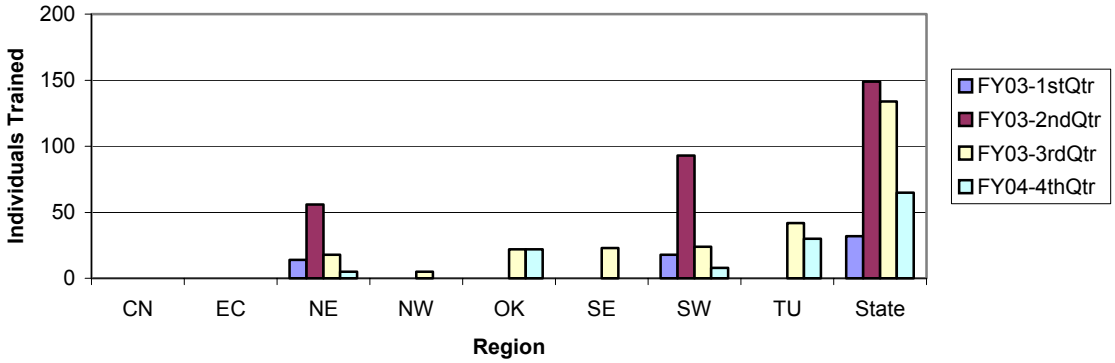


Illness self-management education services were provided to 72 individuals during the 4th Quarter of FY03, bring the total number of participants to 403 for FY03 (Figure 14). Training was offered in the NE, OK and TU regions for the most recent quarter.

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 three quarters.

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



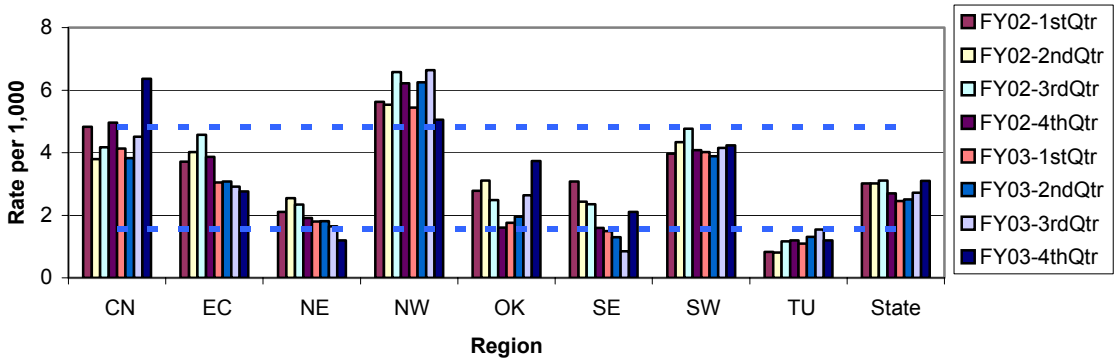
A total of 65 individuals received training in the 4th Quarter of FY03, down from 134 individuals trained in the prior quarter (Figure 15). Training sessions were held in the NE, OK, SW and TU regions during the 4th Quarter of FY03. Training was offered in six of the eight regions during FY03, providing instruction to a total of 380 individuals.

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 RPM report.

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 three children per 1,000 between the ages of six through 17 received ODMHSAS-funded mental health services in the 4th 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 to 6.6 per 1,000 children for the eight measured quarters, with a rate of 5 per 1,000 children for the 4th Quarter of FY03. The CN region increased the number of children receiving mental health services from 4.5% in the 3rd Quarter to 6.4% in the 4th 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 1.5 per 1,000, and a rate of 1.2 per 1,000 children for the 4th Quarter of FY03. The number of children receiving services in the NE region fell to more than one standard deviation below the state average in the 4th Quarter of FY03 and has been decreasing for the last six quarters.

PERFORMANCE MEASURES - SUBSTANCE ABUSE

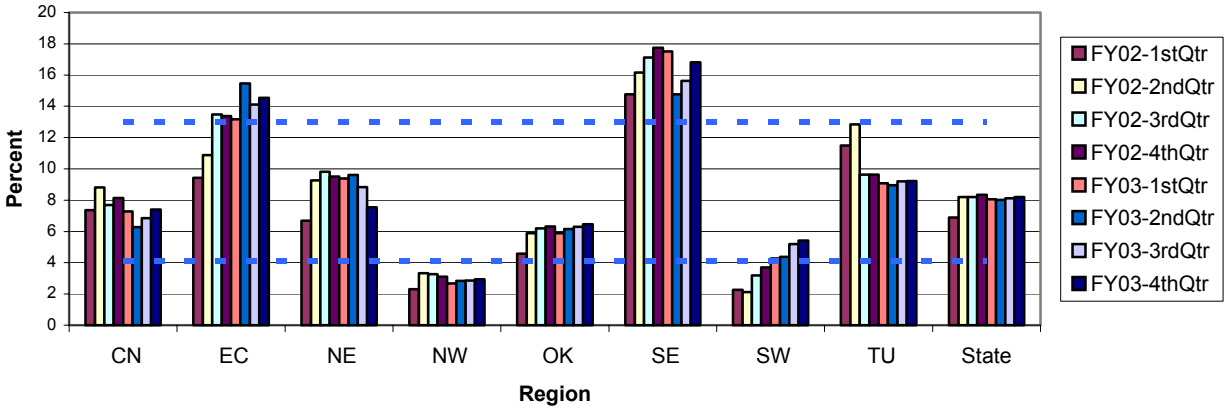
The indicators of substance abuse treatment performance used in this report are measures developed by the Washington Circle with support from the federal Center for Substance Abuse Treatment (CSAT). The indicators are based on the tenet that early recognition and intervention can positively affect the course of an individual's problem with alcohol or other drugs. The indicators 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 3,792 clients identified as in treatment during the 4th Quarter of FY03. Between 3,165 and 3,828 clients were identified in each of the seven prior quarters. The patients were identified by the first substance abuse services they used:

Outpatient – 1,926 clients (51%)
Detoxification – 985 clients (30%)
Community living – 90 clients (2%)
Residential – 763 clients (20%)

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



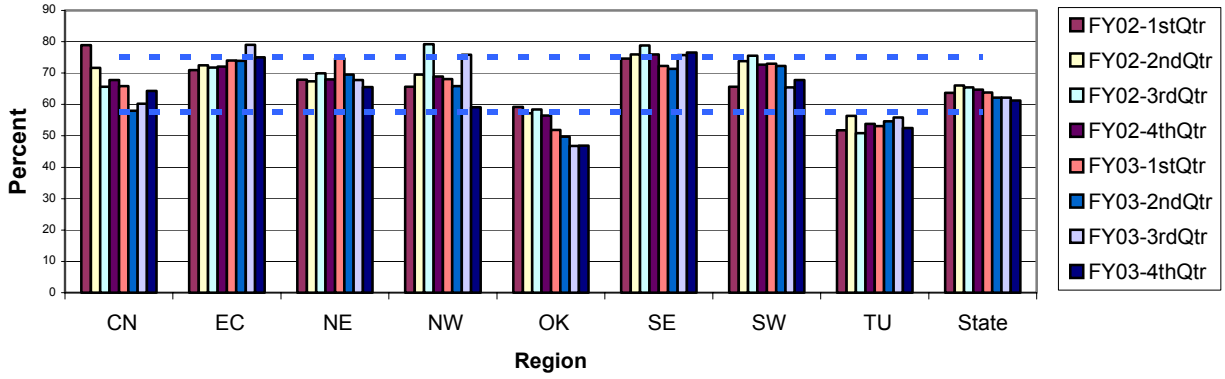
Statewide, the percent of the adults with estimated needs for substance abuse treatment that received a substance abuse service has remained fairly constant for the past eight quarters ranging from 7% to 8% (Figure 17). The 4th Quarter of FY03 fell within this range at 8% of estimated adults with substance abuse problems receiving substance abuse services.

A higher percentage of adults with substance abuse problems in the SE region (between 15% and 18%) 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, ranging from 2.3% to 3%. The SW region has shown a steady increase in the percentage of adults with estimated need that received treatment.

Measure 18: Initiation

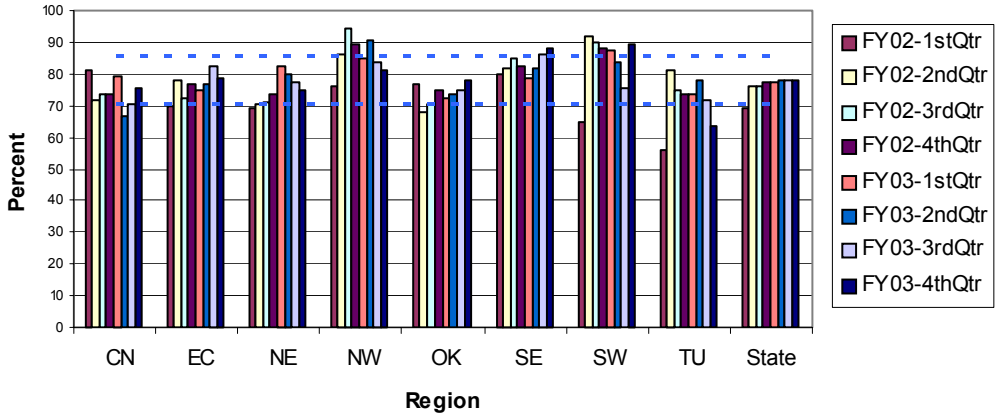
Among those clients who received a first (index) substance abuse service in the quarter (with no services in the past 60 days), initiation rates were calculated based on the level of care in which the clients were first served. Statewide, 61% of clients with a first substance abuse service (as described above) initiated treatment in the 4th Quarter of FY03 (Figure 18a). This was below the range of 62% to 66% 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



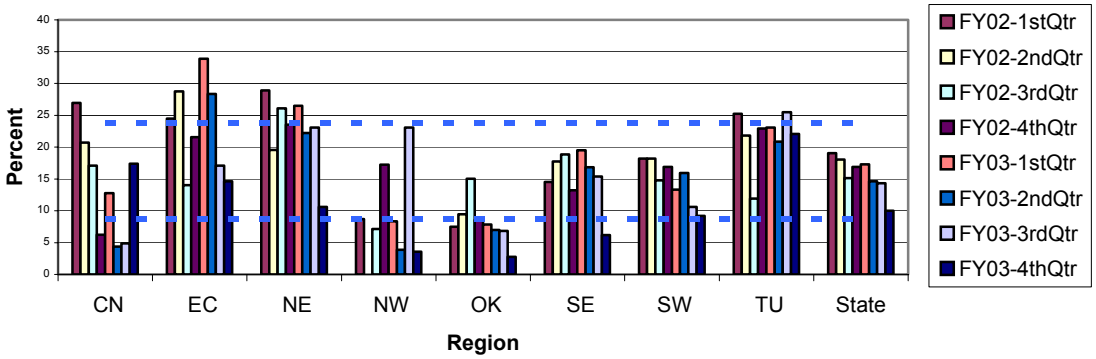
Initiation for residential and community living services were not included in the graph because nearly all clients initiated residential and community living treatment (as defined by the Washington Circle) by remaining in treatment a second day. The Initiation indicator was trended by outpatient and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

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



As shown in Figure 18b, statewide, 78% of adults with first treatment episodes, who started treatment in outpatient care, initiated treatment (had a second service within 14 days). The rate has remained fairly constant for the past seven quarters. The TU region had a low initiation rate at 64%, while the SE and SW regions had high rates at 88% and 89%, respectively.

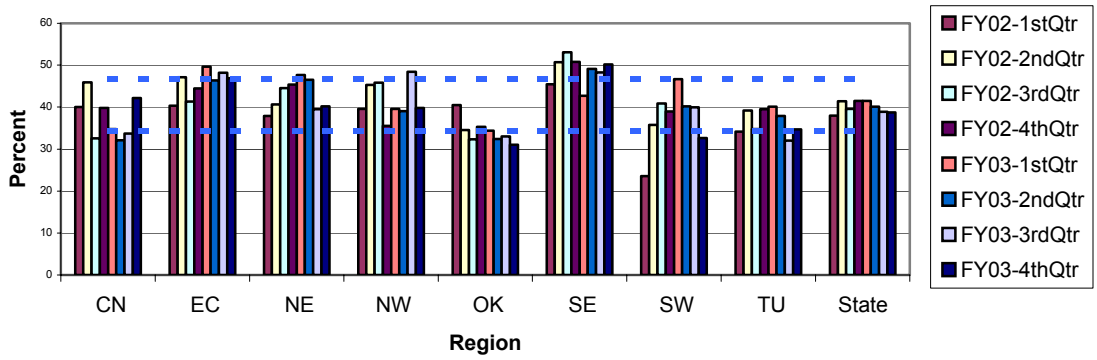
Figure 18c: Initiation of Substance Abuse Treatment Following a First Detoxification Service



Of all adults statewide with a treatment episode that started with a detoxification service, 10% 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 seven quarters. The NW, OK and SE regions all fell more than one standard deviation below the state average at 3.6%, 2.7% and 6.2%, respectively. There has been much more quarter-to-quarter variability in the NW region (because slight changes in the small number of clients make a big change in rates), while the OK region has been declining for five quarters and the SE region experienced a substantial drop from the 3rd Quarter (15%) to the 4th Quarter of FY03 (9%).

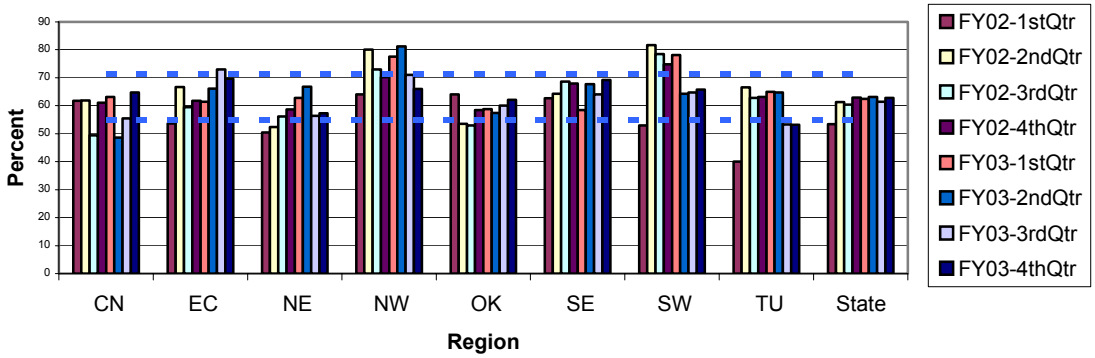
Measure 19: Engagement

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



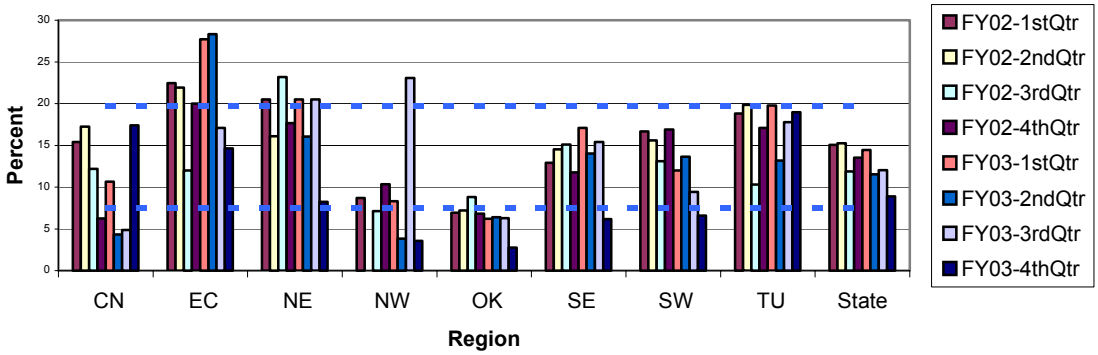
Statewide, 39% of clients with a new substance abuse treatment went on to engage in treatment during the 4th Quarter of FY03 (Figure 19a). This was a decrease from the previous six quarters. Two regions (EC and SE) were at or above one standard deviation from the state average in engaging clients in treatment, while three regions (OK, SW and TU) were at or below one standard deviation from the state average in treatment engagement.

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



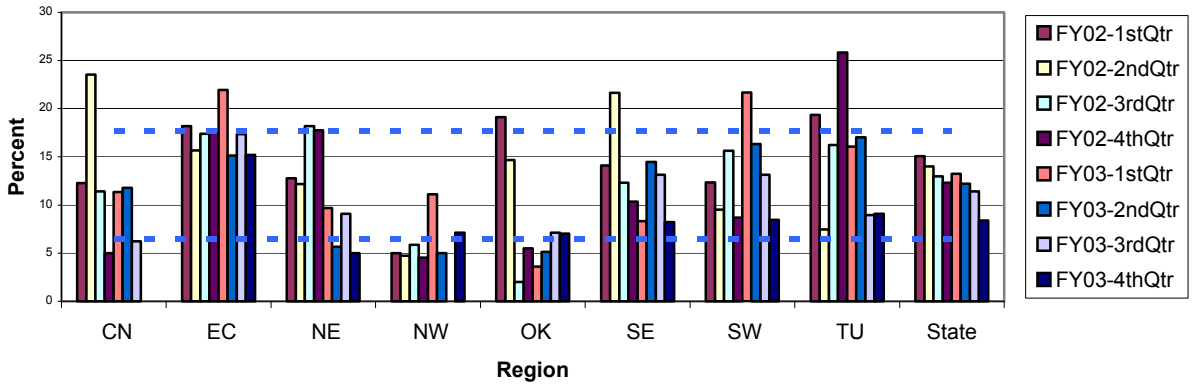
During the 4th Quarter of FY03, 63% of clients who started treatment in outpatient care engaged in treatment (initiated treatment within 14 days after an initial outpatient service and had two more services within 30 days following initiation, refer to Figure 19b). This was within the range of 53% to 63% that engaged in treatment during the seven prior quarters.

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



Nine 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 lower than the prior seven quarters, which ranged from 12% to 15% (Figure 19c). With the exception of the CN and TU regions, engagement after detox treatment fell from the 3rd Quarter to the 4th Quarter of FY03.

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



As shown in Figure 19d, 8% 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 and NE regions had low engagement in substance abuse treatment after discharge from residential treatment, with the CN region having a rate of 6.5%, and the NE region having a rate of 5%. To understand the low engagement rates, each residential treatment facility will be provided an individual performance report and asked to provide feedback as to the difficulties in engaging clients after residential treatment.

Provider Feedback:
Norman Alcohol Information Center (NAIC), providing outpatient services in the CN region, reported that they refer clients to twelve-step programs if they successfully complete treatment. If clients did not complete treatment, NAIC refers them to services near where they live. Individuals needing a higher level of treatment are referred for inpatient services. There are long waiting lists for inpatient services throughout the state. Referrals for woman with children are the most difficult to obtain.

Twenty-five percent of NAIC referrals were to programs outside of their region. Seven to 10% of their referrals are to agencies outside of the ODMHSAS treatment system. If the client leaves before completing treatment, they are not referred. NAIC usually does not call clients to determine whether they attend their follow-up appointments.

Monarch Inc. (EC region) reported that 80% of their clients were referred to the Department of Mental Health Outpatient Programs or twelve-step programs in other counties. In their experience, clients were more likely to follow up in after care if they identified a sponsor and recognized their unmet needs. Monarch reported the largest problems for clients that completed treatment was the lack of appropriate transportation and lengthy travel times to treatment services. The agency also expressed concerns for clients discharged before completing treatment and expressed a need to help motivate these clients for treatment.

Vinita Alcohol and Drug Treatment Center (VADTC), serving the NE region, reported that all of their clients were required to have a discharge plan with an appointment date and location arranged prior to the clients' discharge. They used ASAM criteria and drug testing to determine the appropriate level of care. Primary substance abuse clients were often referred to outpatient substance care and self-help groups. Primary clients involved with the courts were usually referred back to their primary referral source, i.e., drug court.

Nearly 25% of admissions to the VADTC residential program tested positive for methamphetamines and cocaine. These individual were referred to detoxification programs in Tulsa. It was estimated that only half followed through with residential services at VADTC. The counseling staff felt that the low engagement rate was indicative of lack of outpatient substance abuse services in the area and the lack of staff time for follow-up. The emphasis for the dual-diagnosed clients was on their mental disorder rather than their substance abuse disorder.

Ninety-five percent of referrals from VADTC were outside of the city of Vinita. Approximately 60% were referred to the Northeast Region with the remainder throughout the state. An estimated 12% were referred to programs outside of the ODMHSAS system, such as boarding homes, Native American programs and halfway houses.

The lack of outpatient services in this region was reported to be a significant problem. Many clients returned to rural areas where outpatient services were limited; consequently many were referred to AA/NA. Services were more available to clients referred to metropolitan areas.

The Oaks Behavioral Health Centers (SE region) reported their standard practice regarding client referrals is to attempt to link the client with an outpatient and/or 12-step organization or group in the county or town to which the client is returning or moving. The Oaks currently has no formal process for verifying referrals have made contact with the other agency. Because The Oaks provides many levels of care, a client may be referred to a lesser or more intense level of care within the organization, depending on the client's needs. Approximately 20% of clients discharging are referred to programs outside of the region. Approximately 10% are referred to programs outside the ODMHSAS system. The Oaks noted that the greatest barrier in client follow-up care is transportation. Many clients do not have any means or transportation, particularly in the rural areas.

MEASURES PLANNED FOR FUTURE RPM 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 RPM 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 RPM report with the potential of incorporating the RPM report process into is ongoing monitoring and planning activities. The Council requested a presentation on RPM report 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 RPM report reviews, based on the Council's direction following the July presentation. Some of the RPM report 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 RPM report 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 first quarter of fiscal year 2004.

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 seven project sites grow in an effective manner to ensure access to children and their families. Beginning in the first quarter of fiscal year 2004, the number of quarterly enrollments and the number of clients served will be monitored.

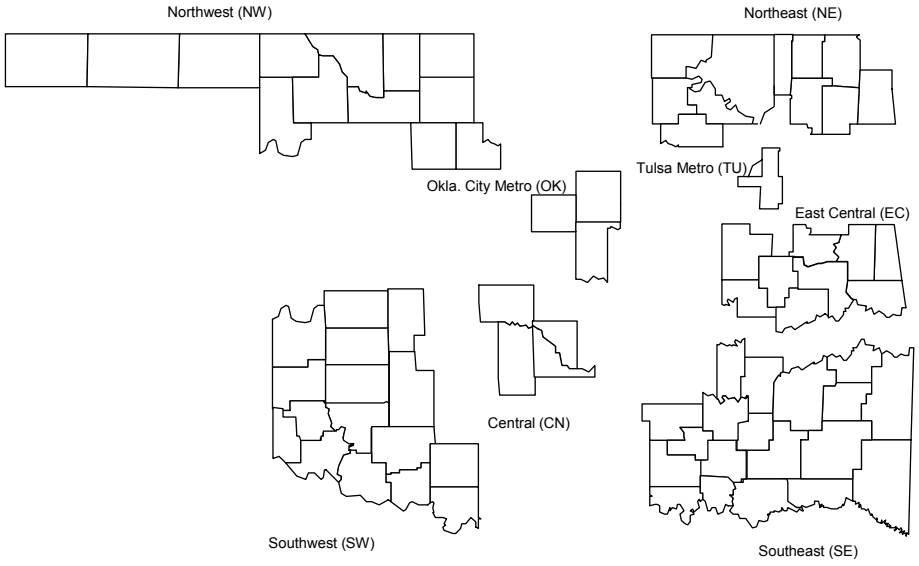
Appendix 1: Selection of Indicators

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 2). 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 RPM 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 RPM report 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 RPM report indicators focus on each of the eight ODMHSAS planning regions of the State (see map in Appendix 3 for more detail).

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 quarterly RPM report 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 RPM report 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.

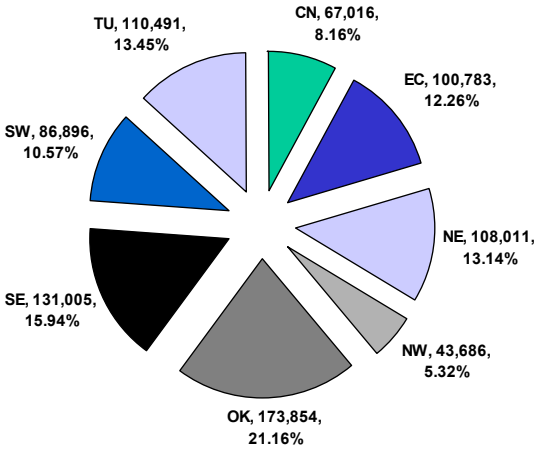
Future Development. System stakeholders were involved in previous indicator development processes, and as stakeholders express their perspectives regarding the utility of the selected RPM report indicators, or as system improvements make monitoring an indicator less important, it is likely other indicators will emerge to include in the RPM report.

[1] Population groups, statistics and terms used in the RPM report rates and analyses are noted with an asterisk (*) in the text and their definitions are provided in a glossary in Appendix 4.

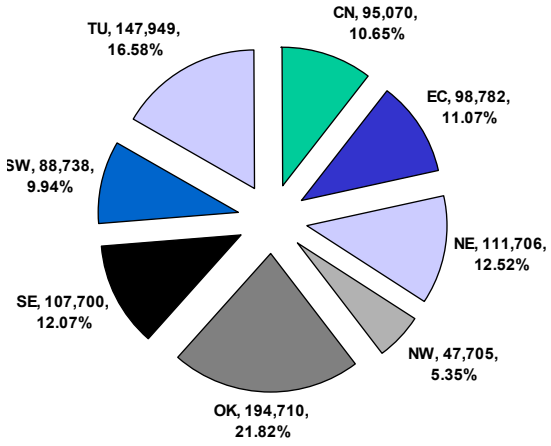
Appendix 2: RPM Report Indicator Definitions

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.

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 RPM report 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

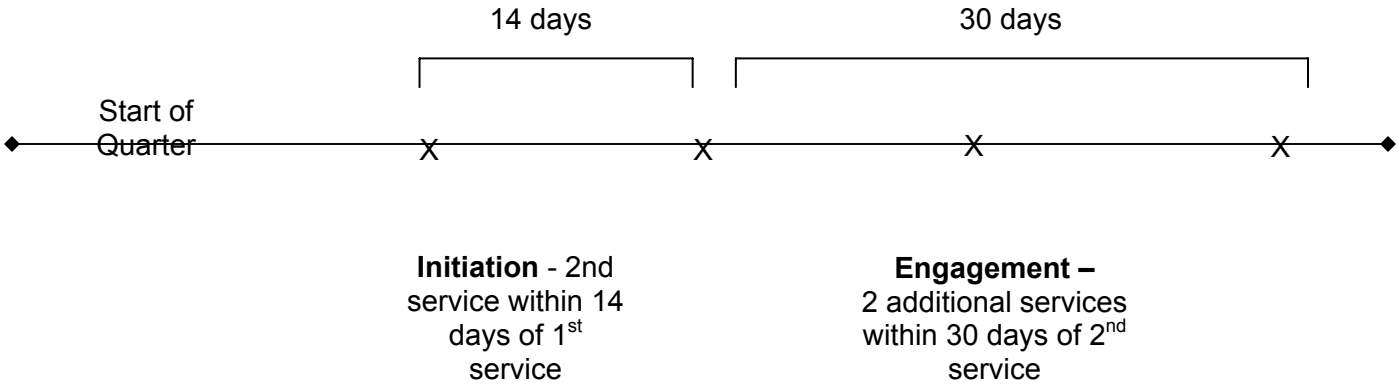


Figure 21: Substance Abuse Treatment - Detox Diagram

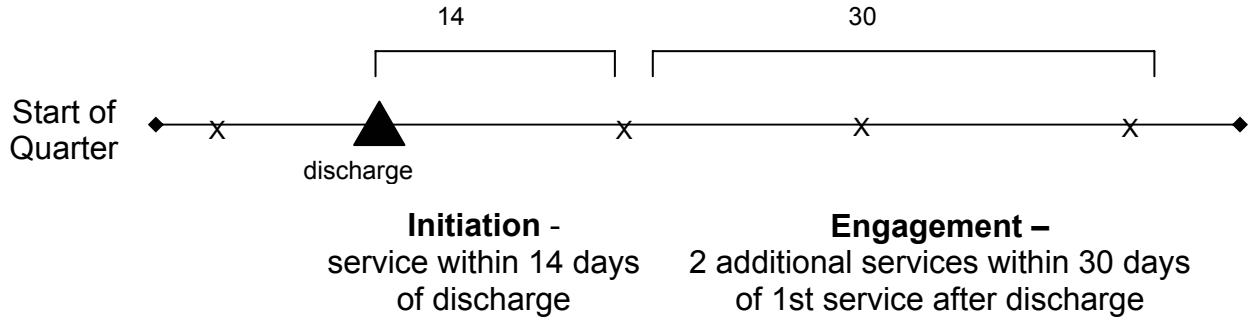
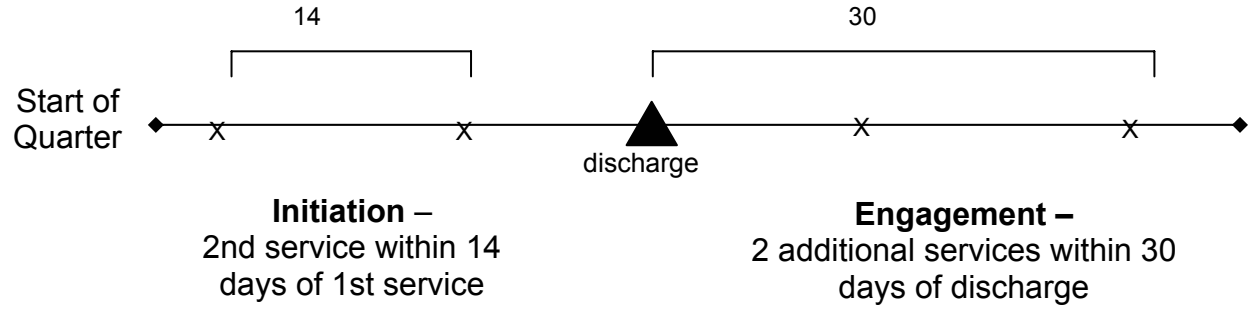
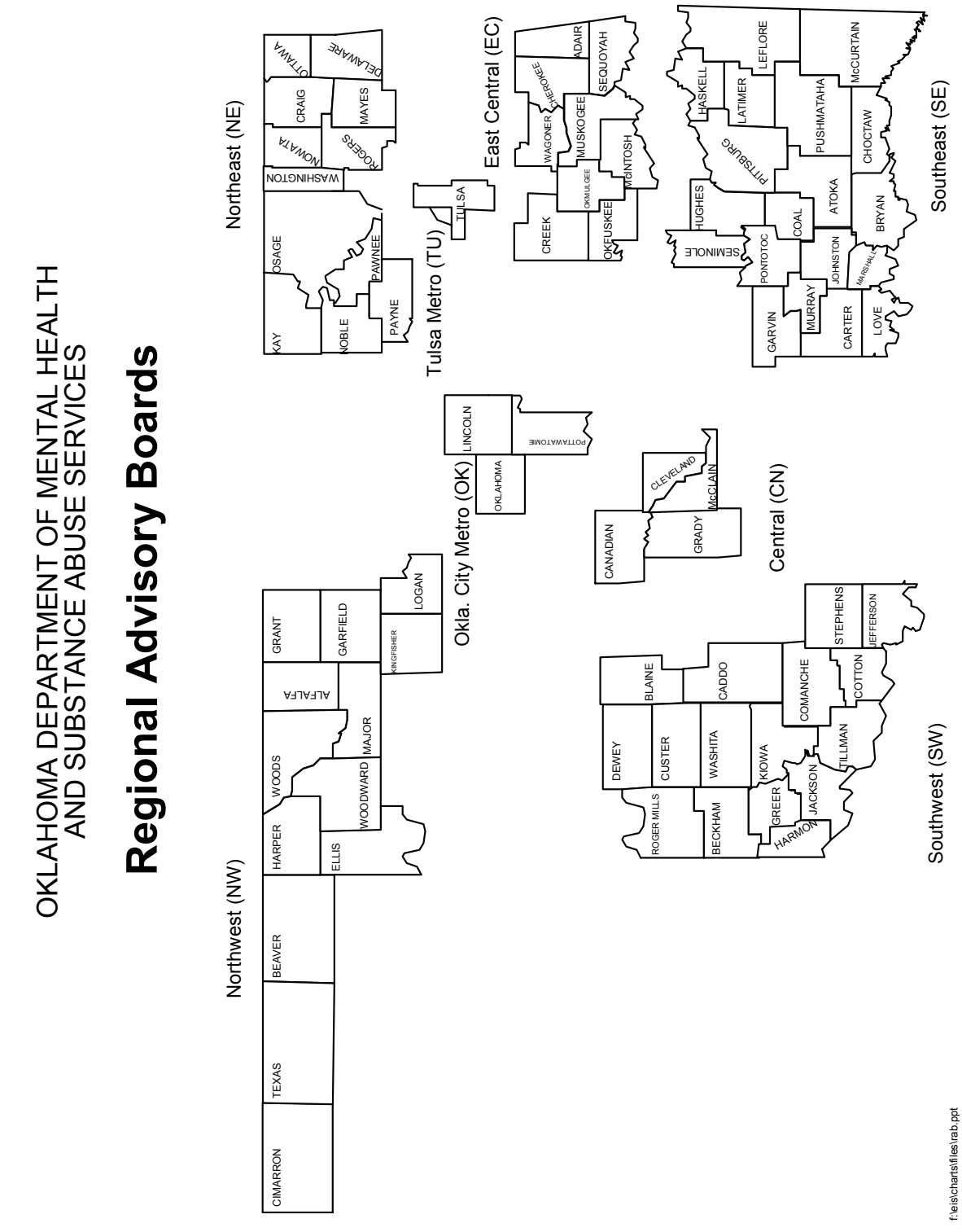


Figure 22: Substance Abuse Treatment – Residential Treatment Diagram



Appendix 3: Map of ODMHSAS Planning Regions



Appendix 4: 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 5: 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
RPM Report– 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