Oklahoma Department of Mental Health And Substance Abuse Services

Regional Performance Management Report

Report for Second Quarter of FY2004

Reported April 2004
By
DMHSAS Decision Support Services

Table of Contents

APPENDICES:

List of Figures and Tables

Regional Performance Management Report
For 2nd Quarter of FY2004

Overview of the 2nd Quarter of FY04.
The format of the Regional Performance Management (RPM) Report has been changed to "focus" on a few indicators viewed as highly indicative of quality of treatment. As these measures show marked improvement, other indicators will become the focus. The focus indicators are shown in Section I of the RPM report, and new segments have been included to illustrate what has been learned to date. These segments include Positive and Negative Influences, items that have been shown to positively or negatively affect the results; Improvement Strategies, as suggested by providers; Actions Taken by providers; and a Discussion section. Goals are also being established for each of the focus measures. If you wish to provide input to what these goals should be, please contact John Hudgens, Director of Community-Based Services, (JHudgens@ODMHSAS.org) or Jennifer Glover, Clinical Treatment Services Coordinator, (JGlover@ODMHSAS.org). The remaining indicators are given in Section II.

To better determine how much of an effect an agency has in each region, Appendix 6 has been added to show the number of adult clients served by provider by region for the 2nd Quarter FY04. The numbers shown represent clients 18 years or older and do not apply to MH17: Children's Systems of Care.

Mental Health Treatment:
The statewide rate of outpatient follow-up within seven days of discharge from inpatient treatment (measure MH4) remained the same as the previous quarter (43%); however, for the first six quarters studied, the rate was roughly half of all discharges from inpatient receiving a follow-up visit within seven days. Four of the regions (CN, EC, NE, and OK) showed an improvement in outpatient follow-up following an inpatient episode in the most recent quarter. Beginning with this report, only clients that were referred to a DMHSAS-funded agency or transferred within the same agency were included in the measure.

For measure MH11, adults with a major mental illness (MMI) receiving case management or individual rehabilitation services, statewide, the rate increased slightly to 46%, the highest rate for the eight quarters studied. Six of the eight regions (CN, NE, NW, OK, SW, and TU) showed an improvement in the percent of clients receiving case management or individual rehab services. Previously, only case management services were included in this measure, but because it was recognized that individual rehab services can include services similar to case management, which contribute to longer community tenure and better quality of life, the indicator was revised to include individual rehab services. Also, the criteria for the MMI population were modified to include unspecified bipolar diagnoses, and exclude some personality disorders, to better match the Department's Core Service Plan eligibility criteria. Further, only clients

active in the quarter were studied, excluding clients that maybe have left treatment before the start of the quarter.

Substance Abuse Treatment:
The percentage of clients initiating treatment within 14 days of discharge from detox services, statewide, increased from 12% in the previous quarter to 17% in the current quarter. This is nearly the highest rate for the two years under study. Seven of the eight regions (EC, NE, NW, OK, SE, SW and TU) showed an increase, with the EC region nearly doubling its rate of initiation.

Engagement into a lower level of care following discharge from residential treatment continued to decrease statewide to 7.4%, the lowest rate in the two years studied. Three of the regions (NE, NW and SE) increased their rate of engagement in the current quarter.

SECTION I – FOCUS INDICATORS

Mental Health

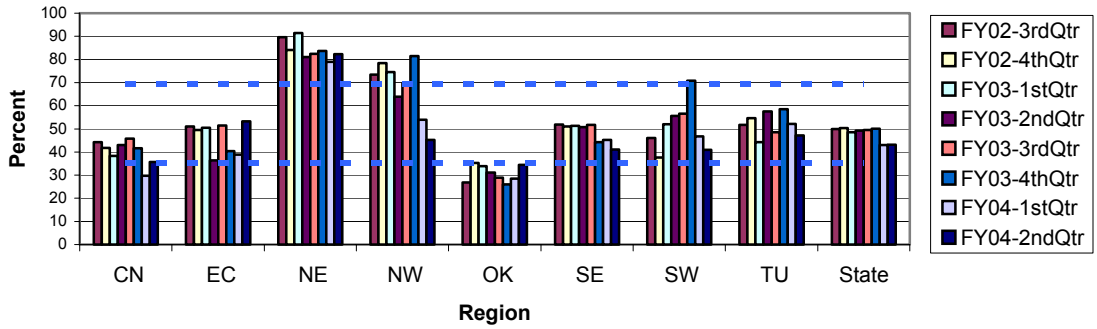
Measure MH4: Adult Inpatient Follow-up in Outpatient Care within 7 Days after Discharge *(for adults referred within the DMHSAS system or transferred within a single agency)*

Rationale for measurement: Persons leaving inpatient care who get involved in community-based services in a timely manner are more likely to have the resources to maintain their community tenure.

Goal: Provider feedback for establishing a goal for this indicator ranged from 45% to 85% of clients discharged and referred to a DMHSAS-funded agency, and one standard deviation above the mean. One provider responded that it would be difficult to arrive at a reasonable goal for all agencies given the many differences among the facilities (e.g., funding, rural vs. urban, poverty rate of area) and, if a goal were set, if might be necessary to weight it in some way to account for the confounding factors.

Chart:

Figure 1: Percent of Adults Discharged from Inpatient Care in the Quarter with Follow-up Outpatient Care within 7 Days (referred/transferred)



Current Status: Statewide rate: 43%. Highest rate: NE region at 81% (more than one standard deviation above the state average). Lowest regions: CN with 36% and OK with 35% (both more than one standard deviation below the state average, although both have improved from the previous quarter).

Trends: Statewide, the 2nd Quarter of FY04 remained at the same rate of follow-up as the 1st Quarter of FY04, which is the lowest rate for the eight quarters studied, with the highest rate being 50%. The inpatient follow-up rates in the NE region were above the state average for all eight quarters. The NW region's rate was high for the first six quarters studied, but fell substantially in the last two quarters. The OK region has consistently been at least one standard deviation below the state average for all eight quarters studied.

Responding Providers: The following agencies responded to the Department's request for performance improvement information related to follow-up after discharge: Associated Centers for Therapy; Inc.; Bill Willis CMHC; Central Oklahoma CMHC; Edwin Fair CMHC; Grand Lake Mental Health Center, Inc.; Griffin Memorial Hospital; Hope Community Services; North Care Center; and Red Rock Behavioral Health Services.

Positive Influences: Training and emphasis on follow-up associated with monitoring the closing of civil beds at the former Eastern State Hospital seem to have developed and maintained a high follow-up rate in the NE region; communication protocols between inpatient and outpatient providers regarding discharges; and contacting clients and setting up appointments before they leave inpatient care.

Negative Influences: Clients admitted under an involuntary status have a lower follow-up rate; clients who may not feel ready for discharge or have no plans to follow-up with outpatient treatment; homeless clients may not intend to follow-up or even remain in the area; issues related to treating clients with substance abuse disorders and the lack of appropriate services; lack of a specific plan to address follow-up with clients if they do not keep an appointment; lack of a performance improvement focus in this area; lack of communication between the inpatient and outpatient facilities; difficulty in obtaining client records from inpatient facility; first contact with outpatient facility is not always reported to DMHSAS so data does not reflect actual percent of clients follow-up within seven days; and no reliable contact information, e.g., disconnected phone, for clients who do not show up for an appointment.

Improvement Strategies Suggested by Providers: Require inpatient-to-outpatient phone calls and/or meetings prior to discharge; ensure transport of client to outpatient services; conduct follow-up calls by inpatient or outpatient staff after discharge and before scheduled follow-up appointment; encourage discharge meds to be taken as prescribed; obtain a daily list from the inpatient facility of all individuals admitted from counties an agency serves to compare to agency's active case load; give clients without an open file with an agency an appointment the day following their release from inpatient and give active clients an appointment within three days of release, and attempt phone contact in either of these categories for individual who do not show for appointments; outpatient case management meet with inpatient clients prior to discharge from inpatient unit; establishment of a liaison at the inpatient facility who facilitates discharges; and develop a priority system to ensure appropriate follow-up for clients who do not show up for their appointments.

Actions Taken: Jim Taliaferro CMHC (SW region), which has a follow-up rate of 48% compared to the state average of 32%, has established a policy to ensure services are provided in a timely and efficient manner by requiring triage evaluation unit staff to see discharged inpatients the next working day after discharge when outpatient staff are too busy to see a client within seven days of discharge. Also, outpatient case managers meet with clients in inpatient prior to discharge.

Hope Community Services (CN region) implemented a protocol which requires clients without open files to be seen the morning after discharge from inpatient and active clients to be seen within three days of discharge. Hope experienced a 12.7% increase in client follow-ups within seven days from the 1st Quarter to the 2nd Quarter of FY04.

Associated Centers for Therapy (TU region) continues to seek ways to improve communication with inpatient discharge staff such as the establishment of a liaison at the inpatient facility who facilitates discharges.

Griffin Memorial Hospital (CN region) and the area CMHCs recently re-established linkage meetings at which improvement strategies for continuity of care are discussed.

Performance Improvement Coordinators for DMHSAS-funded agencies engaged in a Problem-Solving Process to determine barriers to follow-up treatment after inpatient discharge. At their May meeting, they will continue the process to develop possible solutions to decreasing the identified barriers.

Discussion: In previous reports, providers suggested explanations for lower follow-up rates. Analyses found that (1) persons with an involuntary commitment status were less likely to have follow-up than voluntary clients; (2) having dual substance abuse and mental health diagnoses did not negatively impact follow-up contact; and (3) the number of clients hospitalized with dual diagnoses remained about the same across the eight quarters and, thus, did not contribute to lower rates of follow-up services.

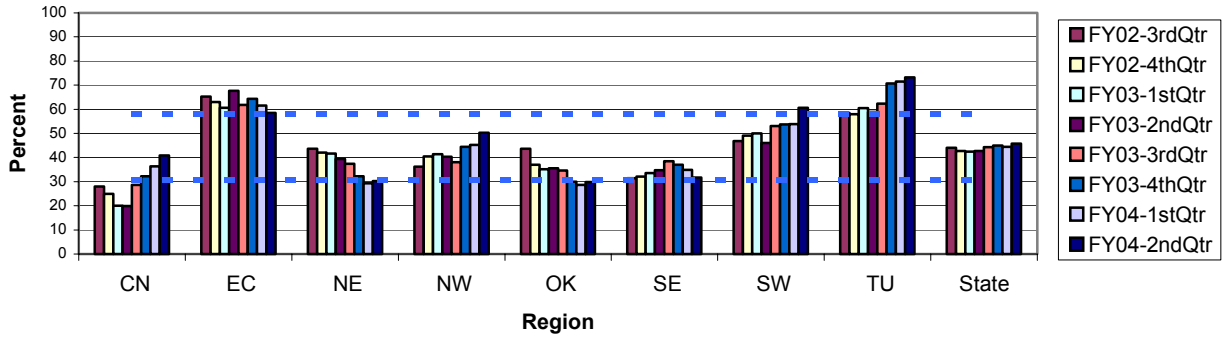
Measure MH11: Adults with MMI Receiving Case Management or Individual Rehab Services

Rationale for measurement: Persons with MMI will maintain longer community tenure and better quality of life if they receive supportive services such as case management or individual rehabilitative services.

Goal: Provider feedback for establishing a goal for this indicator ranged from 35% to 85% of all persons with MMI, and one standard deviation above the mean. One provider responded that it would be difficult to arrive at a reasonable goal for all agencies given the many differences among the facilities (e.g., funding, rural vs. urban, poverty rate of area) and, if a goal were set, if might be necessary to weight it in some way to account for confounding factors.

Chart:

Figure 2: Adults with a Major Mental Illness
Percent Who Received a Case Management or Individual Rehab Service in the Quarter



Current Status: Statewide rate: 46%. Highest rates: The SW and TU regions were one standard deviation above the mean at 61% and 73%, respectively. Lowest rates: The NE and OK regions were more than one standard deviation below the mean at 30%.

Trends: The CN, NW, SW and TU regions have all demonstrated rising rates for at least the past three quarters. The NE and OK regions have declined over the past two years, but have leveled off for at least the last two quarters.

Responding Providers: The following agencies responded to the Department's request for performance improvement information related to the provision of case management services to persons with MMI: Associated Centers for Therapy, Inc.; Central Oklahoma CMHC; Edwin Fair CMHC; Grand Lake Mental Health Center, Inc.; Hope Community Services; North Care Center; and Red Rock Behavioral Health Services.

Positive Influences: Scheduling medication clinics more often to continue engagement with clients.

Negative Influences: Historical emphasis of facility on clinic-based, individual therapy services; small numbers of case management positions and high case loads of all providers; the only service that many consumers want is medication clinic and many are stable without any alternative referral sources in the community; cannot bill DMHSAS for case management services prior to certification training and training is offered infrequently; and Core Service Plan focuses on group services rather than individual-based services.

Improvement Strategies Suggested by Providers: (see Actions Taken below)

Actions Taken: Associated Centers for Therapy (TU region) offers case management to all clients if indicated at admission. Because several clients do not show up for their case management

appointments, but keep their medication clinic appointments, ACT requires individuals to keep appointments with clinicians prior to making a subsequent medication clinic appointment.

Central Oklahoma CMHC (CN region) has filled its staff vacancies with case managers and cost savings in other parts of the agency were shifted to additional case management positions, reducing the case loads and allowing service delivery to all persons with an active case and concentrated services to those individuals with the greatest need.

Jim Taliaferro CMHC's (SW region) outpatient director monitors case manager caseloads and determines which clients have not been seen in the last 90 days. Case managers are scheduling appointments to coincide with medication appointments.

Edwin Fair Community Mental Health Center (NE region) continues to focus on the minimum service threshold established during the downsizing of Eastern State Hospital and has developed a team case management approach covering all counties served.

Performance Improvement Coordinators for DMHSAS-funded agencies engaged in a Problem-Solving Process to determine barriers to case management services for persons with MMI. At their May meeting, they will continue the process to develop possible solutions to increasing case management services to this population.

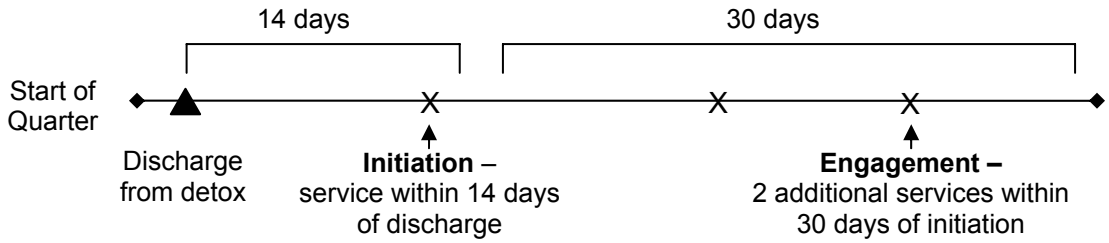
Discussion: Beginning in 2nd Quarter FY04, there were two modifications to the MMI definition. First, the diagnoses included in the MMI definition were modified to more closely match the criteria of the Core Service Plan eligibility criteria (refer to Appendix 4 for explanation of the Core Service Plan). Unspecified bipolar disorders (DSM IV codes 296.00, 296.40, 296.50, 296.60, 296.7) were added and the following disorders were removed: Agoraphobia (300.21), Antisocial Personality Disorder (301.7), and Panic Disorder (300.01). A complete listing of MMI diagnoses is given in Appendix 4, Glossary of Terms, under Major Mental Illness. Further, the inclusion criteria were changed to include only those clients who had a service in the reported quarter, rather than having been active at some time in the past year. This will focus the measures on clients currently receiving treatment and exclude from the measures those clients that have left treatment before the start of the quarter being studied.

Substance Abuse

Measure SA2b: Initiation of Treatment Services Following Detoxification Services

Rationale for measurement: Persons who receive treatment following a detox service are more likely to maintain abstinence.

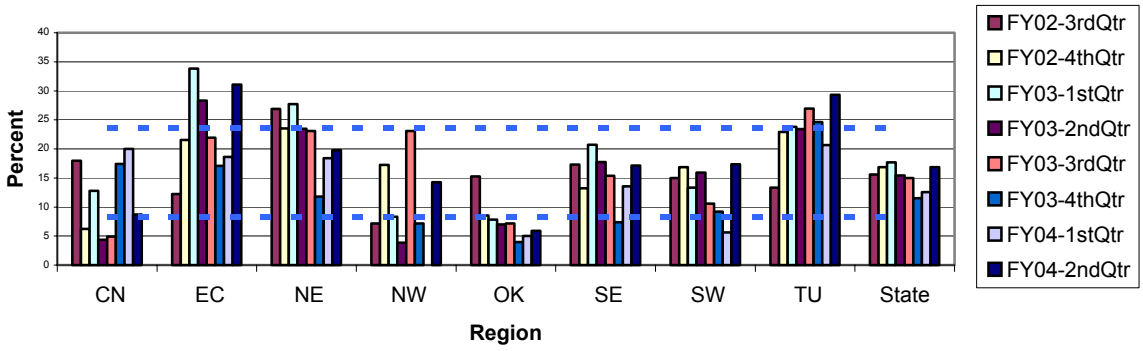
Figure 3: Substance Abuse Treatment - Detox Diagram



Goal: The goal for this indicator is being established. If you have any input concerning this, please contact Jennifer Glover, Clinical Treatment Services Coordinator (JGlover@ODMHSAS.org).

Chart:

Figure 4: Initiation of Substance Abuse Treatment Following a First Detoxification Service



Current Status: Statewide rate: 17%. Highest rate: The EC and TU regions are one standard deviation above the state average at 31% and 29%, respectively. Lowest rate: The OK region is one standard deviation below the state average at 5.9%.

Trends: The statewide rate has increased for the last two quarters, nearly reaching the highest rate (18%) for eight quarters studied. The OK region has been one standard deviation or more below the state average for the last six quarters, although it has shown an increase for the past two quarters.

Responding Providers: One agency, The Referral Center, responded to the Department's request for performance improvement information related to follow-up treatment after detox services.

Positive Influences: Clients who complete detox services and agency's ability to refer to a variety of agencies.

Negative Influences: Staff have had little or no case management training or experience, although case management is their primary responsibility; there are limited resources for state-funded substance abuse treatment; at times, clients are not admitted to state-funded substance abuse treatment facilities until 14

days or more post discharge from Detox; lack of transportation to the facility in which client has been placed; non-DMHSAS-funded programs often require clients to pay for some of the treatment; and lack of documentation as to what extent the above-mentioned issues contribute to barriers to treatment.

Improvement Strategies Suggested by Provides: (see Actions Taken below)

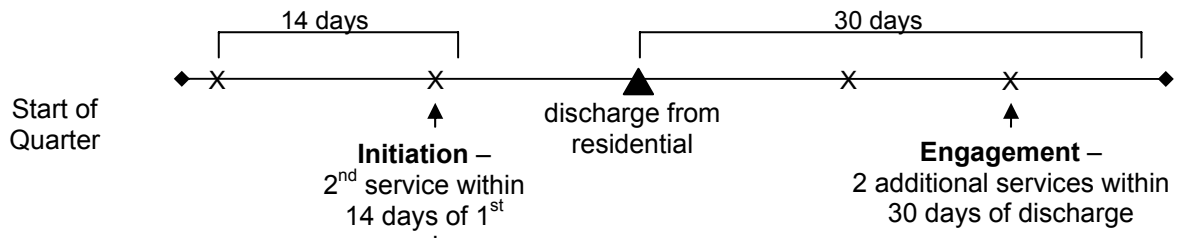
Actions Taken: The Referral Center (TRC) (CN region) has undertaken many initiatives to improve the rate of follow-up for clients referred to DMHSAS-funded agencies. It has been made clear to the staff that TRC is responsible and is being held accountable for our clients after they are discharged until they are in the care of another provider. TRC has reorganized the counseling staff in order to focus more directly on client referral by eliminating the position of Head Counselor. All personnel who are responsible for client care are supervised by the Medical Director. The counselor's primary responsibility will be to complete each client's evaluation and determine level of further care that the client needs according to ASAM criteria (this is accomplished within 48 hours of admission). TRC has established the position of case manager, whose primary responsibility is to refer clients to further substance abuse services. All clients will have case management within 48 hours of admission and all efforts made to refer clients will be documented in writing on the case management worksheet. Other service needs of the client, including transportation, will be addressed by the case managers. TRC will improve the working relationship with agencies to which it refers clients by having face-to-face meetings with the personnel who determine admission to their programs. TRC will cooperate with these agencies in developing methods of facilitating smooth transition of care of mutual clients. The Performance Improvement Supervisor of TRC will develop methods to evaluate the effectiveness of these efforts to discover and document the barriers in implementation.

Discussion: To address agencies' concerns that the low rate of initiation was caused by a lack of substance abuse treatment resources, the DMHSAS examined the relationship between the percentage of persons in need of substance abuse treatment within each region that received a substance abuse service and the percentage of clients that initiated treatment within 14 days of discharge from detoxification (our initiation indicator). The percentage of persons in need of substance abuse treatment within a region that received a service was chosen as the best available measure to indicate the overall availability of substance abuse services in a region. The linear regression model consisted of a dependent variable (percent of clients receiving another substance abuse service within 14 days of discharge from detox), and an independent variable (percent of clients in need of treatment who received treatment). Results from the regression analysis indicate no significant relationship between the dependent and independent variables (Adj. R^2 =0.1015). That is, with the information we had available for analysis, there does not appear to be a relationship between treatment options and the rate of persons initiating treatment after detox.

Measure SA3c: Engagement in Lower Levels of Treatment Following Residential Treatment

Rationale for measurement: The longer persons remain in treatment, the better their outcomes will be.

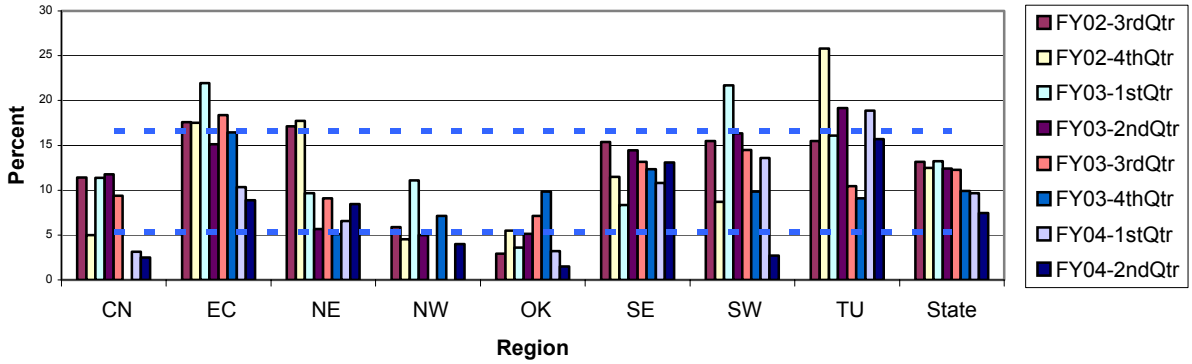
Figure 5: Substance Abuse Treatment – Residential Treatment Diagram



Goal: The goal for this indicator is being established. If you have any input concerning this, please contact Jennifer Glover, Clinical Treatment Services Coordinator (JGlover@ODMHSAS.org).

Chart:

Figure 6: Engagement in Substance Abuse Treatment Following a First Residential Treatment Service



Current Status: Statewide rate: 7.4%. Highest rates: While no region was one standard deviation above the mean, the TU region approached this level at 15.7%. Lowest rates: The CN, NW, OK and SW regions were one standard deviation below the mean, having rates of 2.5%, 4%, 1.5 and 2.7%, respectively.

Trends: Statewide, 2nd Quarter FY04 has the lowest follow-up rate in the eight quarters studied. In the 2nd Quarter FY04, the EC, OK and SW regions showed the lowest rate of follow-up in the past two years and the CN region experienced the second lowest rate.

Responding Providers: One agency, Vinita Alcohol and Drug Treatment Center, responded to the Department's request for performance improvement information related to follow-up treatment after residential treatment.

Positive Influences: (not yet identified)

Negative Influences: Some clients are required to return to jail even though they successfully complete treatment.

Improvement Strategies Suggested by Providers: (see Actions Taken below)

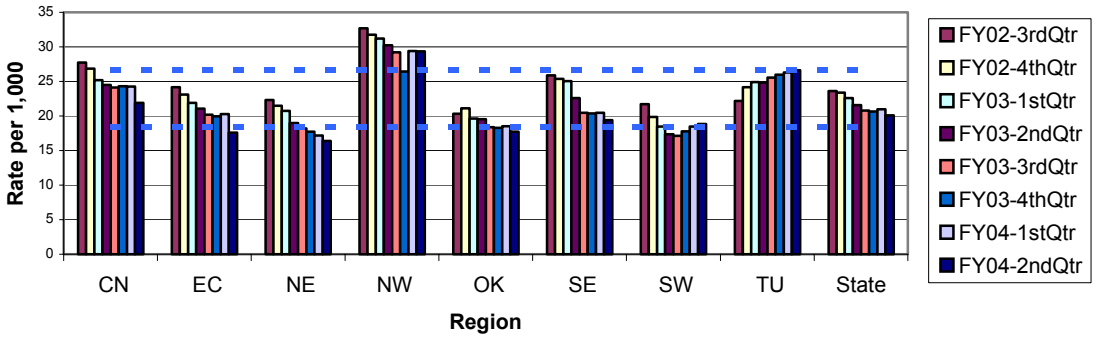
Actions Taken:
Performance Improvement Coordinators for DMHSAS-funded agencies engaged in a Problem-Solving Process to determine barriers to follow-up treatment after residential treatment. At their May meeting, they will continue the process to develop possible solutions to increase follow-up services.

Discussion: (none at this time)

SECTION II: ADDITIONAL INDICATORS

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

Figure 7: Adults Receiving Any ODMHSAS-Funded Mental Health Service in the Quarter
Rate per 1,000 Adults with Household Incomes Below 200% Poverty Level



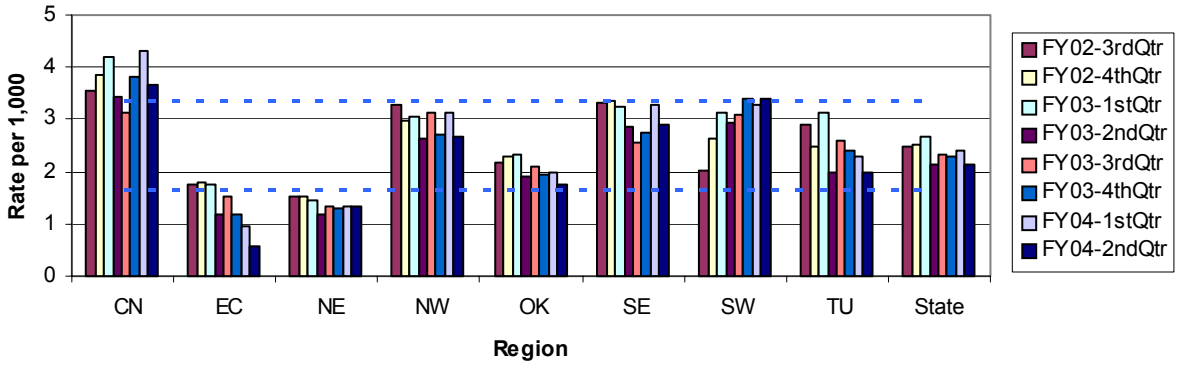
As shown in Figure 7, statewide, 20 of every 1,000 adults in poverty received a DMHSAS-funded mental health service in the 2nd Quarter of FY04 (the focus of this report). The range of adults per 1,000 in poverty that received a service in the prior seven quarters is 21 to 24. There has been a downward trend over the past eight quarters.

Adults in the EC, NE, and OK regions had low utilization of mental health services with rates more than one standard deviation below the state average. In these regions, 18, 16 and 18 adults, respectively, per 1,000 in poverty received a mental health service in the most recent quarter. 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. Five regions (CN, EC, NE, OK, and SE) showed declines in the rate of services provided from the previous quarter, while the TU region utilization rate has steadily climbed for the last eight quarters.

Measure MH2: Adult Mental Health Core Outpatient Services – Indicator Discontinued

Measure MH3: Adult Inpatient Services

Figure 8: Persons Receiving An Inpatient Mental Health Service in the Quarter
Rate per 1,000 Adults with Household Incomes Below 200% Poverty Level



Statewide, 2.1 of every 1,000 adults (21 of every 10,000) in poverty received an inpatient mental health service (in a state hospital or community-based inpatient unit) in the 2nd Quarter of FY04 (Figure 8). This was the lowest rate in the two years. The range for the prior seven quarters was between 2.1 and 2.7 per 1,000.

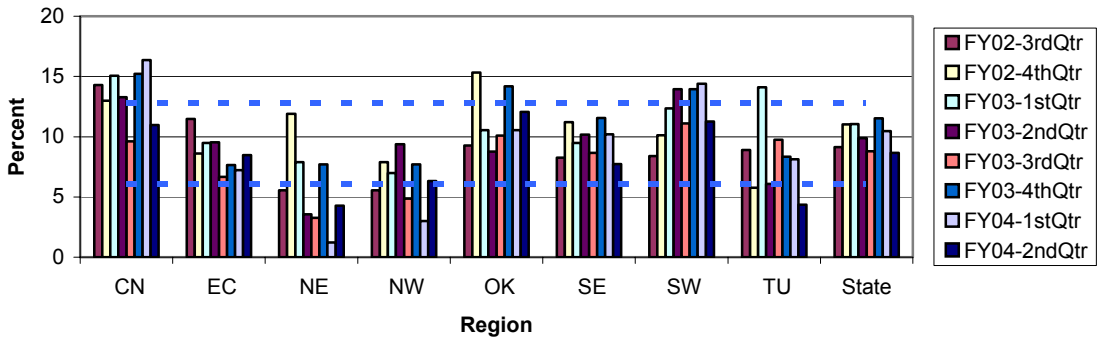
The CN region has had the highest utilization of inpatient services for the past two years, with 3.7 adults per 1,000 in poverty receiving an inpatient service in the 2nd Quarter of FY04. The EC and NE regions trended towards low rates of utilization at 0.6 and 1.3, respectively, per 1,000 adults in poverty. All eight quarters in the NE region were one standard deviation or more below the statewide mean.

Measure MH4: Adult Inpatient Follow-up in Outpatient Care within 7 Days after Discharge – See Section I: Focus Indicators

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

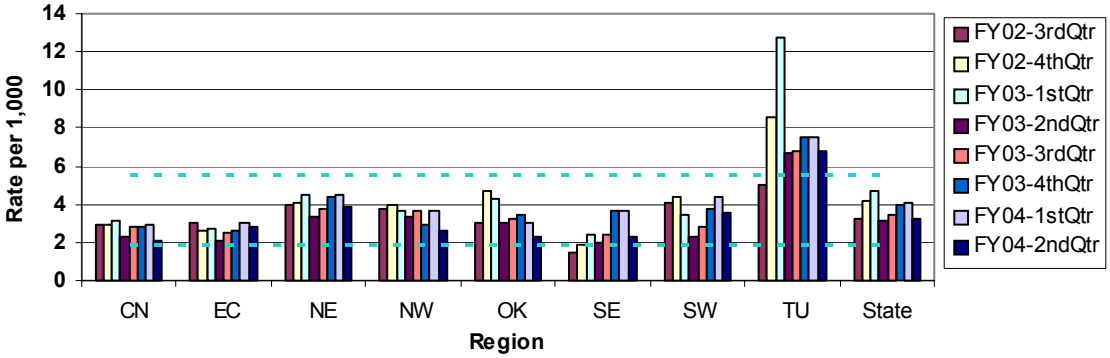
The adult inpatient re-admissions indicator measures the percentage of adults discharged from inpatient care in the quarter who were re-admitted within 30 days following their discharge. Statewide re-admissions ranged between 9% and 12% of discharged inpatient adults for the past two years, with a re-admission rate of 9% in the 2nd Quarter of FY04 (Figure 9). This was the lowest rate in the past two years. The NE and TU regions were more than one standard deviation below the mean at 4% in both regions. None of the regions was more than one standard deviation above the state average.

Figure 9: Adults Discharged from Inpatient Care in the Quarter
Percent Readmitted within 30 Days



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

Figure 10: Adult Face-to-Face Crisis Events during the Quarter
Rate per 1,000 Adults with Household Incomes Below 200% Poverty Level

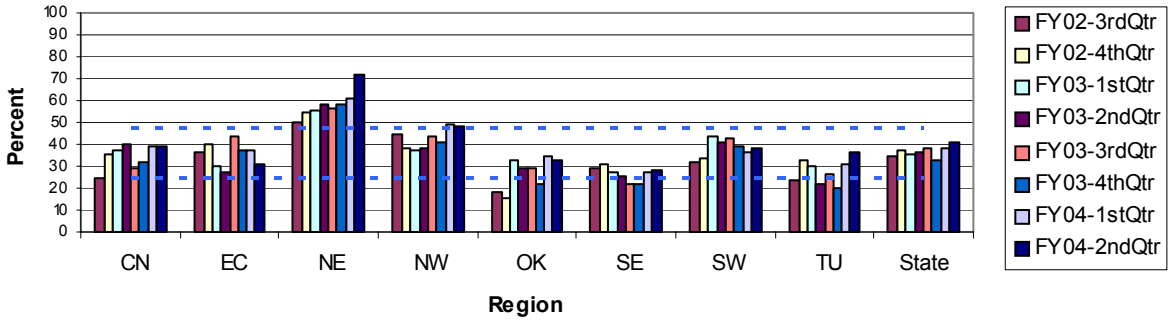


The Adult Mental Health Face-to-Face Crisis indicator measures the rate per 1,000 adults in poverty in each region who received a crisis service in the quarter.

The number of adults with face-to-face mental health crisis services during the 2nd Quarter of FY04 for the state was 3.3 per 1, 000 of the adult population below 200% of the poverty level (Figure 10). The rate fell from the previous quarter and falls within the two-year range of 3.1 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 6.8 for the most recent quarter and has been at least one standard deviation above the state average for the last seven quarters. The remaining regions fell within one standard deviation of the state average for the adult population below 200% of the poverty level.

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

Figure MH11: Adult Mental Health Face-to-Face Crisis Events during the Quarter
Percent Receiving Outpatient Follow-up within Seven Days



For the 2nd quarter of FY04, 41% of all adults with a face-to-face mental health crisis service in the state were seen for a non-crisis outpatient service within the following seven days, (Figure 11). This is the highest rate of crisis follow-up for the eight quarters studied, up from 33% in the 4th Quarter of FY03.

The NE region has the highest rate (72%) for adults with face-to-face crisis events who had outpatient follow-up visits 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 remaining seven regions have rates of follow-up within one standard deviation of the state average for the 2nd Quarter of FY04.

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. 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 in 2nd Quarter FY04, there were two modifications to the MMI definition. First, the diagnoses included in the MMI population were modified to more closely match the criteria of the Core Service Plan eligibility criteria (refer to Appendix 4 for explanation of the Core Service Plan). Unspecified bipolar disorders DSM IV codes 296.00, 296.40, 296.50, 296.60, 296.7 were added and the following disorders were removed: Agoraphobia 300.21, Antisocial Personality Disorder 301.7, and Panic Disorder 300.01. A complete listing of MMI diagnoses is given in Appendix 4, Glossary of Terms, under Major Mental Illness. Further, the inclusion criteria were changed to include only those clients who had a service in the reported quarter, rather than having been active at some time in the past year. This will focus the measures on clients currently receiving

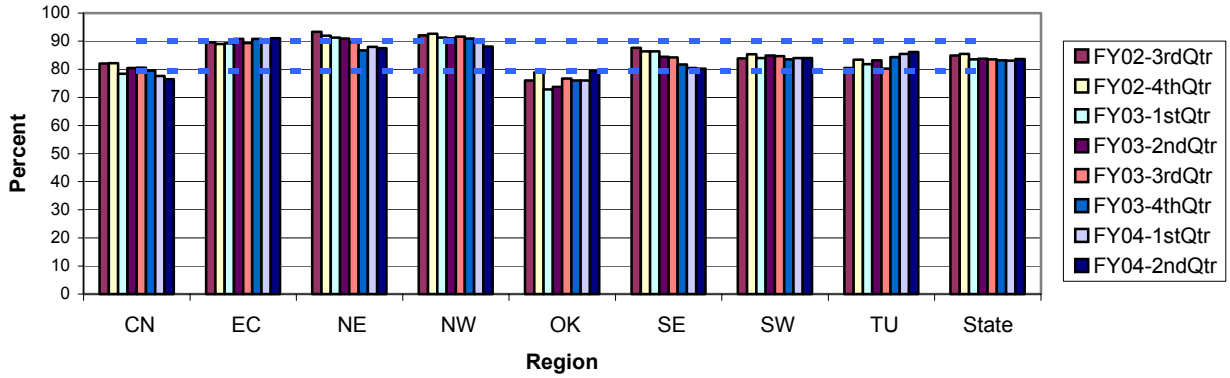
treatment and exclude from the measures those clients that have left treatment before the start of the quarter being studied.

Measure MH8: Adults with MMI Receiving Any DMHSAS-Funded Mental Health Service - Indicator Discontinued

Measure MH9: Adults with MMI Core Outpatient Mental Health Services

About 84% of adults with MMI received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 2nd Quarter of FY04 (Figure 12). This is within the range of 83% and 85% of adults with MMI who received services in the seven prior quarters.

Figure 12: Adults with a Major Mental Illness
Percent Who Received a Core Mental Health Service in the Quarter

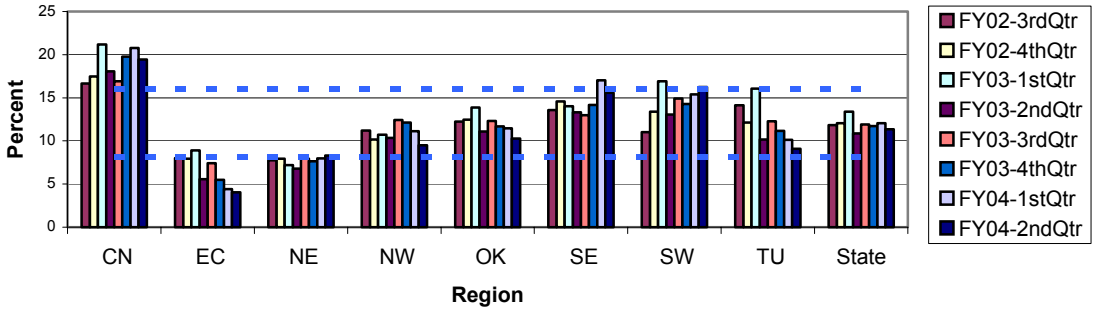


The CN and OK regions have experienced a low percentage of adults with MMI receiving core outpatient services, both below 80% in the 2nd Quarter of FY04. The OK region has been one standard deviation or more below the state average for the eight quarters studied, but had its highest rate in the most recent quarter.

Measure MH10: Adults with MMI Inpatient Services

About 11% of all adults with MMI, statewide, were hospitalized in the 2nd Quarter of FY04 (Figure 13). The range of adults with MMI hospitalized in the prior seven quarters was between 11% and 13%.

Figure 13: Adults with a Major Mental Illness
Percent Who Received an Inpatient Mental Health Service in the Quarter



The CN region's rate of 19% in the 2nd Quarter of FY04 was the highest of any region. The adults with MMI in the EC region have shown a low rate of inpatient hospitalization for the last five quarters, with the lowest rate of 4% in the most recent quarter.

Measure MH11: Adults with MMI Receiving Case Management or Individual Rehab Services - See Section I: Focus Indicators

Measure MH12: Adults with MMI Receiving Independent Housing - Retired

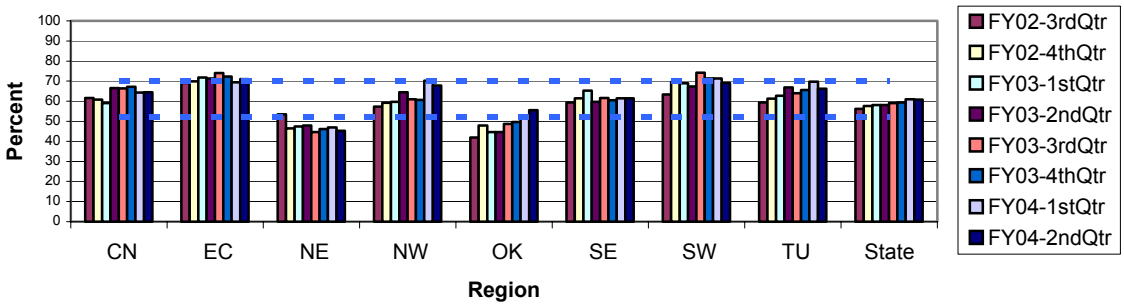
ADULT SELECT PRIORITY GROUP (SPG)

Adult clients with severe mental illness comprise the Select Priority Group (SPG), which was defined to evaluate access to medication services. The diagnoses included in the SPG were broadened beginning with this report to include unspecified bipolar disorders (DSM IV codes 296.00, 296.40, 296.50, 296.60, 296.7). For a complete list of diagnoses, refer to Appendix 4, Glossary of Terms, Select Priority Group. The inclusion criteria were also changed to include only those clients who had a service in the reported quarter, rather than having been active at some time in the prior year. This will focus the measures on clients currently receiving treatment and exclude from the measures clients that have left treatment before the start of the quarter being studied.

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 14: Adults with a Select Priority Group (SPG) Diagnosis
Percent Who Received a Medication Visit in the Quarter



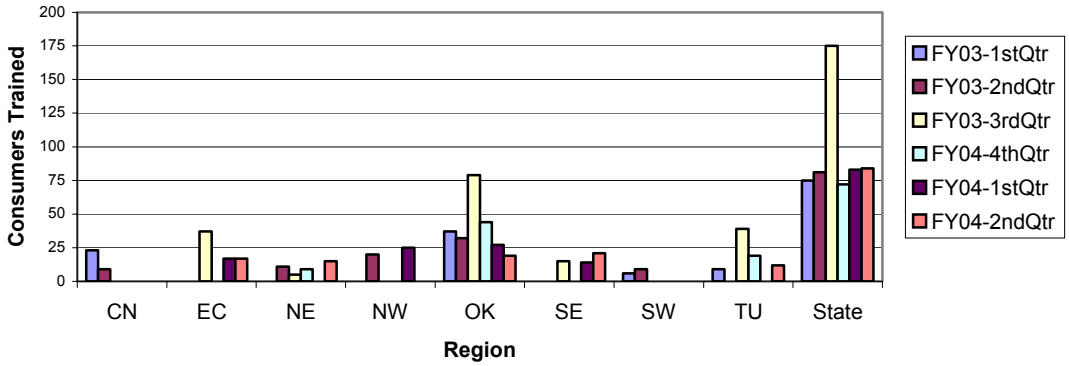
Statewide, 61% of all adults in the SPG received a medication visit in the 2nd Quarter of FY04 (Figure 14). The rate has remained fairly consistent with a range of 56% to 60% in the prior seven quarters. The SW region has had an overall trend toward high rates of medication visits, with 69% occurring in the most recent quarter. The NE region has low percentages of adults in the SPG receiving a medication visit in the last seven quarters measured, with 45% receiving a medication visit in the 2nd Quarter of FY04.

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 DMHSAS. 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 DMHSAS goal is for WRAP to be available in all regions in each quarter. Data reported to DMHSAS for WRAP training does not include participant or client identifiers. Data are currently available for only the last six quarters.

Figure 15: Clients Receiving Illness Self-Management Training
Unduplicated Count by Quarter

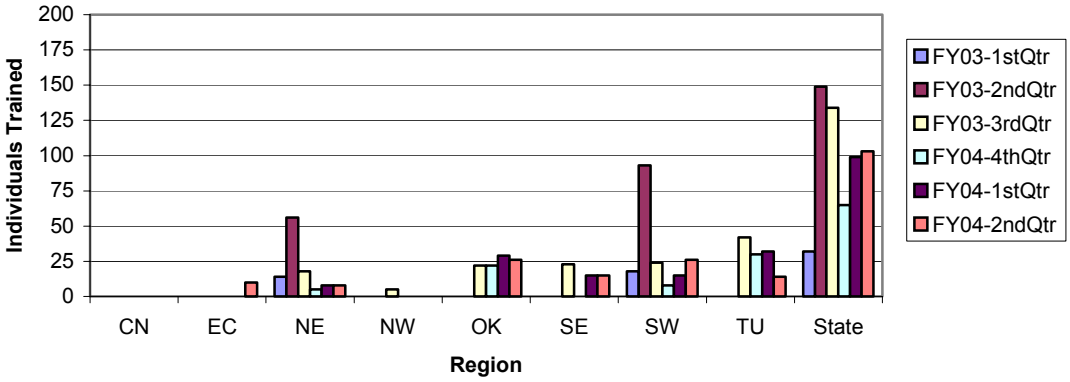


Illness self-management education services were provided to 84 individuals during the 2nd Quarter of FY04, bringing the total participants to 570 (Figure 15). Training was offered in the EC, NE, OK, SE and TU regions for the most recent quarter.

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 DMHSAS. Family-to-Family is a 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 DMHSAS for Family-to-Family training do not include participant or client identifiers. Currently data are available for only the last six quarters.

Figure 16: Family Members Receiving Family-to-Family Training
Unduplicated Count by Quarter



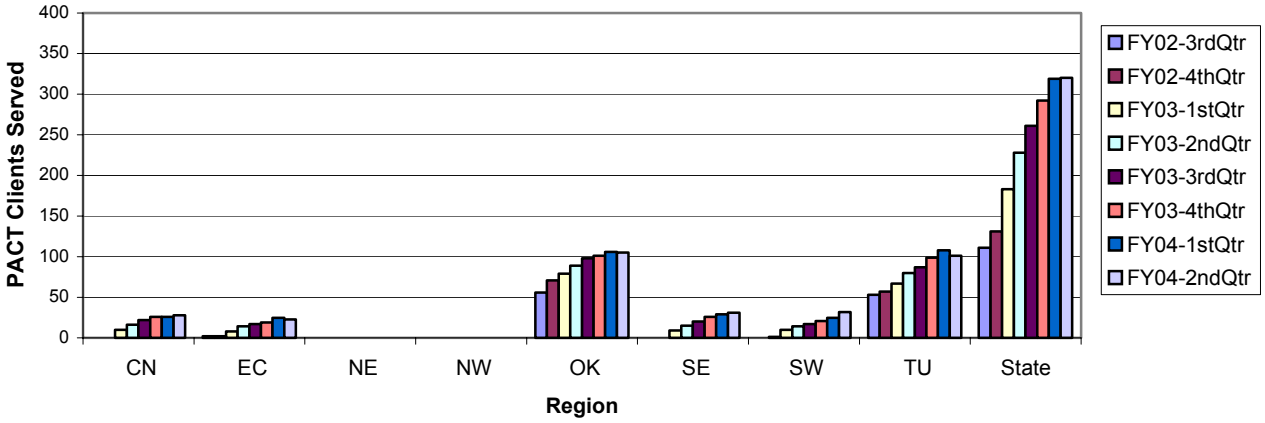
A total of 103 individuals received Family-to-Family training in the 2nd Quarter of FY04, up from 99 individuals trained in the prior quarter (Figure 16). Training sessions were

held in the EC, NE, OK, SE, SW and TU regions during the 2nd Quarter of FY04. To date, training has been provided to 582 individuals.

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 of clients served each quarter is 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 17: Number of Persons Served in PACT by Quarter



As shown in Figure 17, 320 persons were served through the six PACT sites in the 2nd Quarter of FY04. The OK and TU regions provided services to 105 and 101 persons, respectively. The remaining sites are newer and have not reached their maximum capacities (CN region = 28, EC region = 23, SE region = 31, SW region = 32).

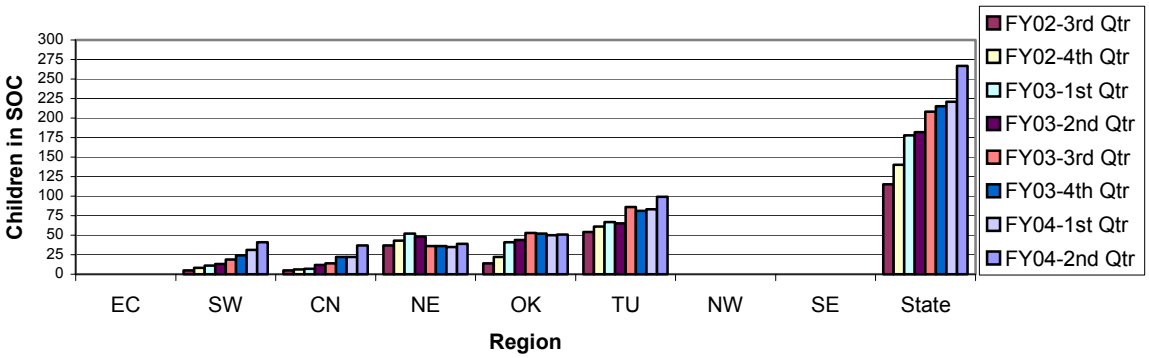
CHILDREN'S SERVICES

Measure MH17: Children's Systems of Care

Systems of Care (SOC) is a promising practice which assists communities in building fully inclusive organized systems of care for families of children who are experiencing a serious emotional disturbance. Currently, there are seven sites located in five regions. Like PACT, it is important that the project sites grow in capacity to ensure access to children and their families. Thus, the number of children served quarterly is monitored.

While there are other SOC programs operating in the state, these data represent only those programs funded through DMHSAS.

Figure 18: Number of Children Served in SOC by Quarter



In 2nd Quarter of FY04, 267 children were served in the SOC sites, the largest number to date (Figure 18). The TU region, which hosts the largest site, served 102 children, followed by 55 children served in the OK region, 35 children served in the NE region, 31 children served in the SW region, and 22 children served in the CN region.

Measure MH18: Children with Any DMHSAS-Funded Mental Health Service – Indicator Discontinued

PERFORMANCE MEASURES - SUBSTANCE ABUSE

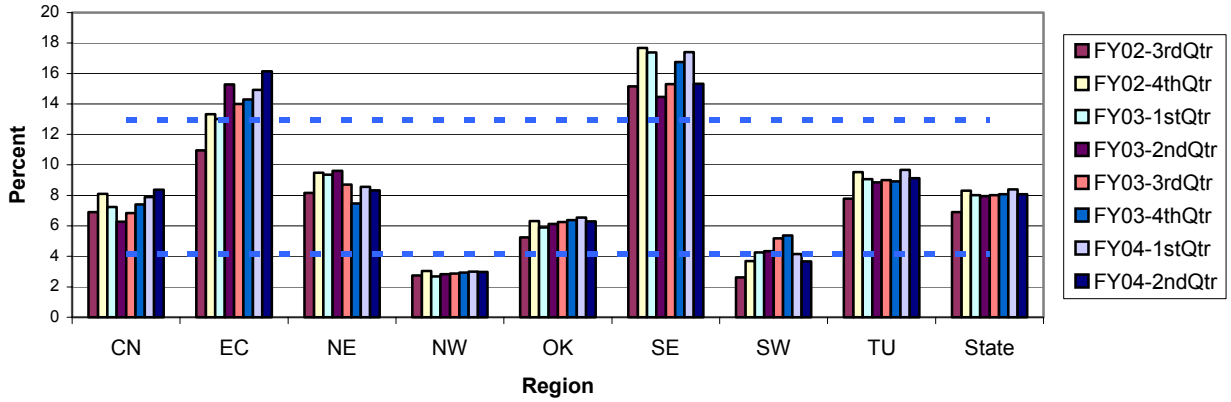
The indicators of substance abuse treatment performance used in this report are measures developed by the Washington Circle with support from the federal Center for Substance Abuse Treatment (CSAT). The indicators' focus on early recognition and intervention can positively affect the course of an individual's 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 3,713 persons identified among those in need of treatment during the 2nd Quarter of FY04. Between 3,314 and 3,899 persons were identified in each of the seven prior quarters. Persons were identified by the first level of substance abuse services they used:

Outpatient – 1,880 clients (51%)
Detoxification – 1,001 clients (27%)
Residential – 735 clients (20%)
Community Living – 97 clients (3%)

Figure 19: Adults in Poverty Estimated to Need Treatment
Percent "Identified" by ReceivingTreatment



Statewide, the percent of the estimated number of adults in need of substance abuse treatment that received a substance abuse service has remained fairly constant for the past eight quarters ranging from 6.9% to 8.4%, with 8% in the most recent quarter (Figure 19).

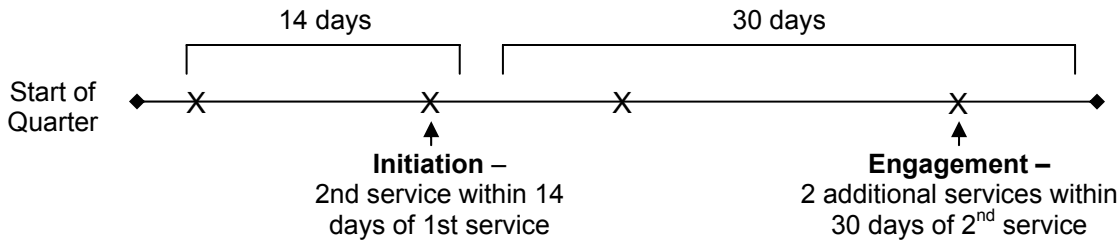
A high percentage of adults with substance abuse problems in the EC and SE regions received a substance abuse service; their rates of identification were more than one standard deviation above the state average in at least seven of the eight quarters measured. A low percentage of adults with substance abuse problems (3%) in the NW region received a substance abuse service in the last quarter. The NW region has been more than one standard deviation below the state average in all eight quarters

measured. The SW region also fell one standard deviation from the state average at 3.7% in the 2nd Quarter of FY04.

Measure SA2a: Initiation Into Outpatient Treatment

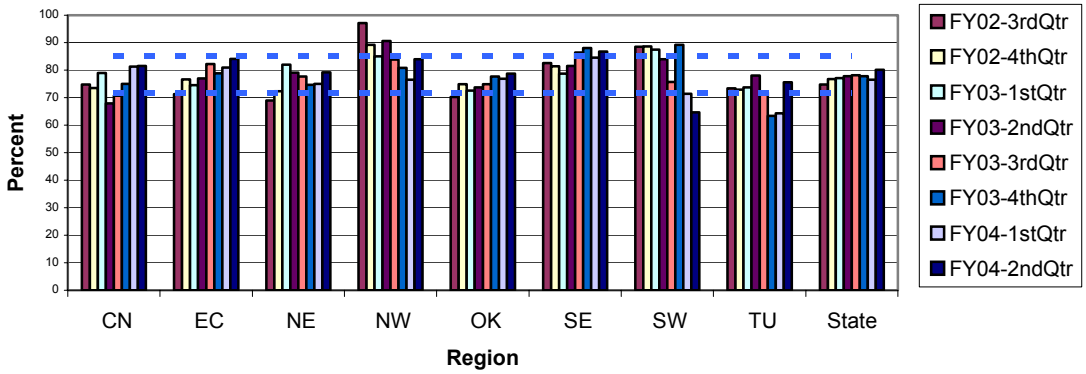
Among those persons who received a first (index) substance abuse service in the quarter (with no services in the past 60 days), initiation rates were calculated based on the level of care in which the persons were first served.

Figure 20: Substance Abuse Treatment - Outpatient Diagram



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

Figure 21: Initiation of Substance Abuse Treatment Following a First Outpatient Service



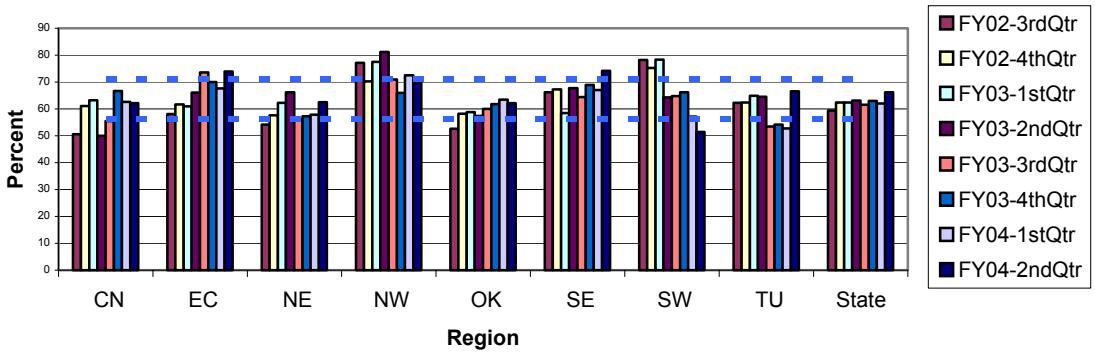
As shown in Figure 21, statewide, 80% of adults with first treatment episodes, who started treatment in outpatient care, initiated treatment (had a second service within 14 days, refer to Figure 20 for diagram). The rate is slightly up from the previous quarter (78%) and the highest percentage in two years. The SE region was one standard deviation above the state average at 87% in the 2nd Quarter of FY04. The SW region

has fallen more than one standard deviation below the state average at 65% in the last quarter.

Measure SA2b: Initiation Following Detox Services – See Section I: Focus Indicators

Measure SA3a: Engagement in Outpatient Treatment

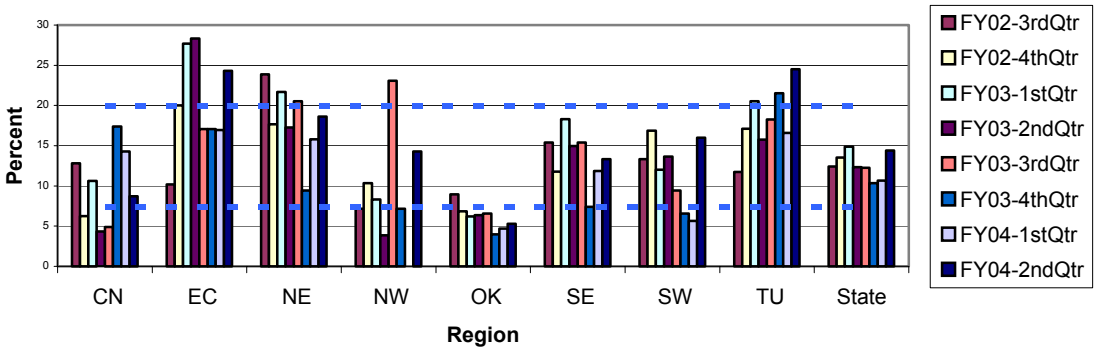
Figure 22: Engagement in Substance Abuse Treatment Following a First Outpatient Service



As shown in Figure 22, during the 2nd Quarter of FY04, 66% 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 – Figure 20). This was up from the previous quarter at 62% that engaged in treatment in the prior quarter and was the highest rate in the past two years. The EC and SE regions were more than one standard deviation above the state average, both at 74% in the 2nd Quarter of FY04. The SW region was more than one standard deviation below the state average at 52%.

Measure SA3b: Engagement Following Detox Services

Figure 23: Engagement in Substance Abuse Treatment Following a First Detoxification Service



Of the clients who started treatment with detoxification services, 14.4% 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 (refer to Figure 3, page 11). This rate of engagement was up from the prior four quarters (Figure 23). The EC and TU regions jumped to more than one standard deviation above the state average, both at 24%. The OK region was more than one standard deviation below the state average at 5%.

Measure SA3c: Engagement Following Residential Treatment – See Section I: Focus Indicators

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 – The Department policies for Provider Certification have been approved and initial meeting of the Performance Improvement Council has been held, at which the RPM Report and review cycle were described. Submitting future RPM reports to the Council and incorporating their feedback will be an element of future council meetings. RPM reports now submitted quarterly to OCARTA, OMHCC and NAMI-OK with a request for feedback.

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 DMHSAS-funded service providers. DMHSAS will rely on stakeholder feedback to develop provider opinion measures that will be meaningful and track useful data over time and between regions.

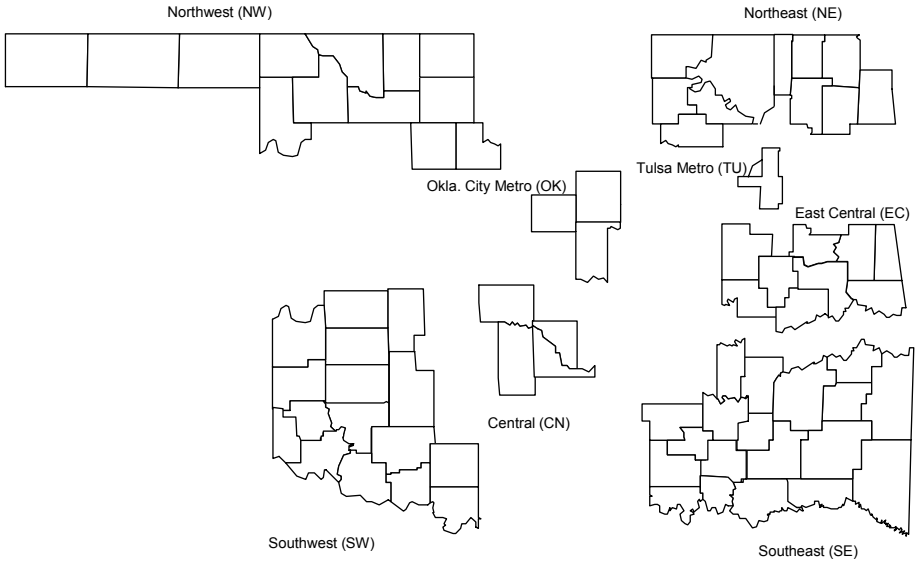
Appendix 1: Selection of Indicators

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 DMHSAS 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 DMHSAS 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.

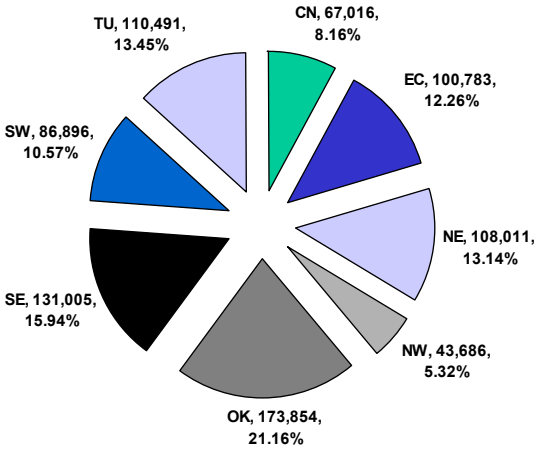
Future Development. System stakeholders were involved in previous indicator development processes, and as stakeholders express their perspectives regarding the utility of the selected RPM report indicators, or as system improvements make monitoring an indicator less important, it is likely other indicators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

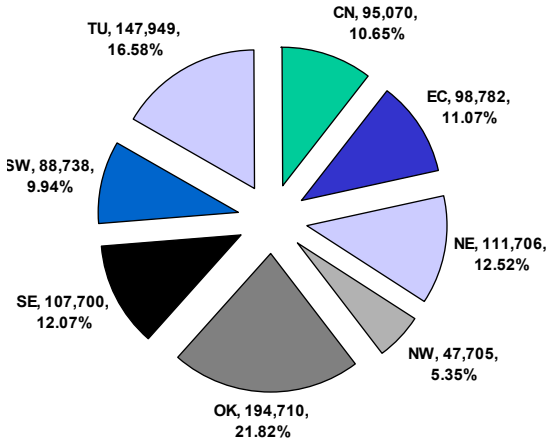
Appendix 2: RPM Report Indicator Definitions

Background: A household income below the 200% of poverty threshold* has been established as an eligibility requirement for receipt of most DMHSAS 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 DMHSAS 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 DMHSAS-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 a DMHSAS-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 DMHSAS 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 DMHSAS-funded Mental Health Service – The rate of people, 18 years or older, who received any mental health service from a DMHSAS-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), unspecified bi-polar disorders, psychotic disorder, post traumatic stress disorder, obsessive/compulsive 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 DMHSAS-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 DMHSAS-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 X 100.

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 a DMHSAS-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 DMHSAS 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 DMHSAS-Funded Mental Health Service -- The rate of children who received any mental health service from a DMHSAS-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 DMHSAS-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.

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.

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.

Numerator: Adults who initiated service after discharge from detox service during the quarter who

received two more services within 30 days of service initiation.

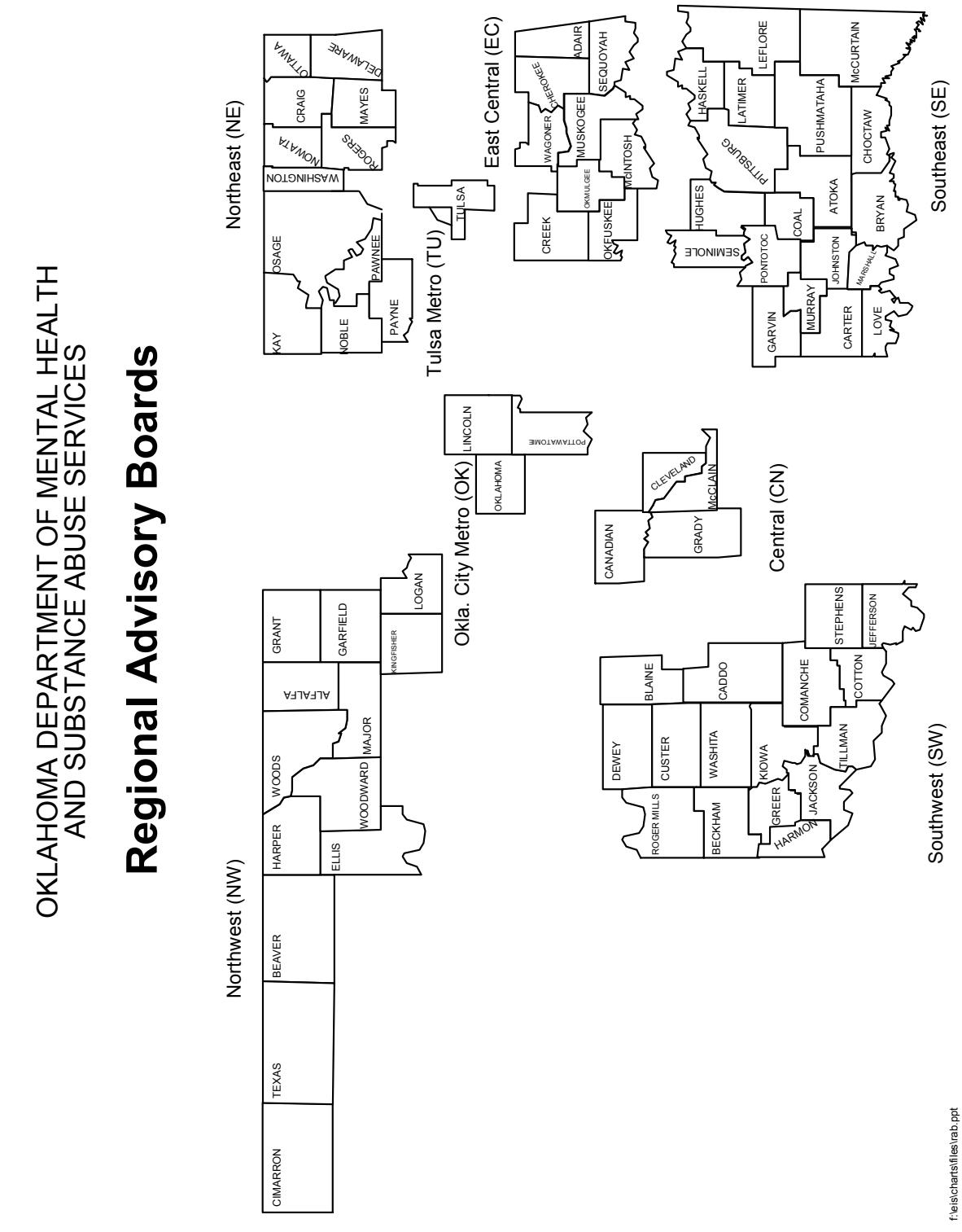
Denominator: Adults who initiated service following discharge from detox service during the quarter.

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*.

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 DMHSAS 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 were diagnosed with one of the following disorders:

- schizophrenia, disorganized (295.10)
- schizophrenia, catatonic type (295.20)
- schizophrenia, paranoid type (295.30)
- schizophrenia, residual type (295.60)
- schizophrenia, undifferentiated (295.90)
- schizoaffective disorder (295.70)
- bipolar NOS (296.80)
- bipolar, depressed, unspecified (296.50)
- bipolar, manic, unspecified (296.40)
- bipolar, mixed, unspecified (296.60)
- bipolar, most recent episode unspecified (296.7)
- bipolar I, single, manic, unspecified (296.00)
- bipolar, manic, with psychotic features (296.44)
- bipolar, mixed, with psychotic features (296.64)
- bipolar, depressed, with psychotic features (296.54)
- bipolar, depressed, with no psychotic features (296.53)
- bipolar I, single, manic, with psychotic features (296.04)

- bipolar I, single, manic, with no psychotic features (296.03)
- bipolar, manic, severe, with no psychotic features (296.43)
- bipolar, mixed, severe, with no psychotic features (296.63)
- depressive mood disorder NOS (311)
- mood disorder NOS (296.90)
- major depression, reoccurring, severe, with psychotic features (296.34)
- major depression, reoccurring, severe, with no psychotic features (296.33)
- major depression, single, with no psychotic features (296.23)
- major depression, with psychotic features (296.24)
- psychotic disorder NOS (298.9)
- post traumatic stress disorder (309.81)
- dissociative identity disorder (300.14)
- borderline personality (301.83)
- paranoid personality (301.0).

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. DMHSAS 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 DMHSAS 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 with one of the following diagnoses:

- schizophrenia, disorganized (295.10)
- schizophrenia, paranoid type (295.30)
- schizophrenia, residual type (295.60)
- schizophrenia, undifferentiated (295.90)
- schizoaffective disorder (295.70)
- major depression, reoccurring, severe, with psychotic features (296.34)
- major depression, reoccurring, severe, without psychotic features (296.33)
- major depression, single episode, severe without psychotic features (296.23)
- major depression, single episode, severe with psychotic features (296.24)
- bipolar, depressed, unspecified (296.50)
- bipolar, manic, unspecified (296.40)
- bipolar, mixed, unspecified (296.60)
- bipolar, most recent episode unspecified (296.7)
- bipolar I, single, manic, unspecified (296.00)
- bipolar, manic, with psychotic features (296.44)
- bipolar, mixed, with psychotic features (296.64)

- bipolar, depressed, with psychotic features (296.54)
- bipolar, depressed, with no psychotic features (296.53)
- bipolar I, single, manic, with psychotic features (296.04)
- bipolar I, single, manic, with no psychotic features (296.03)
- bipolar, manic, severe, with no psychotic features (296.43)
- bipolar, mixed, severe, with no psychotic features (296.63)
- psychotic disorder NOS (298.9)

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
DMHSAS – 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: Adult Clients Served by Provider by Region for 2nd Quarter FY04

Mental Health Agencies

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
ASSOCIATED CENTERS FOR THERAPY, INC.			2			2		880	1	885
BILL WILLIS INPATIENT		58				1		1	1	61
BILL WILLIS MENTAL HEALTH		1030	15			1	1	11	20	1078
CARL ALBERT C.M.H.C.	1	25	1		1	1300		1	2	1331
CENTER FOR CHILDREN & FAMILIES	79				25	1			6	111
CENTRAL OKLAHOMA CMHC	880			1	101	3			3	988
CREOKS MENTAL HEALTH SERVICES	1	485			14	5	1	1	1	508
CROSSROADS INCORPORATED			1		1			77		79
EDWIN FAIR CMHC		1	669	5	2	1		1	3	682
FAMILY & CHILDREN'S SERVICES		2	2	1				1489	2	1496
GRAND LAKE M.H.C.		2	1152				1	4	7	1166
GREEN COUNTRY BEHAVIORAL HEALTH SERVICES, INC.		555	1		2	5	1		5	569
GRIFFIN MEMORIAL HOSPITAL	253	8	20	22	274	171	9	28	12	797
HOMINY HEALTH SRVCS CTR INC.			10					1		11
HOPE COMMUNITY SERVICES, INC.	3	1			549					553
JIM TALIAFERRO CMHC	29	1	2		5	5	1205	1	15	1263
M.H. SERVICES OF SOUTHERN OKLAHOMA		7	1	3	4	1285	6		13	1319
NORTH CARE CENTER	66	3			1479	1	1		68	1618
NORTHWEST CENTER FOR BEHAVIORAL HEALTH	10	6	42	1423	44	18	88	2	24	1657
OKLAHOMA COUNTY CRISIS INTERVENTION CENTER	29	2	16	13	352	7	3	4	12	438
OKLAHOMA FORENSIC CENTER	19	17	16	8	57	26	25	33	1	202
OKLAHOMA YOUTH CENTER	34	1	3	1	26	16	9	3		93
RED ROCK BEHAVIORAL HEALTH SVC	612	3	1	13	695	90	549	109	28	2100
SAFE HAVEN		2						47		49
SOUTHWEST RETIREMENT HOME, INC							28			28
THUNDERBIRD CLUBHOUSE	83				4					87
TRANSITION HOUSE INC.	11				1					12
TULSA CENTER FOR BEHAVIORAL HEALTH		4	4		3	1		347	1	360
TULSA METROPOLITAN MINSTRY			1					242		243

Substance Abuse Agencies

Agency Names	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
12 & 12, INC.		37	29	1	8	8	2	357	1	443
ADA AREA CHEMICAL DEP. CTR						33				33
ALPHA II, INC.		14	14	1	1	2		1		33
BILL WILLIS MENTAL HEALTH	1	186	5			4	7	12	2	217
BRIDGEWAY			16							16
BROADWAY HOUSE, INC.	2		2	2	3	15	3		1	28
CAA TURNING POINT	16		1		188		1			206
CARE FOR CHANGE INC.					101					101
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
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			31							31
FAMILY & CHILDREN'S SERVICES								15		15
FAMILY CRISIS CTR, INC.						42				42
FOCUS		30								30
GATEWAY TO PREVENTION/RECOVERY		6			129	7	1			143
HOMINY HEALTH SRVCS CTR INC.			47							47
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
KIAMICHI COUNCIL ON ALCOHOLISM				1		236	1		1	239
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	4	2		2	108	10		2	131
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
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	74	19	19	5		163
NORMAN ALCOHOL INFORMATION CTR	189	2			13	12				216
NORTH CARE CENTER					37					37
NW SUBSTANCE TREATMENT CNTR	1	2	1	2	3	7	8			24
OKLAHOMA FAMILIES FIRST, INC.						24				24
OPPORTUNITIES, INC., CDTC	9	1	1	13	26	6	37	2	1	96
PALMER DRUG ABUSE PROGRAM INC.								3		3

Agency Names	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
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	10		1	1	34	2	22			70
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
SHEKINAH COUNSELING SERVICES				1		63				64
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	3	69
THE OAKS REHAB. SERVICES CTR	3	71	2	1	4	194	3			278
THE REFERRAL CENTER	29	3	12	16	310	39	24	4	4	441
TOTAL LIFE COUNSELING					102					102
TRI-CITY YOUTH & FAMILY CENTER	56				66					122
TRI-CITY SUBSTANCE ABUSE CTR					1	107	1	1		110
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

Appendix 7: Background and Intent of the Regional Performance Management Report

Background. The Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) 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 Appendix 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, Director of Community Based Services (405-522-3849, jhudgens@DMHSAS.org) or Jennifer Glover, Abuse Clinical Treatment Services Coordinator, (405-522-2347, jglover@DMHSAS.org) or Jan Savage, Performance Improvement Coordinator, (405-522-5379, jsavage@DMHSAS.org).