Oklahoma Department of Mental Health And Substance Abuse Services

Regional Performance Management Report

Final Report for First Quarter of FY2004

Reported February 2004
By
ODMHSAS Decision Support Services

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Regional Performance Management Report
For 1st Quarter of FY2004

INTRODUCTION

Background. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Regional Performance Management (RPM) Report is supported, in part, by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Funding from SAMHSA supports technical assistance from Howard Dichter, MD, a consultant in monitoring of state health programs and Linda Graver, Kay Miller and Dan Whalen, staff with The MEDSTAT Group. The MEDSTAT Group is a healthcare information company that provides services for managing the cost and quality of healthcare and Linda Graver manages the SAMHSA project that funds the technical assistance.

This report reviews activities for the first quarter of FY 2004, i.e., July through September 2003. Based on changes in eligibility criteria for services instituted because of budget reductions, specifications of some of the RPM indicators are being changed to more clearly match the populations providers have contracted to serve. Other indicators may be dropped from reporting (not necessarily from tracking) because of their long-term stability, and others may be added to match new Department efforts to more closely monitor Strategic Plan implementation. As a result, a new indicator numbering system has also been initiated. Discussion of proposed and implemented changes will be included in the text of this and future reports. 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 (PDCA) 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 DMHSAS 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 the Performance Improvement Coordinator for the Department, Jan Savage. Following compilation of the draft report, it is circulated among DMHSAS 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 ‘Steps Taken’ and ‘Conclusions’ 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. 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 1st Quarter of FY04.

Mental Health: The Regional Performance Management (RPM) measures continued to demonstrate the effectiveness of the state's community-based behavioral health system of care for indigent adults. The statewide trend toward a decline in adults utilizing any service and core outpatient services stabilized over the past two quarters. The RPM indicators for adults with a major mental illness (MMI), a group similar to the population of adults with a serious mental illness (SMI) population and all four Core Service Plan priority groups, showed that a higher percentage of adults with major mental illnesses received services. The percentage of people with MMI that received any service or core outpatient services increased in each of the past two quarters. This two-quarter trend of increased utilization for the SMI population reverses a trend of decreased utilization over the prior three quarters.

Measures of continuity of care had mixed findings. The percentage of adults seen for a face-to-face crisis service that followed-up for outpatient care was the highest in the past eight quarters. However, the percentage of adults discharged from inpatient services that followed-up with outpatient care was the lowest in the eight measured quarters. Analyses were performed to determine whether outpatient follow-up after inpatient care is different for people referred to a DMHSAS-funded facility, and, a result, only those clients referred to a DMHSAS-funded facility will be included in the inpatient follow-up measure (MH4).

Several RPM measures pointed toward system stability. The percentage of adults with independent housing, an important outcome indicator, remained steady at 88%. The findings from the RPM measures of inpatient readmissions within 30 days, adult crisis face-to-face visits, adults with MMI inpatient visits and case management services were within the range of the prior seven quarters.

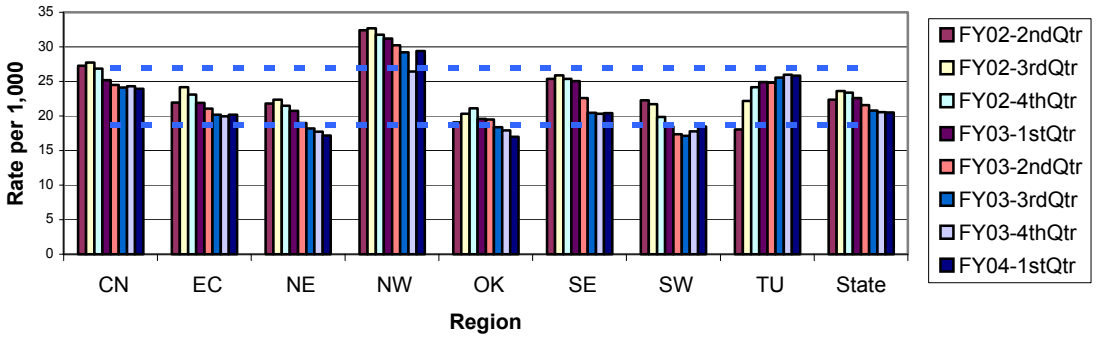
Substance Abuse: Among substance abuse performance measures, the identification measure (SA1) was the highest in eight quarters due to increases in seven of eight regions. However, the number of identified people in need of substance abuse treatment who initiated treatment declined overall for the eight straight quarters (SA2). While the number of clients first seen in outpatient care who initiated treatment had increased statewide for the first six quarters of the past two years, service initiation declined in outpatient care the last two quarters. Initiation of treatment following detox has declined steadily in the past year. Engagement in treatment (receiving additional services after initiating treatment – SA3) also declined overall in the last year, but held steady for people in need of treatment identified in outpatient care. The overall decline

in engagement was produced by the continuing decline among people identified in detox and residential treatment.

PERFORMANCE MEASURES -- MENTAL HEALTH

Measure MH1: Adults Receiving Any ODMHSAS-funded Mental Health Service

Figure MH1: Adults Receiving Any ODMHSAS-Funded Mental Health Service in the Quarter Rate per 1,000 Adults with Household Income Below 200% Poverty Level

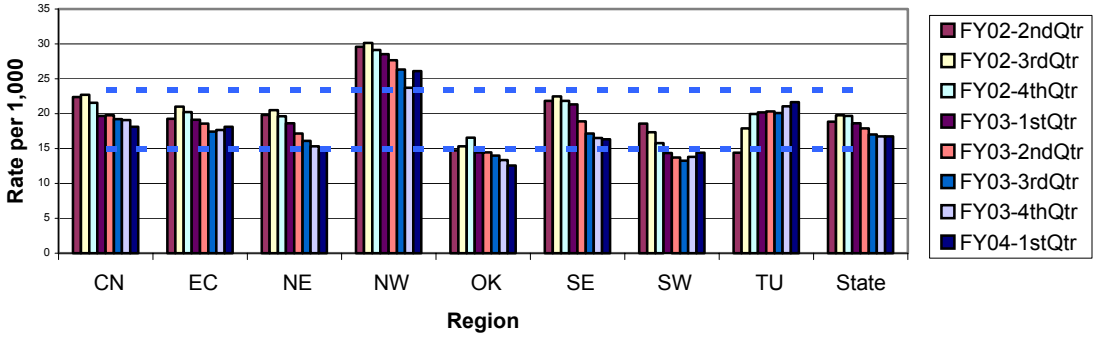


As shown in Figure MH1, statewide, 21 of every 1,000 adults in poverty received an ODMHSAS-funded mental health service in the 1st Quarter of FY04 (the focus of this report). The range of adults per 1,000 in poverty that received a service in the prior seven quarters is 21 to 24, remaining steady at about 21 for the past three quarters.

Adults in the NE, OK and SW regions trended toward low utilization of mental health services. In the most recent quarter, 17, 17 and 18 adults, respectively, per 1,000 in poverty in each region received a mental health service. The NW region served 29 adults per 1,000 in poverty, and was more than one standard deviation above the mean for seven of the eight quarters studied. Three regions (CN, NE, and OK) showed declines in the rate of services provided from the previous quarter.

Measure MH2: Adult Mental Health Core Outpatient Services

Figure MH2: Persons Receiving Any Core Mental Health Service in the Quarter Rate per 1,000 Adults with Household Income Below 200% Poverty Level

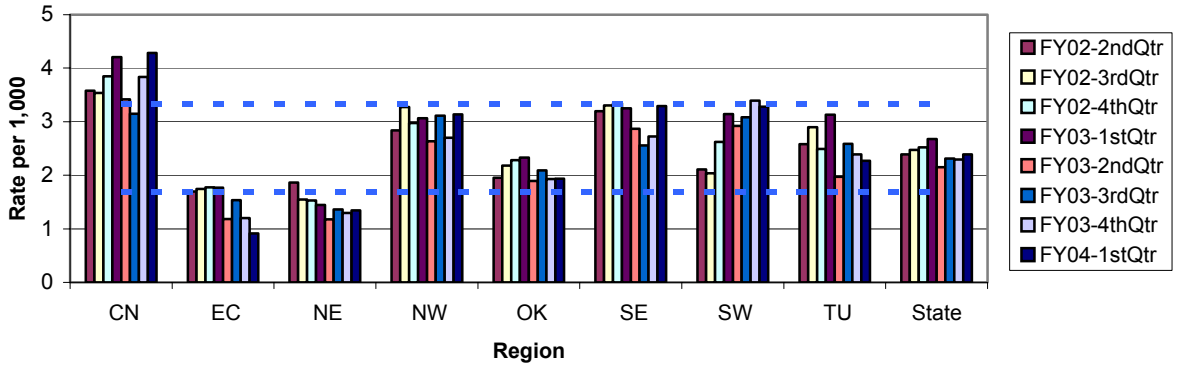


Outpatient services are the most frequently provided, so "Any ODMHSAS-funded" and "Core Outpatient" services follow the same general pattern of utilization. As in the previous quarter, about 17 of every 1,000 adults in poverty in Oklahoma received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 1st Quarter of FY04 (Figure MH2). The range of persons per 1,000 statewide that received services in each of the prior seven quarters is 17 to 20.

The OK and SW regions continued to perform at more than one standard deviation below the state average although the SW region showed an increase in the two most recent quarters. As with the previous measure, adults in the NW region had a high utilization of core outpatient mental health services for the past two years. Four of the regions (EC, NW, SW and TU) showed an increase in core outpatient service utilization from the previous quarter, while four regions (CN, NE, OK and SE) demonstrated a decrease.

Measure MH3: Adult Inpatient Services

Figure MH3: Persons Receiving Inpatient Mental Health Service in the Quarter
Rate per 1,000 Adults with Household Income Below 200% Poverty Level



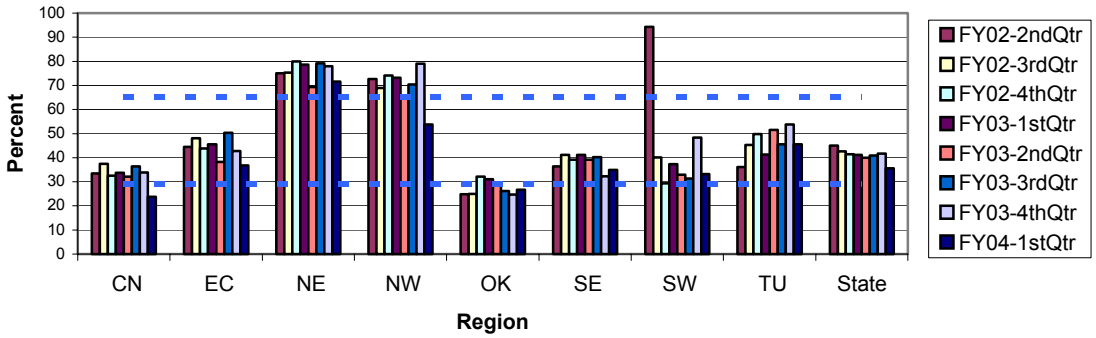
Statewide, 2.4 of every 1,000 adults (24 of every 10,000) in poverty received an inpatient mental health service (in a state hospital or community-based inpatient unit) in the 1st Quarter of FY04 (Figure MH3). The range for the prior seven quarters was between 2.1 and 2.7 per 1,000.

The CN region has had the highest utilization of inpatient services for the past two years, with 4.3 adults per 1,000 in poverty receiving an inpatient service in the 1st Quarter of FY04. The SE and SW regions also demonstrated high inpatient utilization 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 0.9 and 1.3, respectively, per 1,000 adults in poverty. Seven of eight quarters in the NE region were one standard deviation or more below the statewide mean.

Provider Feedback:
Carl Albert Community Mental Health Center (CACMHC): The majority of Mental Health Service of Southern Oklahoma (MHSSO) inpatient services were for clients admitted on a voluntary verses Emergency Detention status to Arbuckle Memorial Hospital; estimated as high as 70 - 80%. Both MHSSO and Carl Albert Community Mental Health Center (CACMHC) fund Emergency Detention units for each of their respective service areas in the Southeast Region. The majority of the admissions to the CACMHC inpatient unit were on an Emergency Detention status, versus a voluntary admission status.

Measure MH4: Adult Inpatient Follow-up in Outpatient Care within 7 Days after Discharge

Figure MH4: Percent of Adults Discharged from Inpatient Care in the Quarter with Follow-up Outpatient Care within 7 Days



Statewide, 36% of adults discharged from an inpatient psychiatric setting received an outpatient visit within seven days of discharge during the 1st Quarter of FY04 (Figure MH4). This is the lowest rate of follow-up in the eight quarters studied, with the highest rate occurring in the 2nd Quarter of FY02 (45%).

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 72% in the 1st Quarter of FY04, followed by the NW region at 54%. The inpatient follow-up rates in both the NE and NW regions were well above the state average for all eight quarters, although the rate in the NW region fell substantially in the most recent quarter. Adult inpatient follow-up were low in the CN and OK regions with 24% and 27%, respectively, of the inpatients being seen in outpatient care within seven days in the 1st Quarter of FY04.

Provider Feedback:
Providers were asked to review their region's trends on measure MH4 and provide any comments they believe would help better understand activities within the region or suggestions on how to improve continuity of care.

Carl Albert CMHC (CACMHC – SE Region): Factors affecting this could include no-show rates and the fact that not all persons admitted to inpatient are discharged back to outpatient services through our system; CACMHC does not have a way to track this. The policies at CACMHC and MHSSO are to provide follow-up care within 72 hours.

Note: Beginning with the 2nd Quarter FY04 report, the measure will include only those clients referred to a DMHSAS-funded agency.

Central Oklahoma Community Mental Health Center (COCMHC – CN Region): COCMHC acknowledged it is not doing well compared to other agencies. It plans to follow-up with DMHSAS to identify clients actually referred to the agency or to determine whether clients are residents of the counties but discharged to other referral sources. However, COCMHC suspects a problem with follow-up regardless of client referrals. Currently, if people are referred to COCMHC and they do not show up, the only action is to send a letter. A case manager is not assigned to try to find or make contact with clients that do not follow up. COCMHC will work with Griffin Memorial Hospital (GMH) to facilitate a better referral process and is interested in other strategies to improve follow-up.

Hope (OK Region): Hope has identified gaps in the referral process by tracking referral calls from GMH and Oklahoma County Crisis Intervention Center (OCCIC) and comparing these calls to referred clients from these two agencies. Hope has been actively working with GMH and OCCIC to close these gaps. Hope's intake process is also set up so that there is never more than a one week wait before a client can begin services.

Red Rock CMHC (TU, SW, OK and CN Regions): Tulsa is well above the state average. The PACT Team is probably a factor. SW is also above the state average. OK is slightly below average. Red Rock's new PACT team may help raise the number of clients successfully followed-up. The OKC main facility consistently makes contact within seven days, with contact being an admission in the majority of cases. CN dropped last quarter. This may be due in part to the recent restructuring of the former Chisholm Trail offices. Hopefully, it will improve as staff and procedures stabilize.

Jim Taliaferro CMHC (SW Region): Jim Taliaferro CMHC, provided Outpatient follow-up services to 48% of those released from inpatient care within 7 days, which was higher than the statewide average of 36%. If the Outpatient staff did not have available space to see recently discharged inpatients within seven days, the Triage Evaluation Unit saw them the next working day. This ensured services were provided in a timely, efficient manner.

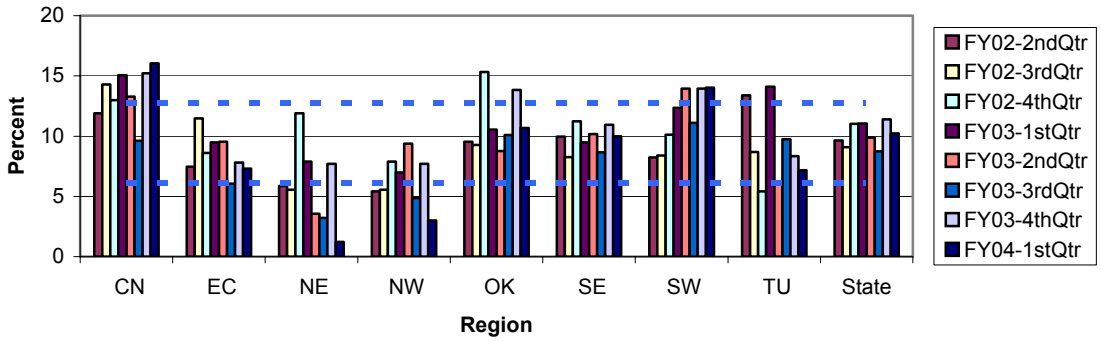
Improvement Strategies:

1. Design intakes to keep wait time to an appointment to less than one week.
2. Use Triage unit to see patients if the Outpatient staff do not have available appointments within one week.
3. Assign a case manager to contact clients that do not follow-up.
4. Implementation and/or utilization of PACT team for recently discharged inpatients.

Measure MH5: Adult Inpatient Re-admissions within 30 Days After Discharge

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 for the past two years, with a re-admission rate of 10% in the 1st Quarter of FY04 (Figure MH5). Statewide and for six regions, re-admissions decreased from the 4th Quarter of FY03 to the 1st Quarter of FY04. The CN and SW regions experienced readmission rates more than one standard deviation above the mean (16% and 14%, respectively). The CN region had the highest rate of re-admissions for any region in seven of the eight measured quarters.

Figure MH5: Adults Discharged from Inpatient Care in the Quarter
Percent Readmitted within 30 Days



Provider Feedback:
Providers were asked to review their region's trends on measure MH5 and provide any comments they believe would help better understand activities within the region or suggestions on how to improve continuity of care.

CACMHC (CN Region): This year, CACMHC's 30-day readmission rate in August was higher than one year before. Analysis of this finding did not reveal a trend. The next step is to interview the admitting physician to ask why those persons were readmitted (this suggestion came from the physicians themselves). The 30-day readmission rate has since dropped again.

Substance abuse is a factor in repeated inpatient admissions. Because the Northwest Center for Behavioral Health (NCBH) has a lower 30-day readmission rate than CACMHC, CACMHC compared their programs to NCBH. The most striking difference was that NCBH had an on-site treatment facility for substance abuse and an onsite residential care facility. CACMHC had much more limited resources, and there reportedly were waiting lists at other facilities around the state. The performance measures for Substance Abuse on page 21 seems to confirm the impressions that a high percentage of adults in poverty were estimated to need treatment.

Jim Taliaferro CMHC (SW Region): Jim Taliaferro CMHC, had a higher rate of re-admissions to their Inpatient Unit within 30 days of discharge as compared to the state average. Fourteen percent of Jim Taliaferro CMHC inpatient clients were readmitted within 30 days, higher than the statewide mean of 10%. The JTCMHC average length of stay decreased to five days, and 81% of all inpatient clients were admitted under an Emergency Detention Order.

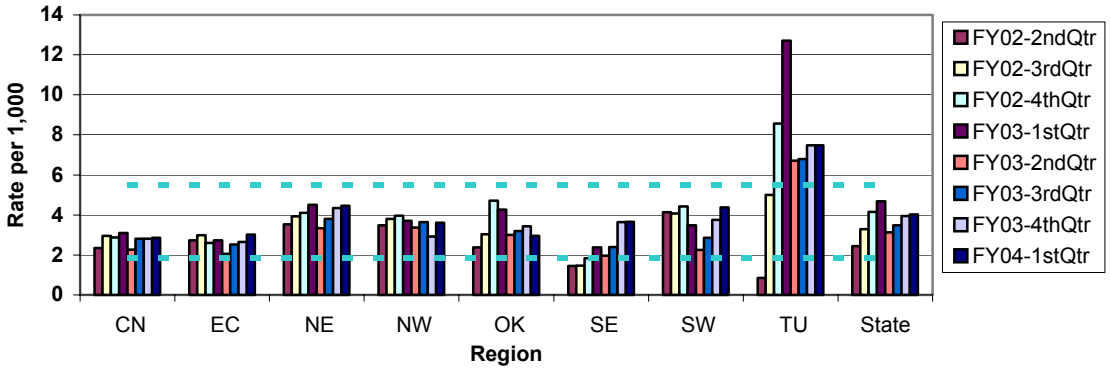
Red Rock (TU, SW, OK and CN Regions): CN had the highest rate in the state. As mentioned last quarter, this may be partially due to the lawsuit that was lost by the former Chisholm Trail. More clinical supervision and training are being provided to staff.

Improvement Strategies:

- On-site substance abuse treatment and residential care may help reduce rehospitalization.
- Additional training and supervision for staff regarding referrals from inpatient to outpatient treatment.

Measure MH6: Adult Mental Health Face-to-Face Crisis

Figure MH6: Adult Face-to-Face Crisis Events during the Quarter
Rate per 1,000 Adults under the 200% Poverty Level

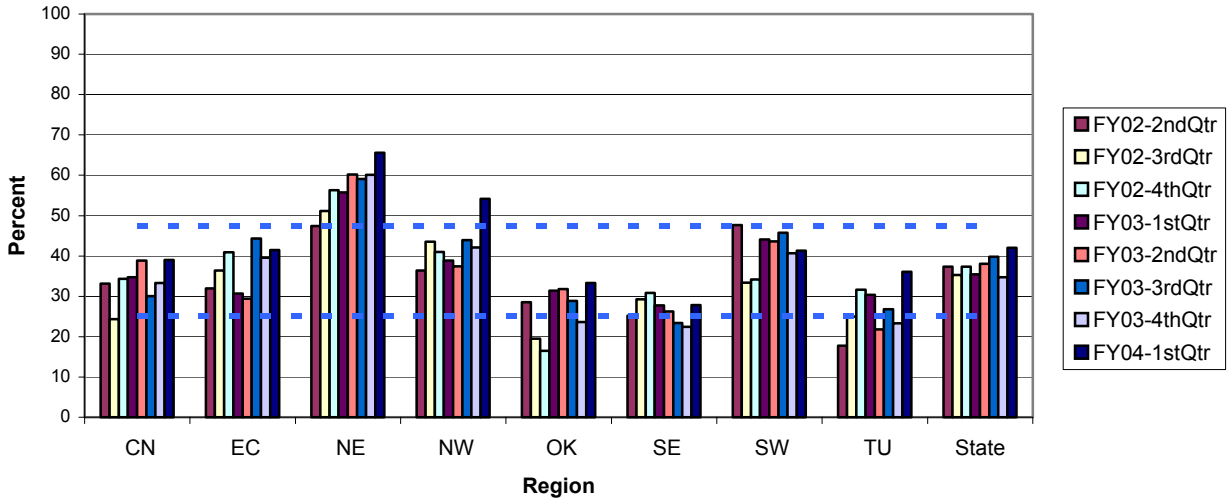


The Adult Mental Health Face-to-Face Crisis indicator measures the rate per 1,000 adults in poverty in each region who received a crisis service in the quarter.

The number of adults with face-to-face mental health crisis services during the 1st Quarter of FY04 for the state was 4 per 1, 000 of the adult population below 200% of the poverty level (Figure MH6). The rate remained the same from the previous quarter and falls within the two-year range of 2.4 to 4.7 per 1, 000 of the adult population below 200% of the poverty level. The TU region's rate of face-to-face crisis services continues to be high at a rate of 7.5 for the two most recent quarters and has been at least one standard deviation above the average for the last six quarters. The remaining regions fell within one standard deviation of the state mean for the adult population below 200% of the poverty level. There seems to be a seasonal pattern to crisis service utilization, which is apparent in the statewide rates and, somewhat in the CN, NE, OK, SE and TU regions, though not all regions follow the same pattern.

Measure MH7: Adult Crisis Follow-up in Outpatient Care within 7 Days

Figure MH7: Adult Mental Health Face-to-Face Crisis Events during the Quarter
Percent Receiving Outpatient Follow-up within Seven Days



For the 1st quarter of FY04, 42% 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 MH7). This is the highest rate of crisis follow-up for the eight quarters studied, up from 35% in the previous quarter.

Two-thirds (66%) of the adults with a face-to-face crisis event in the NE region had an outpatient follow-up within seven days. The NE region has demonstrated a high rate of adult mental health follow-up (one standard deviation or more above the state average) for all eight quarters measured. The NW region also had a high rate of follow-up with 54% of adult crisis services being followed-up within seven days in the 1st Quarter of FY04. The remaining six regions have rates of follow-up within one standard deviation of the state mean for the 1st Quarter of FY04.

Provider Feedback:
Providers were asked to review their region's trends on measure MH7 and provide any comments they believe would help better understand activities within the region or suggestions on how to improve continuity of care.

CACMHC (SE Region): The improvement in these rates may have been due to increased awareness of the need to provide this service.

Jim Taliaferro CMHC (SW Region): Jim Taliaferro CMHC averaged 42% of all adults with a face-to-face mental health crisis service being seen for a non-crisis outpatient service within seven days, which is equal to the statewide mean. The SW region rate has been near or above the state average for the past eight quarter but no known actions took place at the facility or region that account for this trend.

Red Rock CMHC (TU, SW, OK and CN Regions): All regions in which Red Rock has offices were above the state average. The SW region is considerably above for six of the eight regions. PACT and the Red Rock West Crisis Unit are likely contributors to this trend.

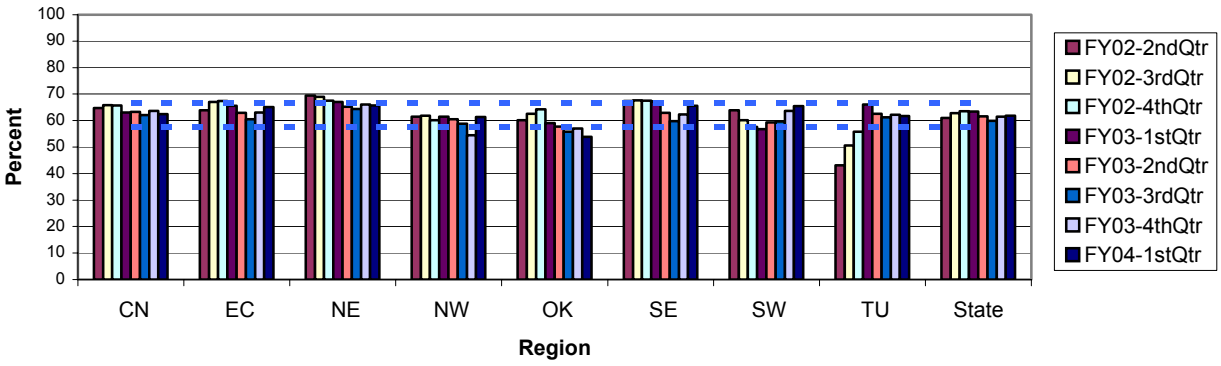
ADULTS WITH MAJOR MENTAL ILLNESS (MMI)

Background: To more clearly define a category of service recipients 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 MMI). 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).

Beginning with the next report, 2nd Quarter FY04, the MMI definition will be modified to more closely match the criteria of the Core Service Plan (refer to Appendix 4 for explanation of the Core Service Plan) eligibility criteria.

Measure MH8: Adults with MMI Receiving Any ODMHSAS-Funded Mental Health Service

Figure MH8: Adults with a Major Mental Illness Served in the Past Year, Percent Who Received Any Mental Health Service in the Quarter



Among ODMHSAS-funded adult mental health service recipients, 62% of those diagnosed with a major mental illness in the past year were seen for a mental health service in the 1st Quarter of FY04 (Figure MH8). There has been little variation over the last eight quarters with a range of 60% to 63%.

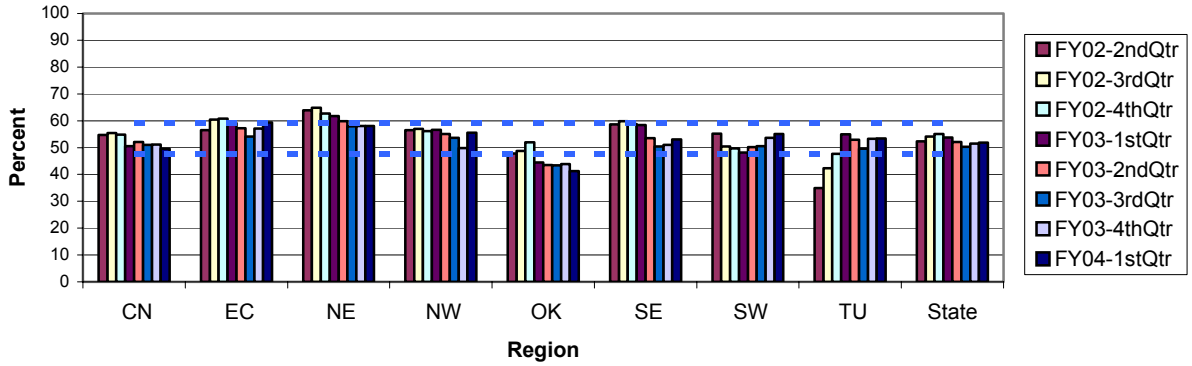
The OK region fell below one standard deviation from the mean with 54% of those diagnosed with a major mental illness in the past year being seen for a mental health service in the 1st Quarter of FY04. The NW region raised its rate back above the "one

standard deviation below the mean" level to which its rate had fallen the previous quarter and TU region maintained a level "within bounds" after three quarters at one standard deviation below the mean in the previous quarter.

Measure MH9: Adults with MMI Core Outpatient Mental Health Services

About 52 percent of adults with MMI received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 1st Quarter of FY04 (Figure MH9). This is within the range of 50% and 55% that received services in the seven prior quarters.

Figure MH9: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received a Core Mental Health Service in the Quarter

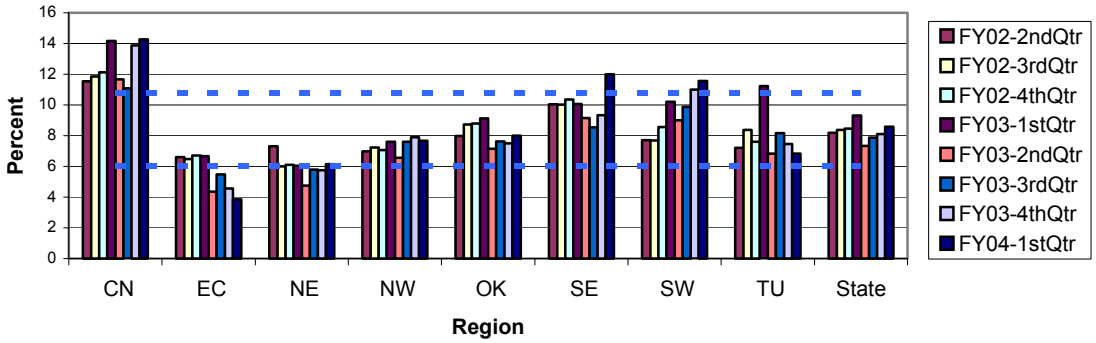


The EC region was one standard deviation above the state average at 59% of adults with MMI receiving a core mental health outpatient service, followed by the NE region at 58%. The OK region has experienced a low percentage of adults with MMI receiving core outpatient services at 41% in the 1st Quarter of FY04 and has been more than one standard deviation below the state average for the previous four quarters.

Measure MH10: Adults with MMI Inpatient Services

About 8.5% of all adults with MMI, statewide, were hospitalized in the 1st Quarter of FY04 (Figure MH10). The range of adults with MMI hospitalized in the prior seven quarters was between 7.3% and 9.3%.

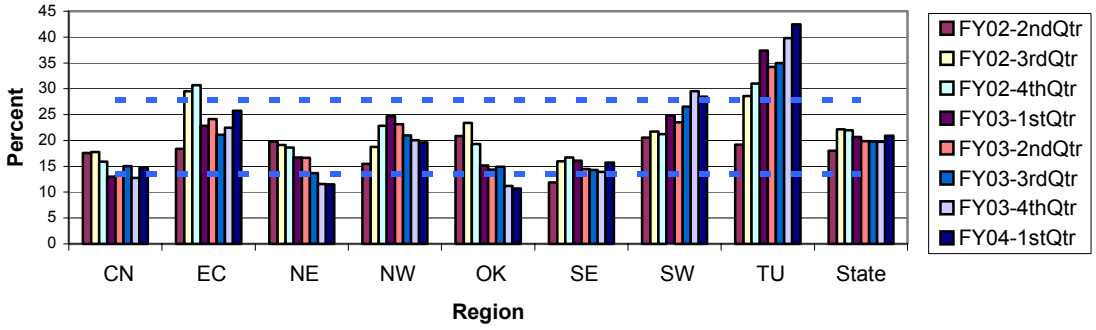
Figure MH10: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received an Inpatient Mental Health Service in the Quarter



The CN region had a rate of 14% in the 1st Quarter of FY04, demonstrating a high rate of adults with MMI hospitalization in all eight quarters. The percentage of adults in the CN region, that received inpatient treatment, was the highest of any region in the eight reported quarters**.** The SE and SW regions were also more than one standard deviation above the state average in the 1st Quarter of FY04 with 12% and 11.5%, respectively. The adults with MMI in the EC region have shown a low rate of inpatient hospitalization for the past four quarters with the lowest rate of 3.8% in the most recent quarter. The percentage of adults with MMI in the EC region that received inpatient services was the lowest of any region in six of the eight reported quarters.

Measure MH11: Adults with MMI Case Management

Figure MH11: Adults Diagnosed with a Major Mental Illness in the Past Year
Percent Who Received a Case Management Service in the Quarter



Statewide, 21% of adults with MMI in the state received case management services in the 1st Quarter of FY04, with a range of 18% to 22% in the prior seven quarters (Figure MH11).

The NE and OK regions were more than one standard deviation below the state average and each experienced a decline from the previous two quarters, to their lowest levels in the eight reported quarters. The SW and TU regions were one standard

deviation or more above the state mean in case management utilization for adults with MMI, with the TU region having the highest utilization rate for the last seven quarters.

Provider Feedback:
Providers were asked to review their region's trends on measure MH11 and provide any comments they believe would help better understand activities within the region or suggestions on how to improve continuity of care.

CACMHC (SE Region): CACMHC was glad to see its numbers edging up. It also discovered that not all outpatient nursing staff and new hires (mental health professionals and behavioral health rehabilitation specialist) have their case management certification. They have made certification a priority.

EDWIN FAIR COMMUNITY MENTAL HEALTH CENTER (EFCMHC – NE Region): The EFCMHC data provided by ODMHSAS show that 27% of MMI clients received case management services during the 1st quarter FY 04 as compared to the state average of 21%. Many of EFCMHC clients with Serious Mentally Illness (SMI) have a long history with the agency and seldom needed linkage and advocacy services. However, virtually all were being provided rehabilitation services by their case managers on a regular basis.

Note: Beginning with the 2nd Quarter FY04 report, MH11 will be modified to include Individual Rehabilitation Services in response to provider feedback.

Jim Taliaferro CMHC (SW Region): Jim Taliaferro CMHC had 28% of adults with MMI receiving Case Management services, which is higher than the statewide mean of 21%. The Director of Outpatient Services monitored the case managers to ensure all clients were seen within 90 days, with some seen much more often, based on the need of the consumer.

Red Rock (TU, SW, OK and CN Regions): OK region is the lowest of its regions. Full-time case managers in OKC are providing Individual Rehab rather than the more traditional (and restricted) Case Management service codes.

Improvement Strategies:
1. Director of Outpatient Services monitor case managers.
2. Certify outpatient nursing staff and new hires to provide case management services.

Measure MH12: Adults with MMI Receiving Independent Housing
This measure has shown very little variance over the last three years; therefore, it will continue to be measured but not reported unless a change of more than five percent occurs in any one region.

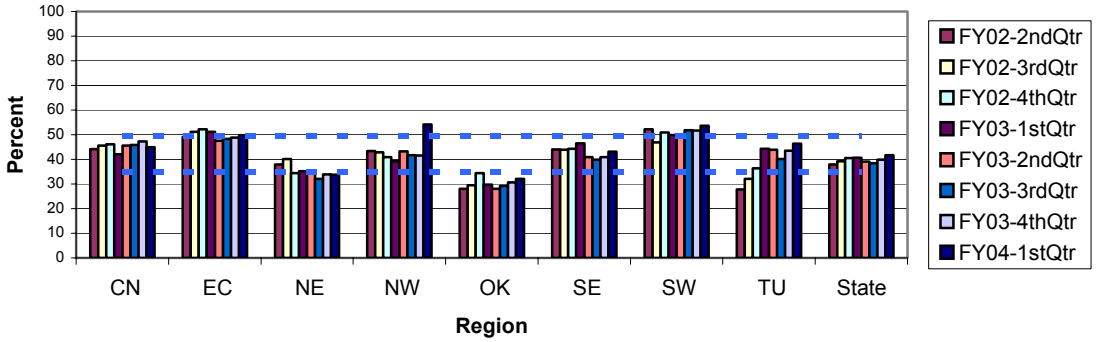
ADULT SELECT PRIORITY GROUP (SPG)

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 MH13: Adult Select Priority Group Medication Visits

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.

Figure MH13: Adults with a Select Priority Group (SPG) Diagnosis in the Past Year
Percent Who Received a Medication Visit in the Quarter



Statewide, 42% of all adults in the SPG received a medication visit in the 1st Quarter of FY04 (Figure MH13). The rate has remained fairly consistent with a range of 38% to 40% in the prior seven quarters. The EC and SW regions have had overall trends toward high rates of medication visits, with 50% and 54%, respectively, occurring in the most recent quarter. Studying practices in these regions may identify activities that could be emulated elsewhere. The NW region also performed at a rate more than one standard deviation above the state average (54%) in 1st Quarter of FY04. The NE and OK regions had low percentages of adults with SPG receiving a medication visit in most quarters measured; with 34% and 32%, respectively, receiving a medication visit in the 1st Quarter of FY04. The OK region has performed at one standard deviation or more below the state average for the eight quarters studied.

Steps Taken. Providers suggested the state evaluate the effect on the measure of incorporating medication services paid by Medicaid, but not included in the ODMHSAS database. The analysis and findings of including Medicaid services are discussed in the following section:

ODMHSAS evaluated medication services for the Adult SPG members to determine the impact of Medicaid fee-for-service payments on the RPM measure Adult Select Priority Group Medication Visits. In the last eight quarters, between 31% and 42% of Adult SPG members received at least one medication service paid by ODMHSAS during a quarter. Given the severity of diagnosis for this group, these results are considered low.

Providers suggested that the exclusion of members that received services paid by Medicaid but not included in the ODMHSAS database, could explain the low percentages.

In response to this suggestion, ODMHSAS evaluated medication services for the SPG population paid by either ODMHSAS or fee-for-service Medicaid during fiscal year 2002. Fiscal year 2002 was used because it is the most recent information available from OHCA. Medicaid managed care data were excluded because they are unavailable.

Statewide for FY02, the percentage of SPG members that received a medication visit paid by either ODMHSAS or fee-for-service Medicaid was 3% higher than the percentage paid by ODMHSAS alone. The regions with low managed care penetration were evaluated in consideration of the effects of members receiving services paid by managed care organizations (MCOs). An analysis was completed with Oklahoma, Tulsa and the SW regions removed, the three regions with the highest managed care penetration in the state. This excluded medication services paid by MCOs from the analysis.

During FY02, on average, 47% of SPG members, each quarter, received a medication visit paid by ODMHSAS or Medicaid in the five regions with low managed care penetration. This was 3% higher than the percentage paid by ODMHSAS alone. The range of differences between the percentages for ODMHSAS-paid services and ODMHSAS- or Medicaid fee-for-service-paid services in each region and quarter was between 0.5% and 6%.

Finding: During FY02, the inclusion of Medicaid fee-for-service data had a modest effect on the measure Adult SPG Medication services, raising the findings statewide for the year from 39% to 42%. Three percent of adult SPG members received services paid by Medicaid fee-for-service, which were not included in the ODMHSAS database. The same percentage differences were seen in regions with low managed care penetration. Regional trends were similar with or without the inclusion of services paid by Medicaid fee-for-service but not included in the ODMHSAS database.

Provider Feedback:
Providers were asked to review findings in light of their own agency's activities and circumstances to help understand the utilization pattern this report portrays. They were also asked to share any actions providers have taken, or circumstances in their region, that may have contributed to better utilization.

CACMHC (SE Region): CACMHC asked whether the select priority group comprised all admitted adults with SPG diagnosis for the last year regardless of pay source because only 29% of outpatient services for clients at CACMHC were paid by ODMHSAS fee for service.

The breakdown for their clients by financial class for FY 2003 were:

Payment Source	Number of Clients
DMHSAS	29%
Medicaid	44%
Medicare	18%
Third Party	4%
Self-Pay	5%
Total	**100%**

If the data included all admitted adults with SPG diagnosis, then CACMHC's results for this indicator were better than reported because ODMHSAS only pays for about 30% of medication services provided. The results for MHSSO may be similarly affected.

COCMHC (CN Region): The individual center report indicated that COCMHC is doing better than the regional or statewide averages. Approximately 75% of COCMHC persons in the SPG receive medication services in a quarter, compared to other agencies for which averages are between 45% and 50%. COCMHC has more psychiatrists (and therefore, doctor time) than most CMHCs, which may explain the difference. In addition, the doctors and the therapists/case managers work well together. They communicate and plan how to respond when a client skips one type of appointment (medical appointment, therapy appointment, etc).

EFCMHC (NE Region): The reported medication visit numbers were not consistent with observations at its clinic. For that reason, EFCMHC reviewed data from their internal information system. Although these data were not specifically for the SPG, the agency's adherence to the Core Service Plan and their limited admission policies for medication clinic ensured a fairly good match with the SPG. The records showed an unduplicated client count for billing code 304 (pharmacy services) during the 1st quarter of FY 04 as follows:

Payment Source	Number of Clients
DMHSAS	132
Title XIX	128
Insurance	7
Medicare	148
Self	2
Total	**417**

Although some clients have outside sources of medication such as a private physician or Indian Health Services, the vast majority of clients are seen internally. The numbers closely match EFCMHC staff observation that a very high percentage of clients with SMI were seen for medication services. EFCMHC staff asks whether there a possibility that

ODMHSAS is getting total client data for intakes and only DMHSAS data on pharmacy services

Hope (OK Regions): Stable clients were seen every four months by the physician and more often by their clinician. This has been the practice at Hope for some time.

Jim Taliaferro CMHC (SW Region): Jim Taliaferro CMHC provided medication services to 54% of all adults in the SPG, which is higher than the statewide average of 42%. The director of their outpatient services printed out a management information system report monthly, indicating consumers who did not follow-up with services within 90 days. This process was initiated to help prompt timely case manager follow-up, especially regarding missed medicine clinic appointments.

Red Rock (TU, SW, OK and CN Regions): Central, Southwest and Tulsa were all above the state average. Oklahoma is consistently below. This was largely due to limited access to data from other third party payers. The table below shows funding sources whose data are currently not available to DMHSAS, which accounts for over 70% of the OKC clients with SMI.

OKC SMI Clients First Quarter:

Payment Source	Visits	Percent
DMHSAS	189	23%
HMO	304	37%
Title XIX	27	3%
Medicare	282	34%
Other	17	2%
Total	**819**	**100%**

Red Rock's data support the 3% Title XIX found over the state.

Improvement Strategies:

1. Ensure sufficient physician availability
2. Ensure communication between doctors and therapist/case managers when clients no show.
3. Use BHIS report to identify clients that did not follow-up.
4. Report all clients without services within 90 days to Outpatient Director for appropriate follow-up actions.

EVIDENCE-BASED PRACTICES

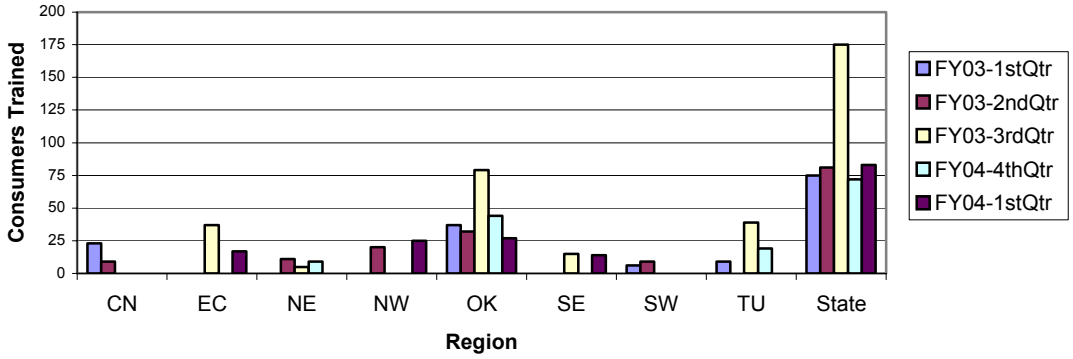
Measure MH14: Illness Self- Management

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 five quarters.

Illness self-management education services were provided to 83 individuals during the 1st Quarter of FY04, bringing the total participants to 486 (Figure MH14). Training was offered in the EC, NW, OK, and SE regions for the most recent quarter.

Figure MH14: Clients Receiving Illness Self-Management Training
Unduplicated Count by Quarter

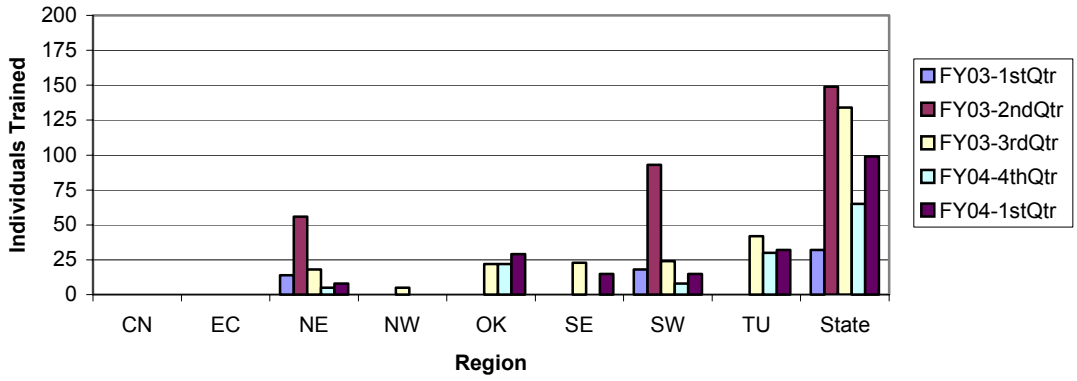


Provider Feedback:
CACMHC (SE Region): CACMHC had WRAP training in Idabel, Hugo, and Heavener (SE Region); Pittsburg County is next on the schedule. The WRAP Training Facilitator and the Director maintain personal contact. Because follow-up was not measured, they are not sure how many clients continued with WRAP. Lead staff will continue to support and encourage WRAP.

Measure MH15: 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 five quarters.

Figure MH15: Family Members Receiving Family-to-Family Training
Unduplicated Count by Quarter



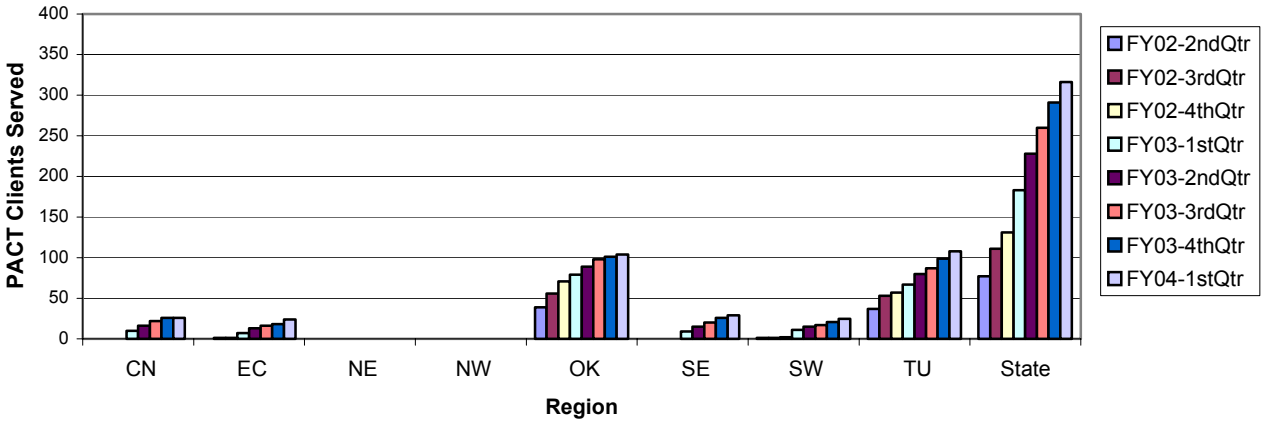
A total of 99 individuals received Family-to-Family training in the 1st Quarter of FY04, up from 65 individuals trained in the prior quarter (Figure MH15). Training sessions were held in the NE, OK, SW, SE and TU regions during the 1st Quarter of FY04. To date, training has been provided to 479 individuals.

Provider Feedback:
CACMHC (SE Region): The NAMI group in Pittsburg County (SE Region) reported they currently were not offering Family-to-Family but hope to in the near future. They have one member trained to teach. They hope to offer it soon because not only is it helpful, but this has been the best way to pick up new members for NAMI.

Measure MH16: 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 served each quarter will be monitored. The two urban sites, located in the OK and TU regions, are staffed to serve 100-120 PACT participants, while the other four sites, considered rural sites, are staffed to serve 50 participants.

Figure MH16: Number of Persons Served in PACT by Quarter



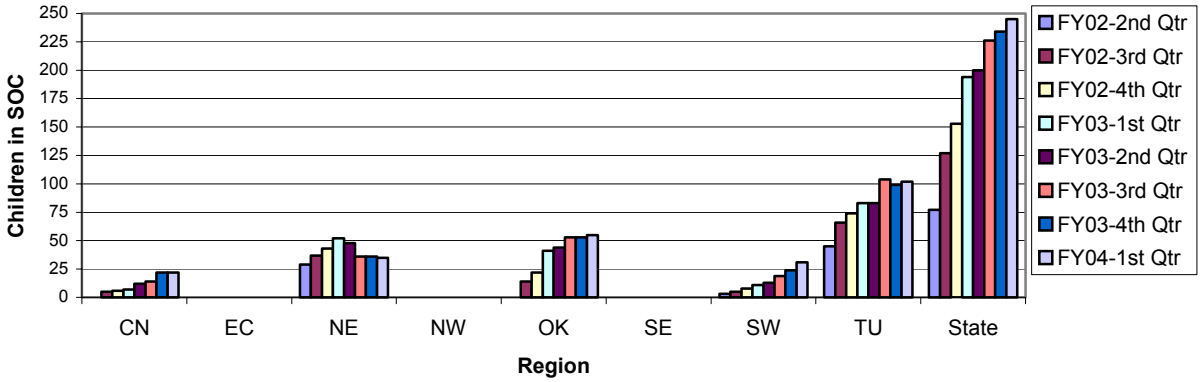
As shown in Figure MH16, 316 persons were served through the six PACT sites in the 1st Quarter of FY04. The OK and TU regions provided services to 104 and 108 persons, respectively. The remaining sites are newer and have not reached their maximum capacities.

CHILDREN'S SERVICES

Measure MH17: Children's Systems 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. Currently, there are seven sites located in five regions. Like PACT, it is important that the project sites grow in an effective manner to ensure access to children and their families, thus, the number of children served quarterly will be monitored. While there are other SOC programs operating in the state, these data represent only those programs funded through ODMHSAS.

Figure MH17: Number of Children Served in SOC by Quarter



In 1st Quarter of FY04, 245 children were served in the SOC program, the largest number to date (Figure MH17). The TU region, which is the largest site, served 102 children, followed by 55 children served in the OK region, 31 children served in the SW region, 35 children served in the NW region, and 22 children served in the CN region.

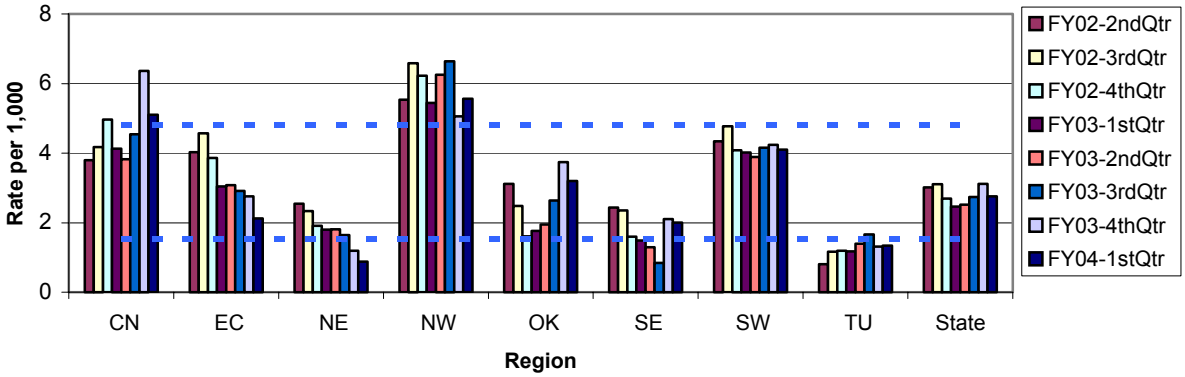
Provider Feedback:
CACMHC (SE Region): CACMHC posted a position in January for their Systems of Care coordinator. The SOC coordinator will work with the Child Welfare League of America in the continued development of the Comprehensive Services for Children Center, an Oklahoma Centennial Initiative.

Measure MH18: Children with Any ODMHSAS-Funded Mental Health Service

Background: Mental health services to children ages 6 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 DMHSAS-funded services. The denominator for the children's measure is 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. Due to the absence of children receiving mental health services funded by Medicaid, this measure depicts only a small fraction of the true number being served. **Therefore, following this report, this measure will be retired.** Additional children's measures are being developed that will better represent the level of effort by ODMHSAS to serve this population.

Statewide about 2.7 children per 1,000 (27 per 10,000) between the ages of 6 through 17 received DMHSAS-funded mental health services in the 1st Quarter of FY04 (Figure MH18). The range was between 2.5 and 3.1 per 1,000 children in the seven preceding quarters. Based on the data reported to ICIS, children in both the CN and NW regions had high rates of service utilization, 5.1 and 5.6 per 1,000 children, respectively.

Figure MH18: Children Receiving Any ODMHSAS-Funded Mental Health Service
Rate per 1,000 Children



The NW region has demonstrated a high service utilization for all eight quarters measured. 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 1.3 per 1,000 children for the 1st Quarter of FY04. The number of children receiving services in the NE region fell more than one standard deviation below the state average for the past two quarters and has been declining over the past two years.

PERFORMANCE MEASURES - SUBSTANCE ABUSE

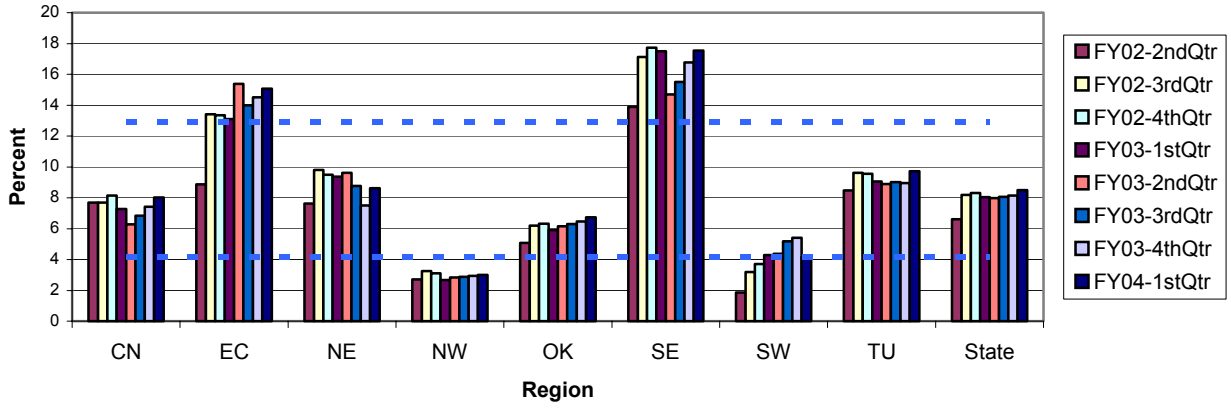
The indicators of substance abuse treatment performance used in this report are measures developed by the Washington Circle with support from the federal Center for Substance Abuse Treatment (CSAT). The indicators focus on early recognition and intervention can positively affect the course of an individual's problem with alcohol and other drugs. The indicators measure the extent to which persons in need are identified, initiated into treatment and engaged to stay in treatment.

Measure SA1: Identification

Persons were considered "identified" (as substance abusers in need of treatment) if they received a substance abuse service in the quarter. There were 3,899 persons identified as in need of treatment during the 1st Quarter of FY04. Between 3,314 and 3,883 persons were identified in each of the seven prior quarters. Persons were identified by the first level of substance abuse services they used:

Outpatient – 1,974 clients (51%)
Detoxification – 1,051 clients (27%)
Residential – 772 clients (20%)
Community living – 102 clients (3%)

Figure SA1: Adults in Poverty Estimated to Need Substance Abuse Treatment
Percent "Identified" by ReceivingTreatment



Statewide, the percent of adults with an estimated need for substance abuse treatment that received a substance abuse service has remained fairly constant for the past 8 quarters ranging from 6.6% in the first quarter studied to 8.5% in the most recent quarter (Figure SA1).

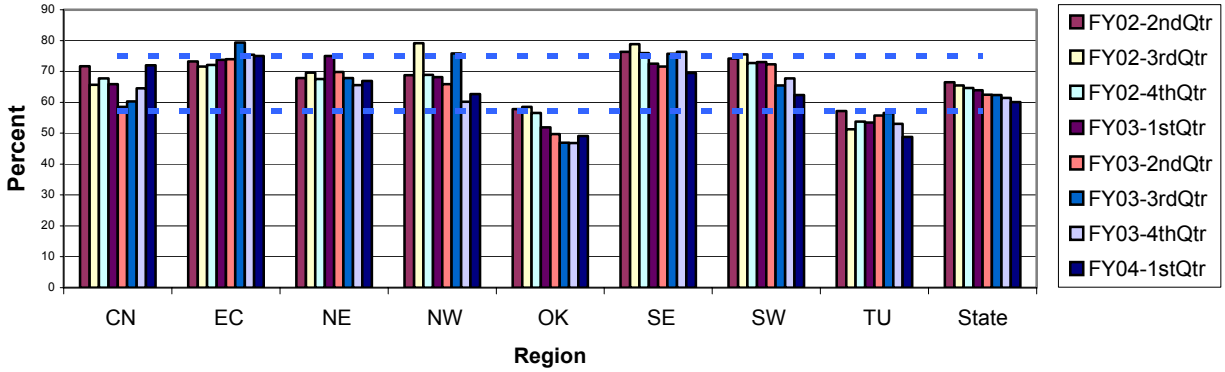
A high percentage of adults with substance abuse problems in the EC and SE regions received a substance abuse service at more than one standard deviation above the state average in at least seven of the eight quarters measured. A low percentage of adults with substance abuse problems in the NW region received a substance abuse service in all eight quarters measured, ranging from 2.6% to 3.2%. The SW region

also fell one standard deviation below the state average at 4% in the 1st Quarter of FY04.

Measure SA2: Initiation

Among those persons 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 persons were first served. Statewide, 60% of persons with a first substance abuse service (as described above) initiated treatment in the 1st Quarter of FY04 (Figure SA2a). The initiation rates have fallen in each of the last eight quarters from 66% two years ago.

Figure SA2a: 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 for outpatient and detoxification services separately because of the variation in the percent of clients initiating treatment in the two levels of care.

As shown in Figure SA2b, statewide, 76% of adults with first treatment episodes, who started treatment in outpatient care, initiated treatment (had a second service within 14 days, refer to Figure SA2c for diagram). The rate has remained fairly constant for the past seven quarters, ranging from 76% to 78%. The TU region had a low initiation rate at 64, while the SE region had a high rate at 85%. The SW region, which generally has a high rate of initiation, fell substantially from 89% to 71% over the last two quarters.

Figure SA2b: Initiation of Substance Abuse Treatment Following a First Outpatient Service

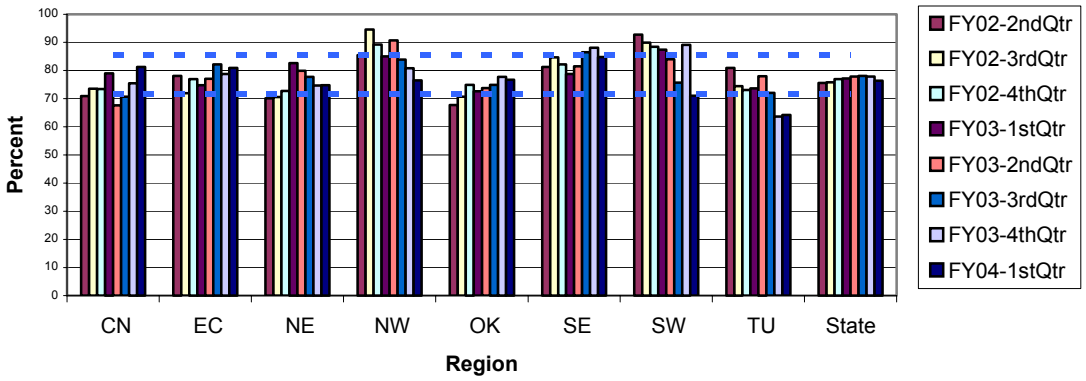


Figure SA2c: Substance Abuse Treatment - Outpatient Diagram

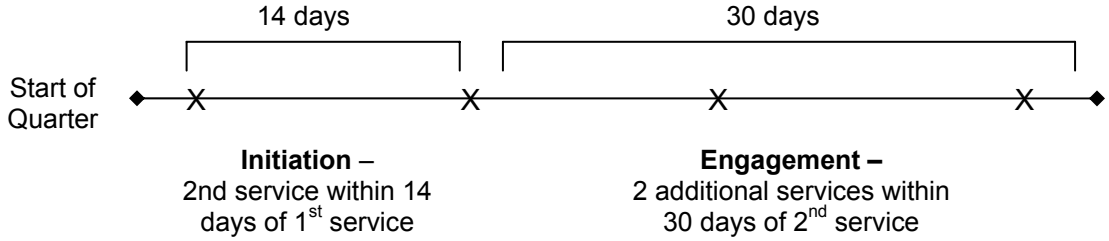
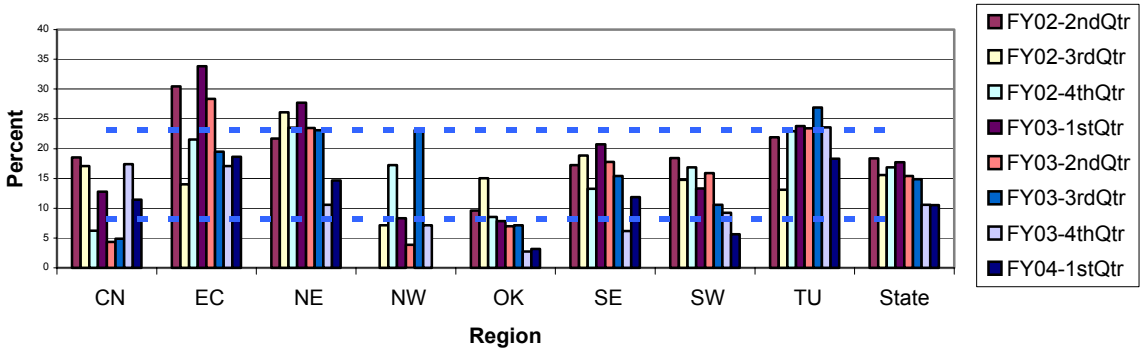


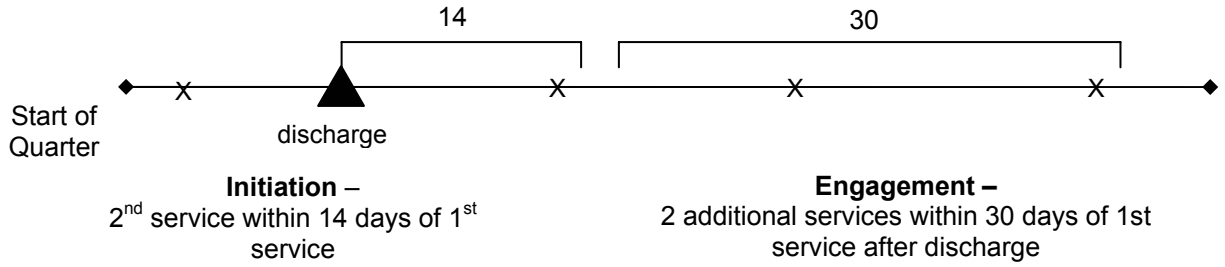
Figure SA2d: Initiation of Substance Abuse Treatment Following a First Detoxification Service



As shown in Figure SA2d, 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 SA2e). This is down from 18% two years ago. The NW, OK and SW regions all fell to one standard deviation below the state average at 0%, 3.2% and 5.6%, respectively. There has been significant

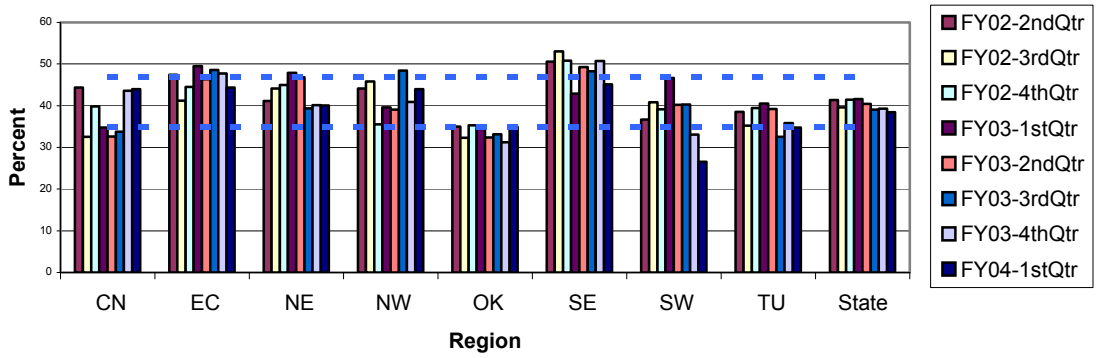
quarter-to-quarter variability in the NW region because slight changes in the small number of clients in that region produce a big change in rates. The SW region has been declining for three quarters and the OK region has been one standard deviation or more below the state average for the last four quarters.

Figure SA3d: Substance Abuse Treatment - Detox Diagram



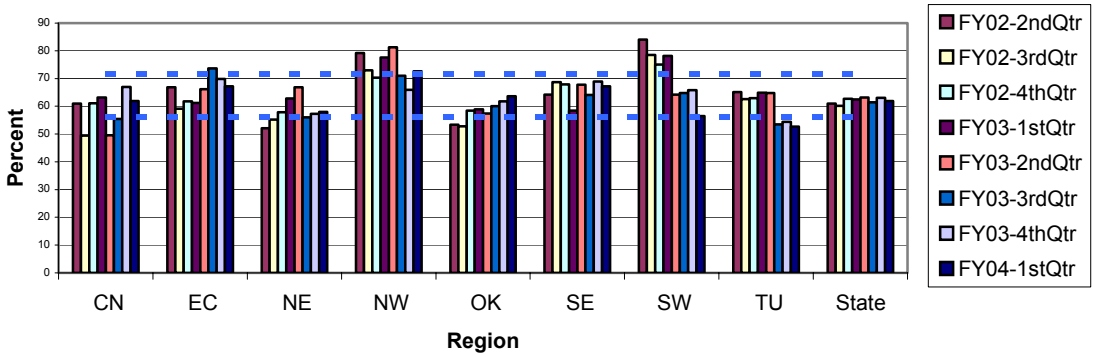
Measure SA3: Engagement

Figure SA3a: Engagement in Substance Abuse Treatment Following a First Service at Any Level of Care



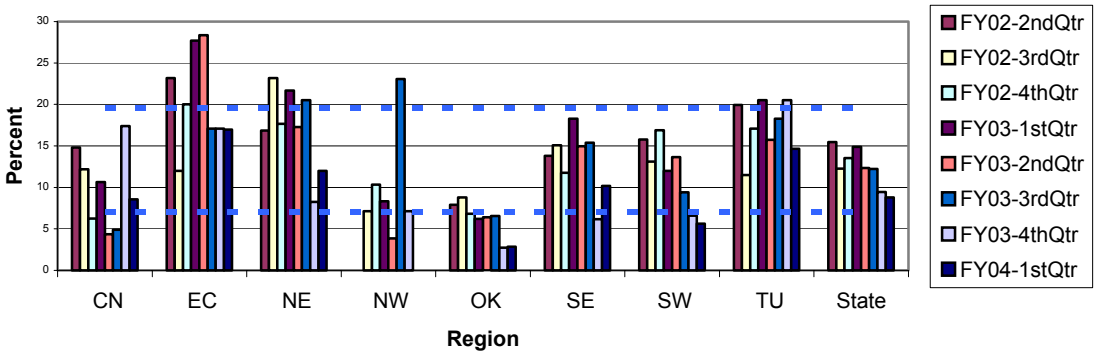
Statewide, 39% of persons with a new substance abuse treatment went on to engage in treatment during the 1st Quarter of FY04 (Figure SA3a). This was a decrease from the previous seven quarters. While none of the regions performed at more than a standard deviation above the state average in engaging clients in treatment, both the EC and SE regions typically demonstrate a higher rate of engagement and reported rates at 44% and 45%, respectively, in the 1st Quarter of FY04. Three regions (OK, SW and TU) were at or below one standard deviation from the state average in treatment engagement.

Figure SA3b: Engagement in Substance Abuse Treatment Following a First Outpatient Service



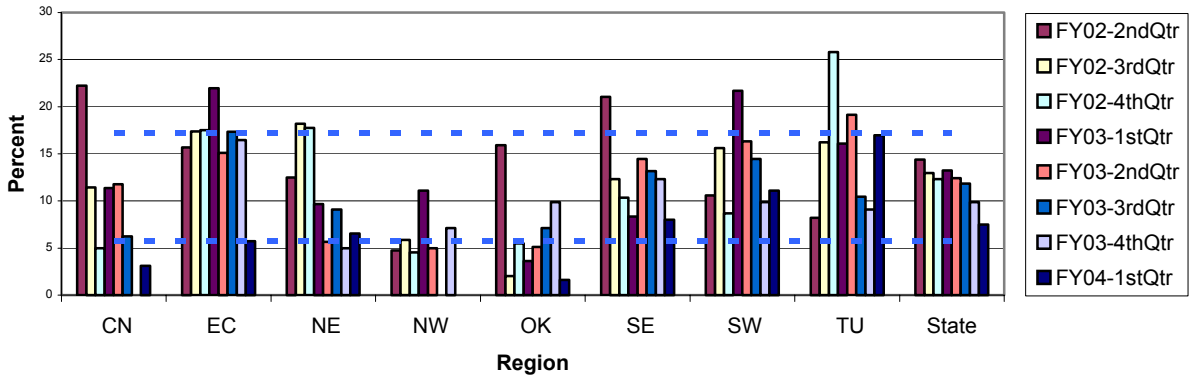
During the 1st Quarter of FY04, 63% of clients who started treatment in outpatient care engaged in treatment (initiated treatment within 14 days after an initial outpatient service and had two more services within 30 days following initiation, refer to Figure SA3b). This was within the range of 60% to 63% that engaged in treatment during the seven prior quarters. The NW region was one standard deviation above the state average at 73% while the TU region was more than one standard deviation below the state average at 53%.

Figure SA3c: Engagement in Substance Abuse Treatment Following a First Detoxification Service



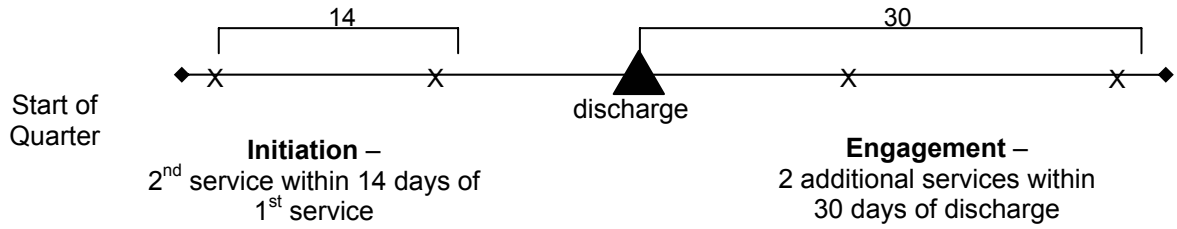
Nine percent of clients who started treatment with detoxification services engaged in treatment (had one service within 14 days of discharge from detoxification services and two additional services within 30 days of the first post-discharge service). This was lower than the prior seven quarters, which ranged from 9.4% to 15% (Figure SA3c). The NW, OK and SW regions were more than one standard deviation below the state average at 0%, 3% and 6%, respectively.

Figure SA3d: Engagement in Substance Abuse Treatment Following a First Residential Treatment Service



As shown in Figure SA3d, 7.5% of clients who started treatment with residential services engaged in treatment (had two substance abuse services within 30 days after discharge from residential treatment, refer to Figure SA3e). This fell below the range of 10% to 14.4% in the prior seven quarters. The CN, NW and OK regions had low engagement in substance abuse treatment after discharge from residential treatment, with the CN region having a rate of 3%, the NW region having a rate of 0%, and the OK region having a rate of 2%.

Figure SA3e: Substance Abuse Treatment – Residential Treatment Diagram



Provider Feedback:
Providers were asked to assess what is happening statewide and regionally regarding follow-up to detoxification and residential treatment services. For regions doing a good job at this linkage task, respective providers were asked to share their agency's activities or circumstances that may have contributed to a better outcome.

Bill Willis CMHC (BWCMHC – NE Region): BWCMHC has been identifying ways of engaging clients in treatment following discharge from residential treatment. The agency is in the planning stages of re-organizing its admission process. Residential admissions will go through one of the four agency outpatient clinics for the Addiction Severity Index (ASI) and American Society for Addiction Medicine (ASAM) assessments prior to referral to residential treatment. BWCMHC anticipates that this will increase the

number of persons returning to their outpatient clinics upon discharge. It will also help them to prioritize referrals from the four county offices.

12&12 (TU Region): 12 & 12 staff postulate the low 7.5% of clients who started treatment in residential services and engaged in treatment may, at least partially, be accounted for by difficulty in arranging for aftercare services for consumers who return to rural areas after they discharge from treatment, where such services are often inaccessible.

Improvement Strategies:

- Ensure linkage to outpatient clinics for ASI and ASAM assessments
- Assess client continued treatment need and availability of services prior to discharges and link with OCARTA or other self-help services were treatment programs are not available.

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.

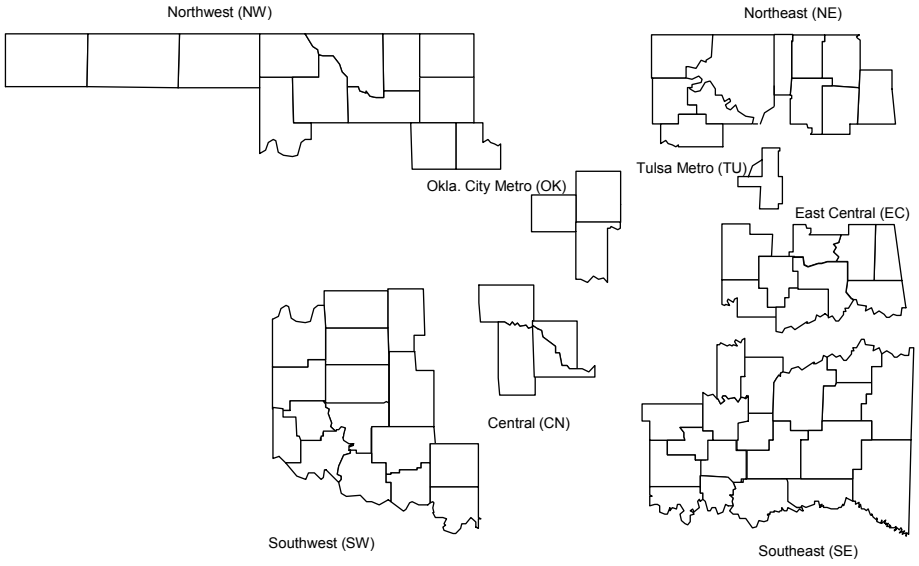
Appendix 1: Selection of Indicators

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.

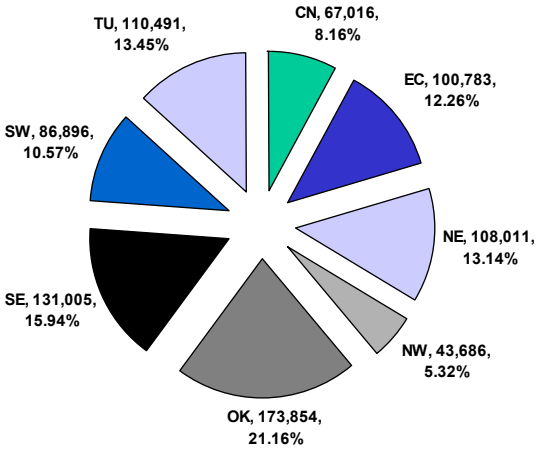
Future Development. System stakeholders were involved in previous indicator development processes, and as stakeholders express their perspectives regarding the utility of the selected RPM report indicators, or as system improvements make monitoring an indicator less important, it is likely other indicators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

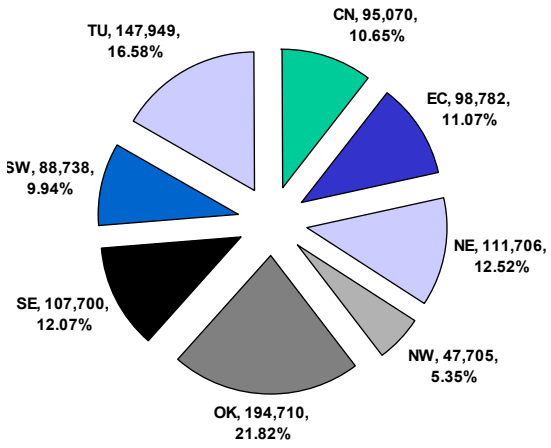
Appendix 2: RPM Report Indicator Definitions

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, persons had to be admitted to an 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 MH1: 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: Adults 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 MH2: Adult Mental Health Core Outpatient Services – The rate of persons, 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: Adults 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 MH3: Adult Inpatient Services – The rate of persons, 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: Adults 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 MH4: Adult Inpatient Follow-up in Outpatient Care within Seven Days after Discharge – The percent of persons, 18 years or older, who received an outpatient service within seven days of being discharged from inpatient.

Numerator: Adults 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 MH5: Adult Inpatient Re-admissions within 30 Days – The percent of persons, 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: Adults re-admitted to an inpatient unit within 30 days of a discharge from an inpatient unit during the quarter X 100.

Denominator: Adults discharged from an inpatient unit during the quarter.

Measure MH6: Face-to-Face Mental Health Crisis Service - The rate of persons, 18 years or older, who received a face-to-face mental health crisis per 1,000 adults in poverty.

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

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

Measure MH7: Mental Health Crisis Follow-up – The percent of persons, 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: Adults receiving a non-crisis outpatient service within 7 days of receiving an hourly face-to-face crisis service X 100.

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

Adults with Major Mental illness (MMI):
Persons, 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 MH8: Any ODMHSAS-Funded Mental Health Service for Adults with MMI – The rate of persons 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: Persons with MMI who received a service during the quarter X 1000.

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

Measure MH9: Core Outpatient Mental Health Service for Adults with MMI -- The rate of persons, 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: Persons with MMI who received a core outpatient service during the quarter X 1000.

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

Measure MH10: Inpatient Services for Adults with MMI – The percent of persons with MMI who had an inpatient service during in the quarter.

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

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

Measure MH11: Case Management Services for Adults with MMI – persons with MMI who received a case management service (ICIS service codes = 204, 225, or 226) in the quarter.

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

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

Measure MH12: Independent Housing for Adults with MMI (Monitored but not currently reported) – The percent of persons with MMI 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: Persons with MMI who live in independent housing X 100.

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

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

Measure MH13: SPG Medication Visits – The percent of SPG members who received a medication visit (ICIS service codes = 301, 304, 305, or 308).

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

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

Measure MH14: Illness Self-Management Training – The count of persons who received the WRAP training by region by quarter as reported by the Oklahoma Mental Health Consumer Council.

Measure MH15: Family-to-Family Training - The count of persons who received the Family-to-Family training by region by quarter as reported by NAMI-OK.

Measure MH16: Program of Assertive Community Treatment (PACT) – The count of persons served in PACT programs by region by quarter.

Measure MH17: Systems of Care (SOC) - The count of children served in SOC programs by region by quarter.

Children's Services:
For all Mental Health measures of children's services, persons 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 MH18: 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, persons 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 SA1: Identification – The rate of persons, 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: Adults 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 SA2b: Initiation (Outpatient) – The percent of persons, 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: Adults 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: Adults admitted to outpatient care during the quarter who had received no other substance abuse service in the previous 60 days.

Measure SA2c: Initiation (Detox) – The percent of persons, 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: Adults 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: Adults admitted to detox during the quarter who had not received any other substance abuse service in the previous 60 days.

Measure SA3b: Engagement (Outpatient) – Of the persons, 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: Adults who received two or more services within 30 days of service initiation during the quarter.

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

Measure SA3c: Engagement (Detox) – Of the persons, 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: Adults who initiated service after discharge from detox service during the quarter who received two more services within 30 days of service initiation.

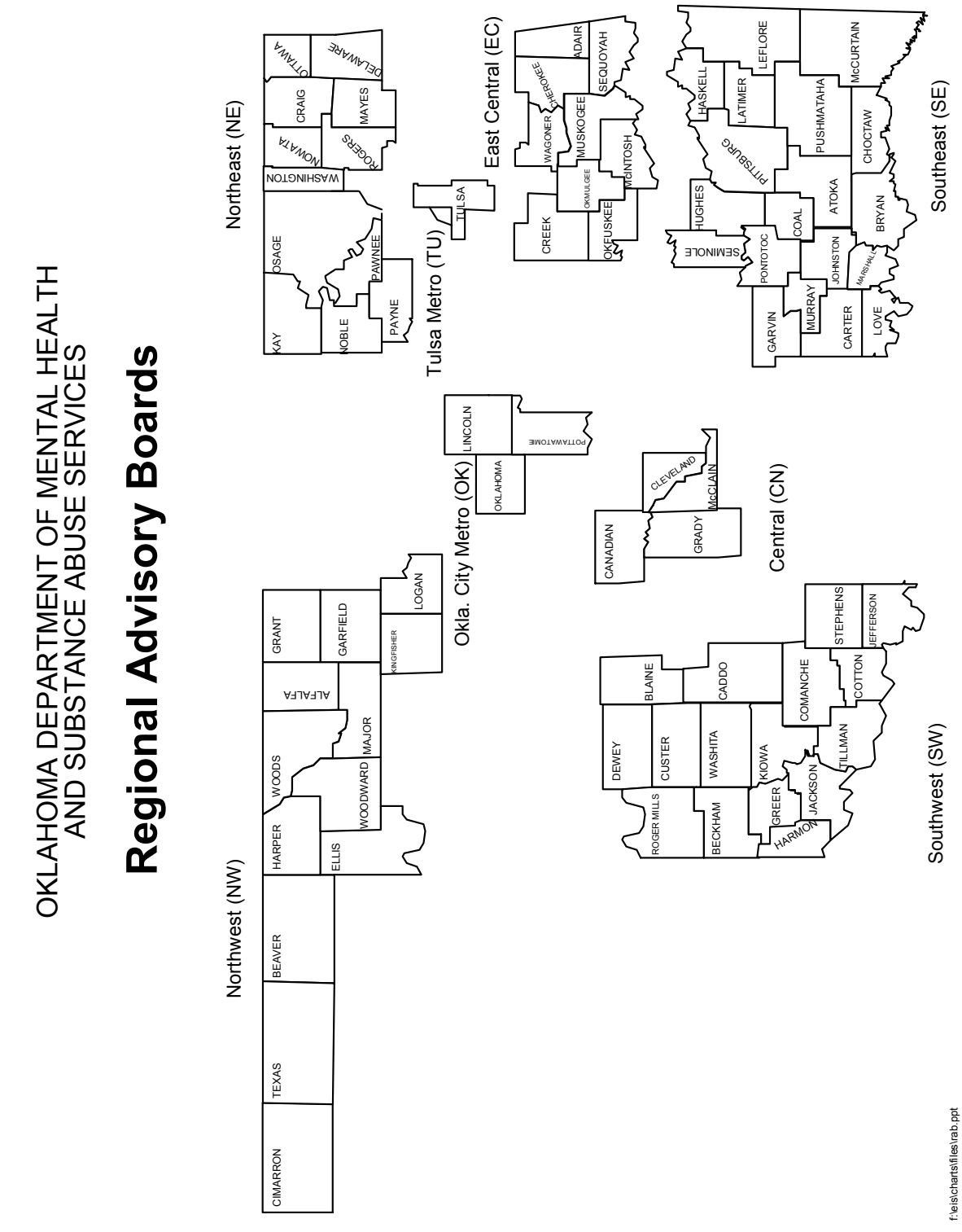
Denominator: Adults who initiated service following discharge from detox service during the quarter.

Measure SA3d: Engagement (Residential) – Of the persons, 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: Adults who initiated treatment following residential treatment discharge during the quarter who received two more services within 30 days of initiating treatment.

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

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

Appendix 6: Clients Served by Provider by Region

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	Grand Total
12 & 12, INC.		37	29	1	8	8	2	357	442
ADA AREA CHEMICAL DEP. CTR						33			33
ALPHA II, INC.		14	14	1	1	2		1	33
ASSOCIATED CENTERS FOR THERAPY, INC.			2			2		881	885
BILL WILLIS INPATIENT		58				1		1	60
BILL WILLIS MENTAL HEALTH	1	1121	19			5	8	21	1175
BRIDGEWAY			16						16
BROADWAY HOUSE, INC.	2		2	2	3	15	3		27
CAA TURNING POINT	16		1		188		1		206
CARE FOR CHANGE INC.					101				101
CARL ALBERT C.M.H.C.	1	25	1		1	1300		1	1329
CENTER FOR CHILDREN & FAMILIES	81				26	1			108
CENTRAL OKLAHOMA CMHC	883			1	101	3			988
CHISHOLM TRAIL COUNSELING SVS	8				2				10
COMMUNITY ALCOHOLISM SERVICES		24	54				1		79
COMMUNITY DEVELOPMENT SUPPORT ASSOCIATION				12					12
COPE, INC.					54		1		55
COUNSELING CENTER OF S.E. OKLAHOMA			1			103			104
CREOKS MENTAL HEALTH SERVICES	1	486			14	5	1	1	508
CROSSROADS INCORPORATED			1		1			77	79
DIVORCE VISITATION ARBITRATION			13		1				14
DOMESTIC VIOLENCE INTERVENTION SERVICES, INC.		8	2					40	50
DRUG RECOVERY, INC.	9	3		2	115	3	9	3	144
EAGLE RIDGE INSTITUTE	3	50	2	2	21	3	2	13	96
EDMOND FAMILY SERVICES, INC.				1	13				14
EDWIN FAIR CMHC		1	692	5	2	1		1	702
FAMILY & CHILDREN'S SERVICES		2	2	1				1493	1498
FAMILY CRISIS CTR, INC.						42			42
FOCUS		30							30
GATEWAY TO PREVENTION/RECOVERY		6			129	7	1		143
GRAND LAKE M.H.C.		2	1152				1	4	1159
GREEN COUNTRY BEHAVIORAL HEALTH SERVICES, INC.		560	1		2	5	1		569
GRIFFIN MEMORIAL HOSPITAL	253	8	20	22	274	171	9	28	785
HOMINY HEALTH SRVCS CTR INC.			57					1	58
HOPE COMMUNITY SERVICES, INC.	3	1			549				553
HOUSE OF HOPE INC		9	21			2	1	4	37
HUMAN SKILLS & RESOURCES		50	43	2				129	224
INDIAN HEALTH CARE RESRCE CTR			2					57	59
JIM TALIAFERRO CMHC	29	1	2		5	5	1211	1	1254
KIAMICHI COUNCIL ON ALCOHOLISM				1		236	1		238
LATINO COMMUNITY DEV. AGENCY					2				2
LEFLORE CO. YOUTH/FAMILY SERVICES, INC.			1			1			2
LOGAN COUNTY YOUTH & FAMILY SERVICES, INC.	3			33	11				47
M.H. SERVICES OF SOUTHERN OKLAHOMA	3	11	3	3	6	1372	16		1414
MARIE DETTY YOUTH SVC CTR							8		8
METRO TULSA SUBSTANCE ABUSE SERVICE	1	37	17		4	7	2	416	484
MONARCH, INC.	5	36	3		5	19	3	4	75
MOORE ALC/DRUG CTR	15				6				21

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	Grand Total
MUSKOGEE COUNTY COUNCIL OF YOUTH SERVICES		85						1	86
N.E. OK COUNCIL ON ALCOHOLISM		1	123		1	1		1	127
NATIVE AMERICAN CENTER OF RECOVERY				14	6				20
NEW HOPE OF MANGUM	2				2	2	157		163
NORMAN AL/DRUG TREATMENT CTR	35	4	3	4	75	19	19	7	166
NORMAN ALCOHOL INFORMATION CTR	189	2			13	12			216
NORTH CARE CENTER	99	3			1526	1	1		1630
Northwest Center for Behavioral Health	10	6	42	1435	44	18	88	2	1645
NW SUBSTANCE TREATMENT CNTR	1	2	1	2	3	7	8		24
OKLAHOMA COUNTY CRISIS INTERVENTION CENTER	29	2	16	13	352	7	3	4	426
OKLAHOMA FAMILIES FIRST, INC.						24			24
Oklahoma Forensic Center	19	17	16	8	57	26	25	33	201
OKLAHOMA YOUTH CENTER	34	1	3	1	26	16	9	3	93
OPPORTUNITIES, INC., CDTC	9	1	1	13	26	6	37	2	95
PALMER DRUG ABUSE PROGRAM INC.								3	3
PAYNE CO COUNSELING SVC,INC.		1	49		3				53
PAYNE COUNTY DRUG COURT, INC.			18			3			21
PEOPLE INCORPORATED		61	20						81
RED ROCK BEHAVIORAL HEALTH SVC	621	3	2	14	722	93	583	109	2147
RIVERSIDE COUNSELING	21				2	13			36
ROADBACK, INC.		2	1			2	70		75
ROCMND AREA YOUTH SERVICE			2						2
ROGERS COUNTY DRUG ABUSE			92					1	93
S.W. YOUTH & FAMILY SERVICES	35						4		39
SAFE HAVEN		2						47	49
SHEKINAH COUNSELING SERVICES				1		63			64
SOUTHWEST RETIREMENT HOME, INC							28		28
SPECIALIZED OUTPATIENT SERVICES, INC.					103				103
STARTING POINT II, INC.	3	2	61	7	12	4	1	3	93
SUBSTANCE ABUSE SERVICES								1	1
THE BROWN SCHOOLS OF OKLAHOMA, INC								20	20
THE NEXT STEP NETWORK, INC.	1		1	48	2	6	7	1	66
THE OAKS REHAB. SERVICES CTR	3	71	2	1	4	194	3		278
THE REFERRAL CENTER	29	3	12	16	310	39	24	4	437
THUNDERBIRD CLUBHOUSE	83				4				87
TOTAL LIFE COUNSELING					102				102
TR1-CITY YOUTH & FAMILY CENTER	56				66				122
TRANSITION HOUSE INC.	11				1				12
TRI-CITY SUBSTANCE ABUSE CTR					1	107	1	1	110
TULSA CENTER FOR BEHAVIORAL HEALTH		4	4		3	1		347	359
TULSA METROPOLITAN MINSTRY			1					242	243
TULSA WOMEN AND CHILDREN'S CENTER	1	6	2	2	2	1	1	22	37
TURNING POINT			91						91
VINITA AL/DG TREATMENT CTR	1	17	33		2	5	1	13	72
WOMEN IN SAFE HOMES, INC.		17	1		1	1			20
YWCA CRISIS CENTER				7	1		1	1	10
Grand Total	2609	2893	2770	1675	5117	4023	2353	4402	25842