Oklahoma Department of Mental Health And Substance Abuse Services

Regional Performance Management Report

Report for Third Quarter of FY2004

Reported May 2004 By DMHSAS Decision Support Services

http://www.odmhsas.org/statisticsother.htm

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Regional Performance Management Report
For 3rd Quarter of FY2004

Overview of the 3rd Quarter of FY04.

Mental Health Treatment:
The statewide rate of outpatient follow-up within seven days of discharge from inpatient treatment (measure MH4) fell slightly from the previous quarter from 41% to 39%. This is the lowest rate of the eight quarters studied. Three of the regions (NE, NW and SW) showed an improvement in outpatient follow-up following an inpatient episode in the most recent quarter.

For measure MH11, the rate of adults with a major mental illness (MMI) receiving case management or individual rehabilitation services increased slightly statewide from 46% to 47%, the highest rate for the eight quarters studied. Seven of the eight regions (CN, EC, NW, OK, SE, SW, and TU) showed an improvement in the percent of clients receiving case management or individual rehab services.

Substance Abuse Treatment:
The percentage of clients initiating treatment within 14 days of discharge from detox services, statewide, increased from the lowest rate of 14% in the 4th quarter of FY03 to 21% in the current quarter. This is the highest rate for the two years under study. Two of the eight regions (CN and OK), which had shown low rates in the previous quarter, demonstrated substantial increases in the most recent quarter studied.

Engagement into a lower level of care following discharge from residential treatment rose from 8.3% to 9%, statewide. Five of the regions (CN, NE, OK, SW and TU) increased their rate of engagement in the current quarter.

SECTION I – FOCUS INDICATORS

Mental Health

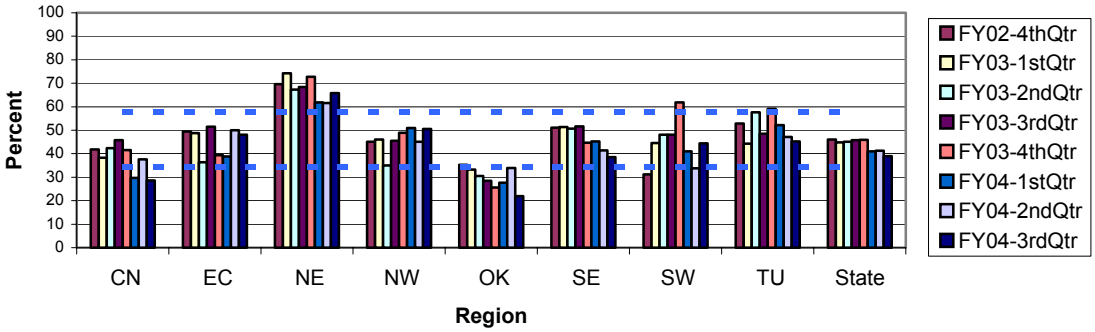
Measure MH4: Adult Inpatient Follow-up in Outpatient Care within 7 Days after Discharge *(for adults referred within the DMHSAS system or transferred within a single agency)*

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 discussions will be held in the fall to set targets and strategies for each goal.

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: 39%. Highest rate: NE region at 66% (more than one standard deviation above the state average). Lowest regions: CN with 29% and OK with 22% (both more than one standard deviation below the state average).

Trends: Statewide, the 3rd Quarter of FY04 decreased slightly from the 1st and 2nd quarters of FY04, and is the lowest rate for the eight quarters studied, with the highest statewide rate being 46%. The inpatient follow-up rates in the NE region were above the state average for all eight quarters. The OK region has consistently been at least one standard deviation below the state average for all eight quarters studied.

Responding Providers: HOPE Community Services and Grand Lake Mental Health Center.

Positive Influences: (previously reported by providers)

- Training and emphasis on follow-up associated with monitoring the closing of civil beds at the former Eastern State Hospital
- Communication protocols between inpatient and outpatient providers regarding discharges
- Contacting clients and setting up appointments before they leave inpatient care

Negative Influences: (previously reported by providers)

- Clients admitted under an involuntary status
- Clients may not feel ready for discharge
- Client may 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 do not reflect actual percent of clients followed up within seven days
- No reliable contact information, e.g., disconnected phone, for clients who do not show up for an appointment

Improvement Strategies Suggested or Actions Taken 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
- Attempt phone contact in either of these categories for individuals who do not show for appointments; develop a priority system to ensure appropriate follow-up for clients who do not show up for their appointments
- Require 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
- Establish a liaison at the inpatient facility who facilitates discharges

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.

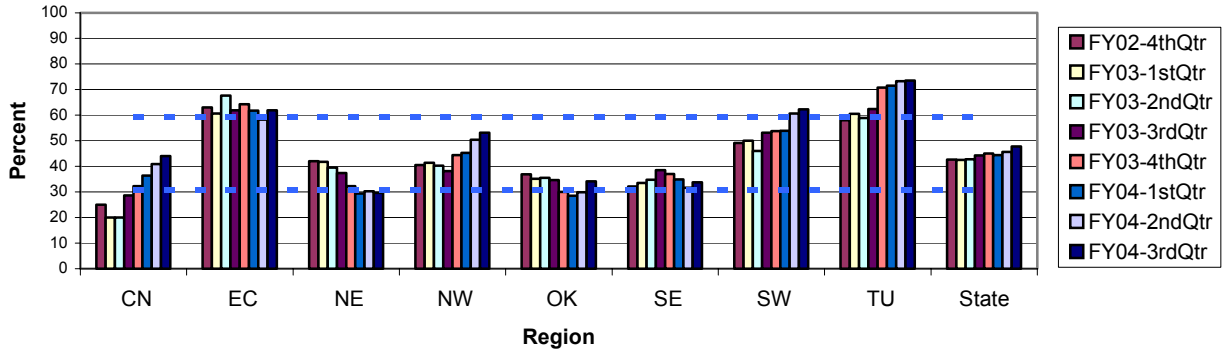
Measure MH11: Adults with MMI Receiving Case Management or Individual Rehabilitative Services *(active at the facility during the quarter studied)*

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 discussions will be held in the fall to set targets and strategies for each goal.

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: 47%. Highest rates: The EC, SW and TU regions were one standard deviation above the mean at 62%, 62% and 73%, respectively. Lowest rates: The NE region was more than one standard deviation below the mean at 30%.

Trends: The CN, NW, SW and TU regions, as well as the state overall, have all demonstrated rising rates for at least four of the past five quarters. The NE region has declined over the past two years, but has leveled off for at least the last three quarters.

Responding Providers: HOPE Community Services and Grand Lake Mental Health Center.

Positive Influences: (previously reported by providers)
- Scheduling medication clinics more often to continue engagement with clients

Negative Influences: (previously reported by providers)
- Historical emphasis of facility on clinic-based, individual therapy services
- Small numbers of case management positions and high case loads of all providers
- 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
- Core Service Plan focuses on group services rather than individual-based services

Improvement Strategies Suggested or Actions Taken by Providers:
- Offer case management to all clients if indicated at admission
- Require individuals to keep case management appointments prior to making a subsequent medication clinic appointment. Schedule case management appointments to coincide with medication appointments.
- Fill staff vacancies with case managers, concentrate services to those individuals with the greatest need

- Have outpatient director monitor case manager caseloads and determine which clients have not been seen in the last 90 days
- Focus on the minimum service threshold established during the downsizing of Eastern State Hospital
- Develop a team case management approach covering all counties served

Discussion: A provider suggested adding a footnote to the indicator stating that some CMHCs may provide other services that are effective and efficient as the codes included in the measure, such as individual counseling, group counseling, and group rehabilitative treatment.

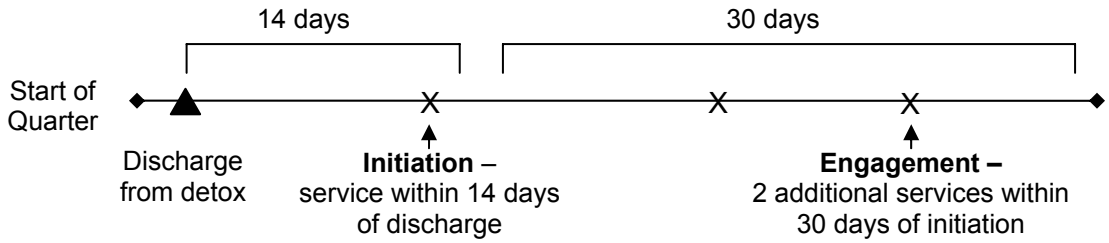
Beginning in 3rd Quarter FY04, there were two modifications to the MMI definition. First, the diagnoses included in the MMI definition were modified to more closely match the criteria of the Core Service Plan eligibility criteria (refer to Appendix 4 for explanation of the Core Service Plan). Unspecified 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.

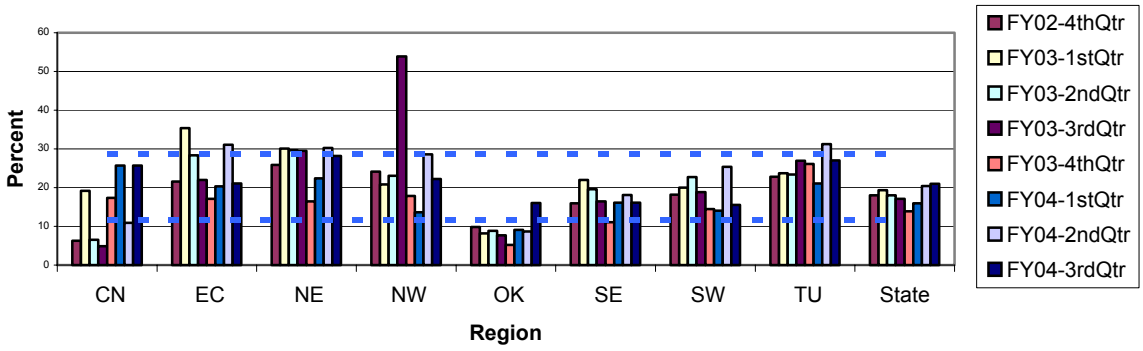
Figure 3: Substance Abuse Treatment - Detox Diagram



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: 21%. Highest rate: All eight regions were within one standard deviation of the two-year state average.

Trends: The statewide rate has increased for the last three quarters, reaching the highest rate for eight quarters studied. The OK region rate, which had been one standard deviation or more below the state average for the last seven quarters, increased to within one standard deviation of the statewide average.

Responding Providers: The Referral Center.

Positive Influences: (previously reported by providers)

- Clients who complete detox services
- Agency's ability to refer to a variety of agencies

Negative Influences: (previously reported by providers)

- Staff have had little or no case management training or experience, although case management is their primary responsibility
- 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
- Lack of documentation as to what extent the above-mentioned issues contribute to barriers to treatment

Improvement Strategies Suggested or Actions Taken by Providers:

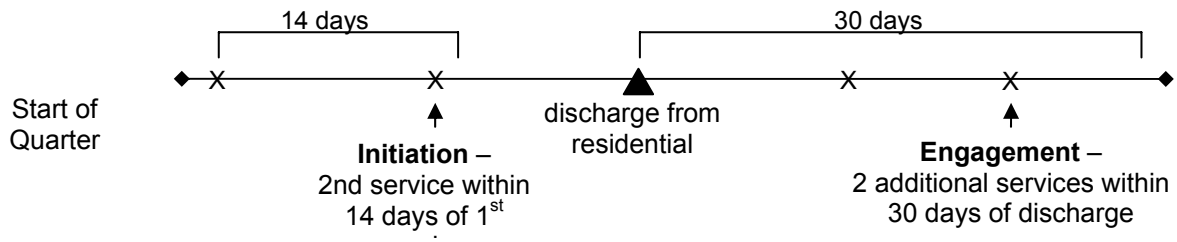
- Staff is held accountable for clients after they are discharged until they are in the care of another provider
- All personnel responsible for client care are supervised by the Medical Director
- Counselor's primary responsibility is to complete each client's evaluation and determine level of further care that the client needs according to ASAM criteria (accomplished within 48 hours of admission)
- Establish the position of case manager, whose primary responsibility is to refer clients to further substance abuse services
- All clients have case management within 48 hours of admission and all efforts made to refer clients are documented in writing on the case management worksheet
- Service needs of the client, including transportation, are addressed by the case managers
- Improve the working relationship with agencies to which clients are referred by having face-to-face meetings with the personnel who determine admission to their programs
- Develop methods to evaluate the effectiveness of performance improvement efforts to discover and document the barriers

Discussion: To determine whether 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). Based on the analysis of available data, no relationship was found 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.

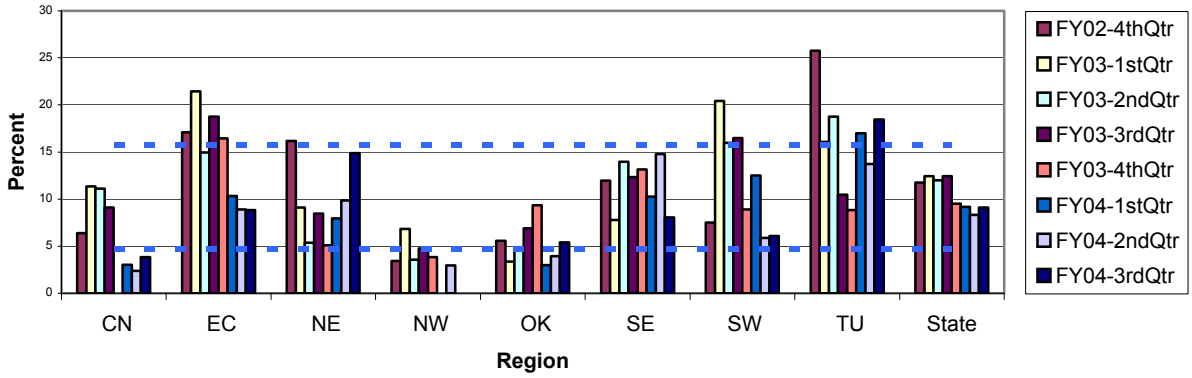
Figure 5: Substance Abuse Treatment – Residential Treatment Diagram



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: 9%. Highest rates: The TU region was one standard deviation above the mean at 18.5%. Lowest rates: The CN and the NW regions were one standard deviation below the mean, having rates of 3.8% and 0%, respectively.

Trends: Statewide, 3rd Quarter FY04 increased slightly from the lowest follow-up rate in the eight quarters studied which was observed in the previous quarter. In the 3rd Quarter FY04, the EC and NW regions had their lowest rates of follow-up in the past two years.

Responding Providers: The Referral Center.

Positive Influences: (not yet identified)

Negative Influences: (previously reported by providers)

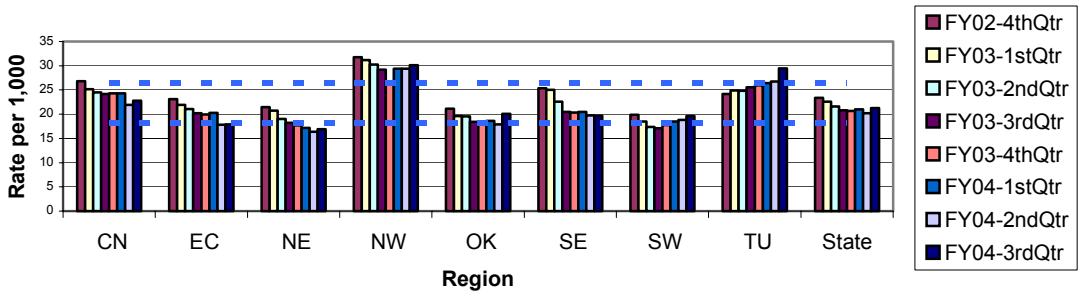
- Some clients are required to return to jail even though they successfully complete treatment

Improvement Strategies Suggested or Actions Taken by Providers: (none at this time)
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



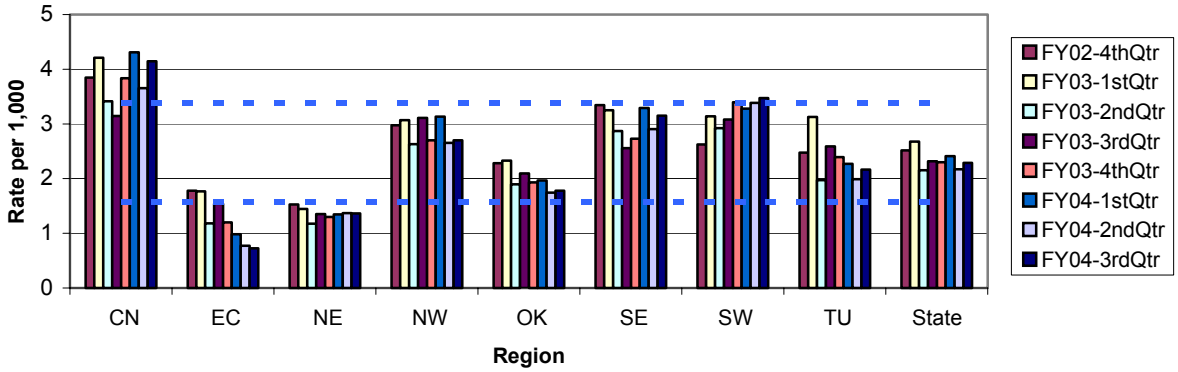
As shown in Figure 7, statewide, 21 of every 1,000 adults in poverty received a DMHSAS-funded mental health service in the 3rd Quarter of FY04. The range of adults per 1,000 in poverty that received a service in the prior seven quarters is 20 to 23. There was a downward trend in the first four quarters but the rate has leveled out in the most recent four quarters.

Adults in the EC and NE regions had low utilization of mental health services with rates more than one standard deviation below the state average. In these regions, 17 and 18 adults, respectively, per 1,000 in poverty received a mental health service in the most recent quarter. The NW and TU regions both served 30 adults per 1,000 in poverty, and were more than one standard deviation above the state average. The NW region has been one standard deviation above the average for all eight quarters studied. Two regions (EC and SE) have shown declines in the rate of services provided over the last eight quarters, 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



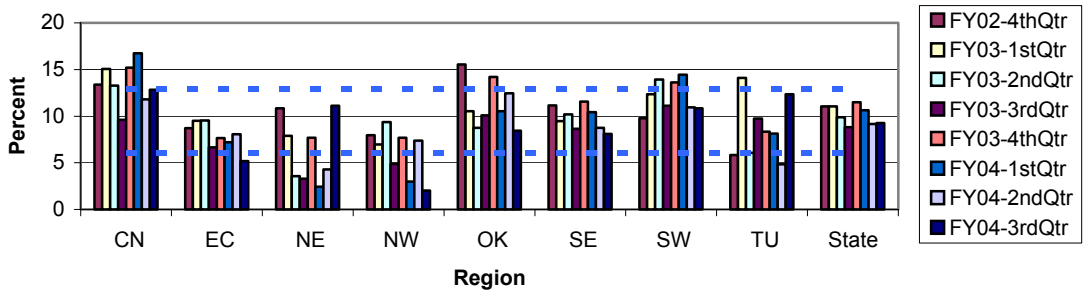
Statewide, 2.3 of every 1,000 adults (23 of every 10,000) in poverty received an inpatient mental health service (in a state hospital or community-based inpatient unit) in the 3rd Quarter of FY04 (Figure 8). The range for the prior seven quarters was between 2.2 and 2.7 per 1,000.

The CN and SW regions have had high utilization of inpatient services for the past two years, with 4.1 and 3.5 adults per 1,000 in poverty receiving an inpatient service in the 3rd Quarter of FY04. The EC and NE regions trended towards low rates of utilization at 0.7 and 1.4, 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

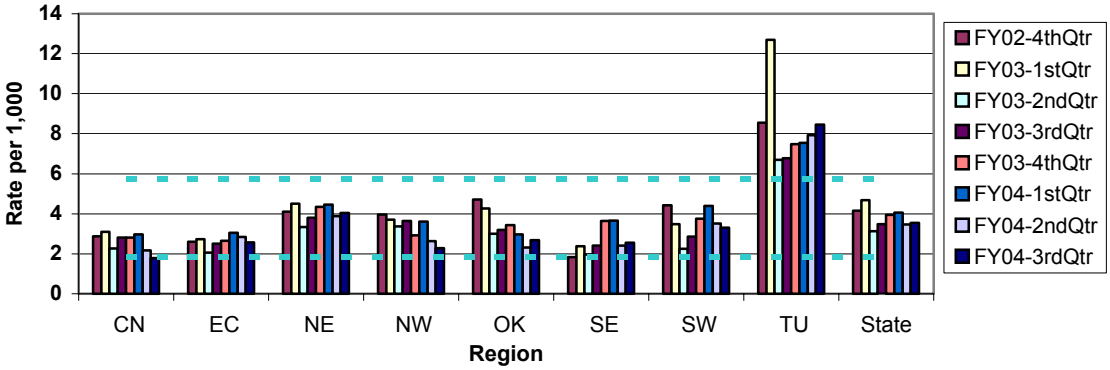
Figure 9: Adults Discharged from Inpatient Care in the Quarter
Percent Readmitted within 30 Days



The adult inpatient re-admissions indicator measures the percentage of adults discharged from inpatient care in the quarter who were re-admitted within 30 days following their discharge. Statewide re-admissions ranged between 8.8% and 11.5% of discharged inpatient adults for the past two years, with a re-admission rate of 9.3% in the 3rd Quarter of FY04 (Figure 9). The EC and NW regions were more than one standard deviation below the mean at 2% and 5.2%, respectively. None of the regions was more than one standard deviation above the state average.

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

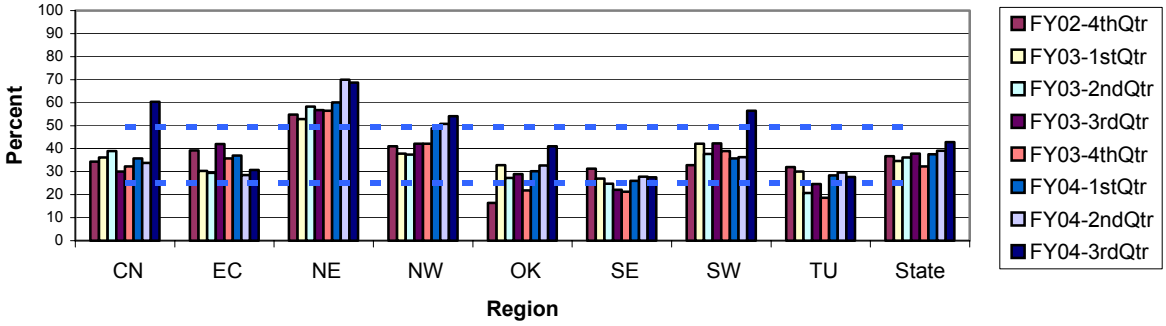
Figure 10: Adult Face-to-Face Crisis Events during the Quarter
Rate per 1,000 Adults with Household Incomes Below 200% Poverty Level



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 3rd Quarter of FY04 for the state was 3.5 per 1,000 of the adult population below 200% of the poverty level (Figure 10). The rate rose slightly 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 8.5 for the most recent quarter and has been at least one standard deviation above the state average for all eight quarters. The CN region fell one standard deviation below the state average for the adult population below 200% of the poverty level with a rate of 1.8.

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 3rd quarter of FY04, 43% 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 32% in the 4th Quarter of FY03.

The NE region has the highest rate (54%) for adults with face-to-face crisis events who had outpatient follow-up visits within seven days, followed by the CN region at 60% (with the largest increase over the past quarter), the SW region at 56% (also with a significant increase over the last quarter, and the NW at 54%. 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 four regions have rates of follow-up within one standard deviation of the state average for the 3rd Quarter of FY04.

ADULTS WITH MAJOR MENTAL ILLNESS (MMI)

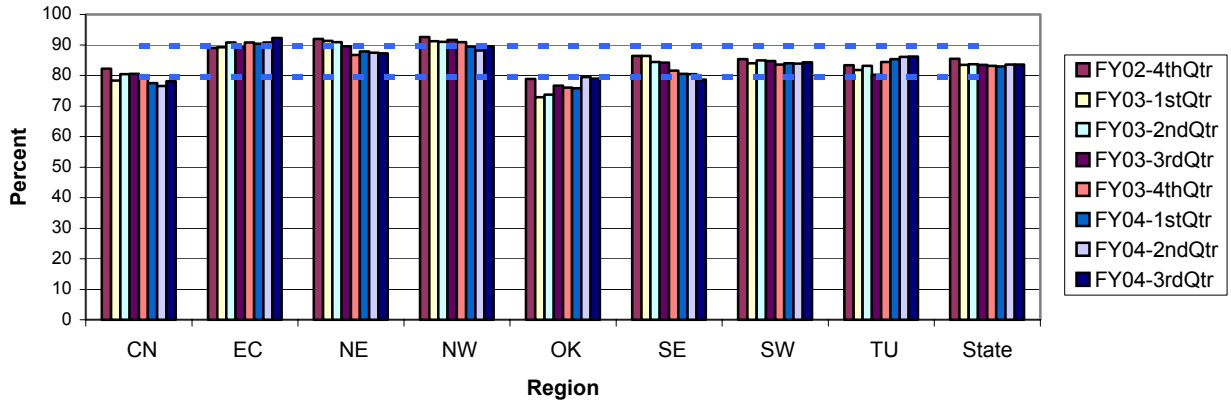
Background: To more clearly define a category of service recipients with more serious disorders that could be identified in data also collected by the Oklahoma Health Care Authority (OHCA), criteria for Major Mental Illness (MMI) were selected. This population is similar to the group of adults designated by providers as having a Serious Mental Illness (SMI), without considering level of functioning (which is not collected by OHCA). A complete listing of MMI diagnoses is given in Appendix 4, Glossary of Terms, under Major Mental Illness. To be included in the measure, a client had to have received a service in the reported quarter.

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 83.5% of adults with MMI received a core mental health outpatient service (face-to-face mental health, non-crisis, treatment service) in the 3rd Quarter of FY04 (Figure 12). This is within the range of 83% and 85.4% 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

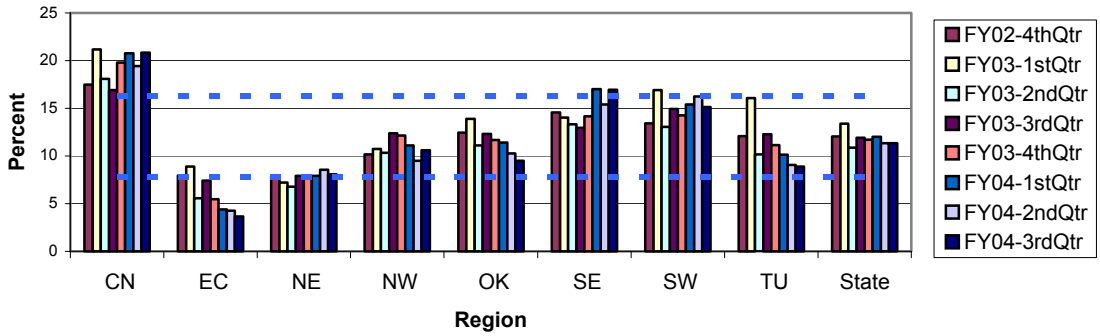


The CN and OK regions have experienced a relatively low percentage of adults with MMI receiving core outpatient services, both at 79% in the 3rd Quarter of FY04, which is one standard deviation below the state average. The OK region has been one standard deviation or more below the state average for the eight quarters studied.

Measure MH10: Adults with MMI Inpatient Services

About 11.3% of all adults with MMI, statewide, were hospitalized in the 3rd Quarter of FY04 (Figure 13). The range of adults with MMI hospitalized in the prior seven quarters was between 10.9% and 13.4%.

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



The CN and SE regions were one standard deviation above the state average at 21% and 16.9%, respectively in the 3rd Quarter of FY04. The CN region has consistently been one standard deviation about the state average for the eight quarters studied**.** The adults with MMI in the EC region have shown a low rate of inpatient hospitalization for the seven of the last eight quarters, with the lowest rate of 3.7% 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

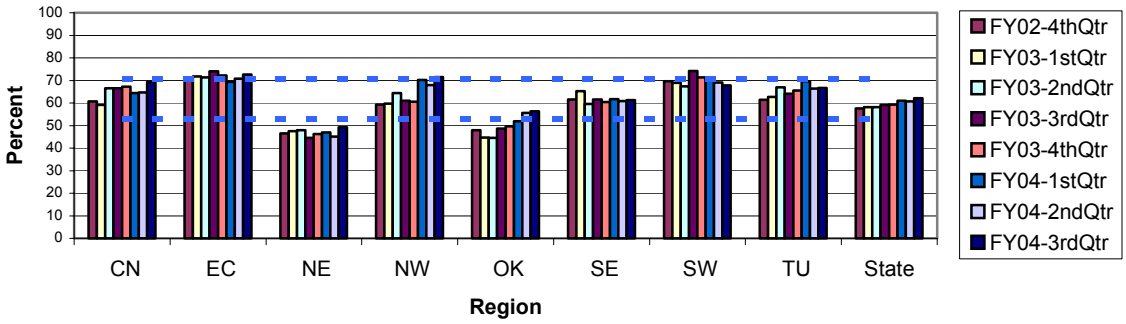
ADULT SELECT PRIORITY GROUP (SPG)

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 (SPG) 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, 62% of all adults in the SPG received a medication visit in the 3rd Quarter of FY04 (Figure 14). The rate has remained fairly consistent with a range of 58% to 62% in the prior seven quarters. The EC region has had a high rate of medication visits for the past eight quarters, with 73% occurring in the most recent quarter. The NW region's rate has increased over the past two years and is one standard deviation from the state average at 72% in the 3rd Quarter of FY04. The NE region has low percentages of adults in the SPG receiving a medication visit in the last eight quarters, with 49% receiving a medication visit in the most recent quarter studied.

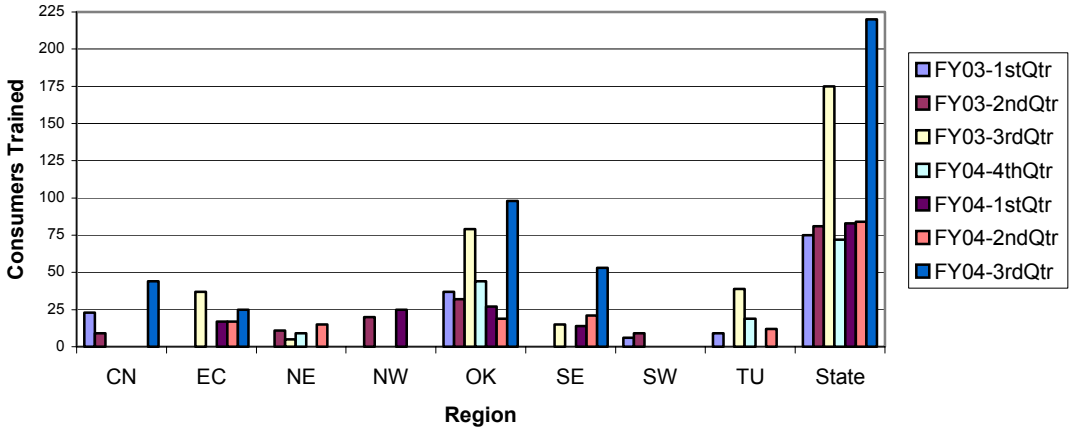
EVIDENCE-BASED PRACTICES

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

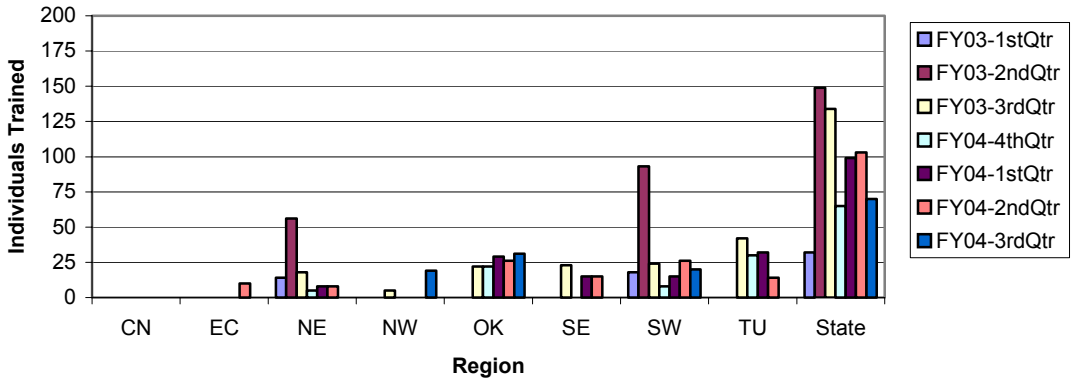


Illness self-management education services were provided to 220 individuals during the 3rd Quarter of FY04, bringing the total participants to 690 (Figure 15). Training was offered in the CN, EC, OK, and SE regions for the most recent quarter.

Measure MH15: Family-To-Family Training

The Family-to-Family indicator measures the number of unique 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

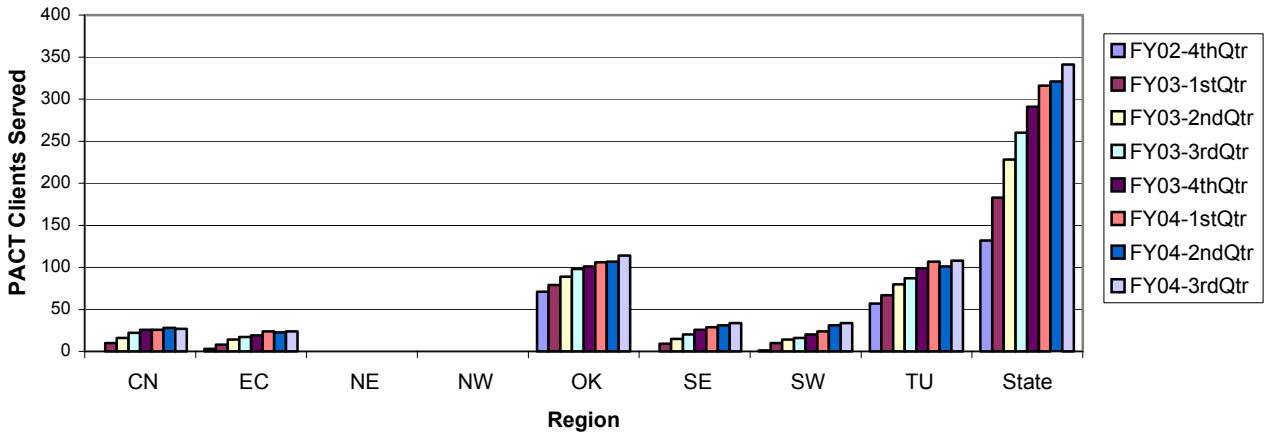


A total of 70 individuals received Family-to-Family training in the 3rd Quarter of FY04, down from 103 individuals trained in the prior quarter (Figure 16). Training sessions were held in the EC, NE, OK, SE, SW and TU regions during the 3rd Quarter of FY04. To date, training has been provided to 652 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, 341 persons were served through the six PACT sites in the 3rd Quarter of FY04.

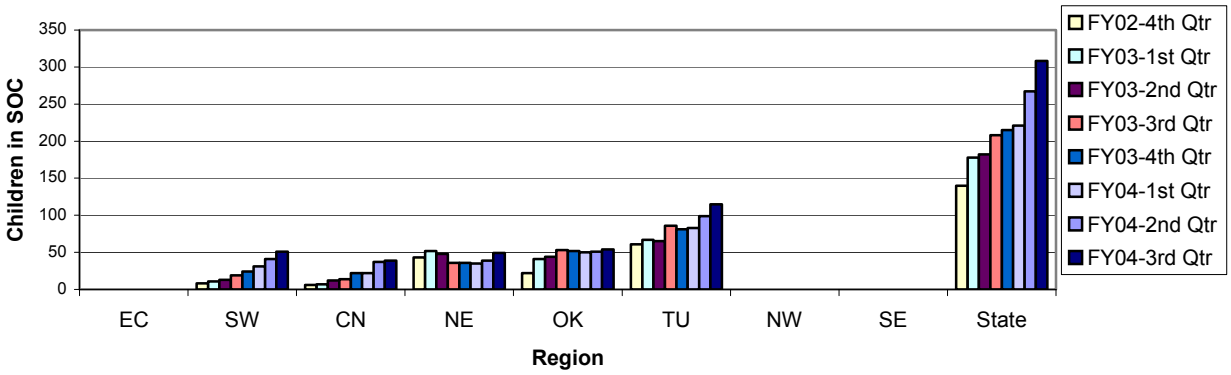
The OK and TU regions provided services to 114 and 108 persons, respectively. The remaining sites are newer and have not reached their maximum capacities (CN region = 27, EC region = 24, SE region = 34, SW region = 34).

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 3rd Quarter of FY04, 308 children were served in the SOC sites, the largest number to date (Figure 18). The TU region, which hosts the largest site, served 115 children, followed by 54 children served in the OK region, 49 children served in the NE region, 51 children served in the SW region, and 39 children served in the CN region.

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

PERFORMANCE MEASURES - SUBSTANCE ABUSE

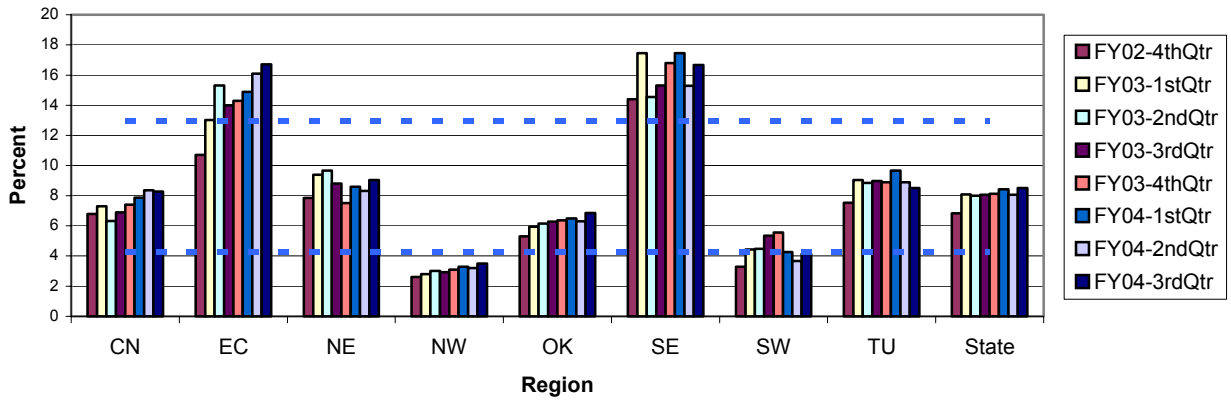
The indicators of substance abuse treatment performance used in this report are measures developed by the Washington Circle with support from the federal Center for Substance Abuse Treatment (CSAT). The indicators focus on early recognition and intervention which can positively affect the course of an 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 3,900 persons identified among those in need of treatment during the 3rd Quarter of FY04. Between 3,138 and 3,861 persons were identified in each of the seven prior quarters. Persons were identified by the first level of substance abuse services they used:

Outpatient – 1,884 clients (48%)
Detoxification – 966 clients (25%)
Residential – 890 clients (23%)
Community Living – 160 clients (4%)

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



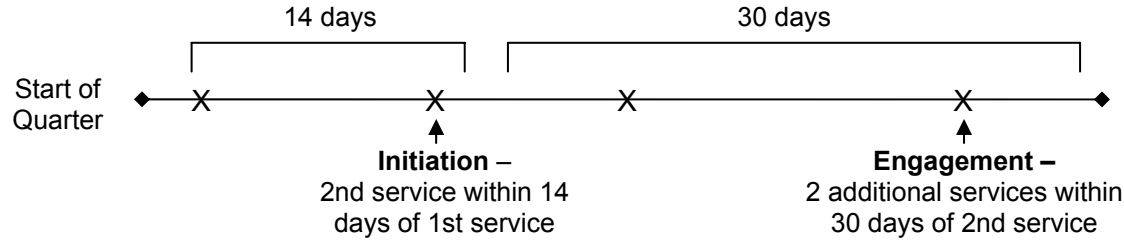
Statewide, the percent of the estimated number of adults in need of substance abuse treatment that received a substance abuse service has remained fairly constant for the past eight quarters ranging from 6.8% to 8%, with 8% in the most recent quarter (Figure 19).

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 (3.5%) 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 4.1% in the 3rd Quarter of FY04.

Measure SA2a: Initiation Into Outpatient Treatment

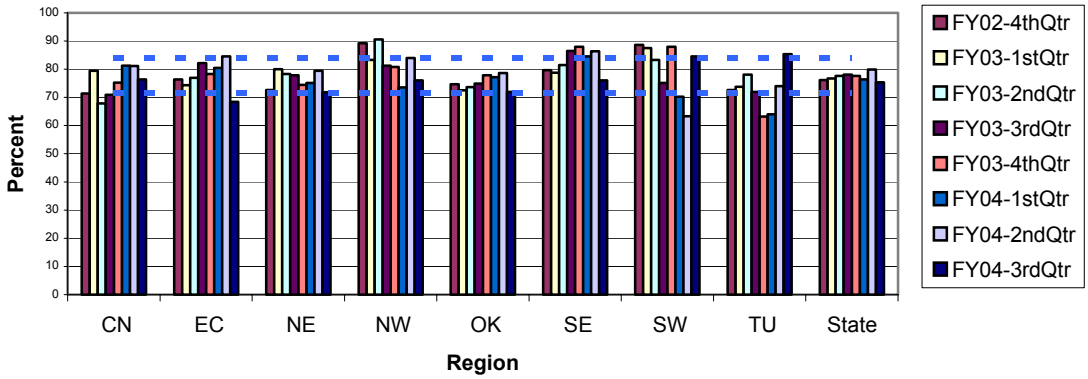
Among those persons who received a first (index) substance abuse service in the quarter (with no services in the past 60 days), initiation rates were calculated based on the level of care in which the persons were first served.

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

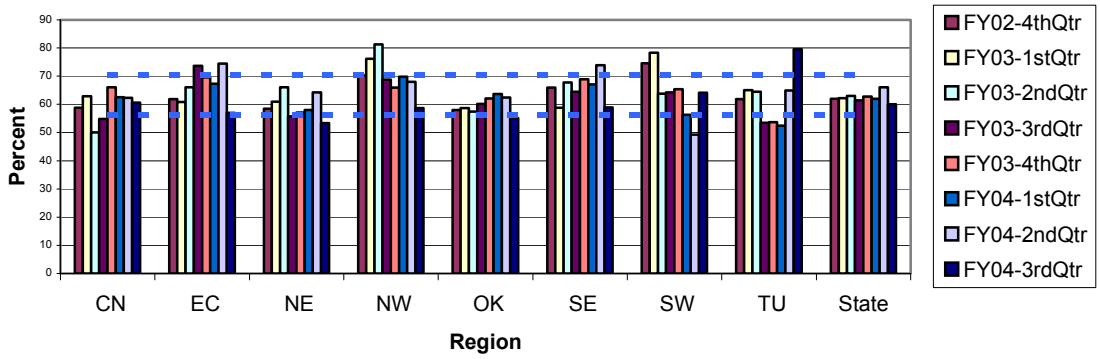


As shown in Figure 21, statewide, 75.4% of adults with first treatment episodes, who started treatment in outpatient care, initiated treatment (had a second service within 14 days, refer to Figure 20 for diagram). Although the range is narrow, this is the lowest rate in two years. The SW and TU regions were more than one standard deviation above the state average, both at 85% in the 3rd Quarter of FY04. The EC region fell more than one standard deviation below the state average at 68% in the last quarter studied.

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

Measure SA3a: Engagement in Outpatient Treatment

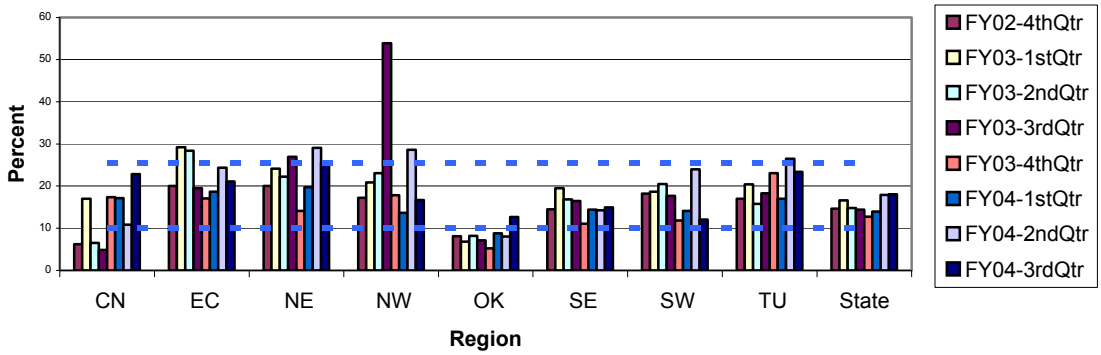
Figure 22: Engagement in Substance Abuse Treatment Following a First Outpatient Service



As shown in Figure 22, during the 3rd Quarter of FY04, 60% of clients who started treatment in outpatient care engaged in treatment (initiated treatment within 14 days after an initial outpatient service and had two more services within 30 days following initiation – Figure 20). This was down from the previous quarter at 66%, which was the highest rate in the past two years. The TU region was more than one standard deviation above the state average at 65%. The EC, NE and OK regions were more than one standard deviation below the state average, at 57%, 53% and 55%, respectively, in the 3rd Quarter of FY04.

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, 18% 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 remained consistent from the previous quarter and is the highest rate in the two years studied (Figure 23). All of the eight regions fell within one standard deviation of the state average.

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

MEASURES PLANNED FOR FUTURE RPM REPORTS:

Domestic Violence Performance Indicators – Beginning with the 1st quarter FY05 report, domestic violence performance indicators will be included in the RPM report. These indicators will include: the number of clients served and the number discharges due to client breaking rules, the client leaving against counselor advice, or client failing to begin treatment.

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.

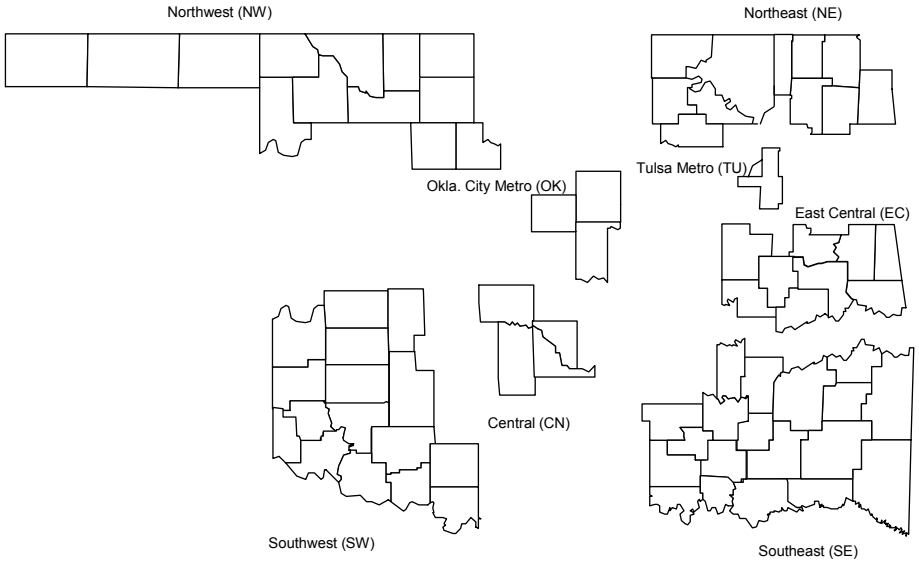
Appendix 1: Selection of Indicators

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.

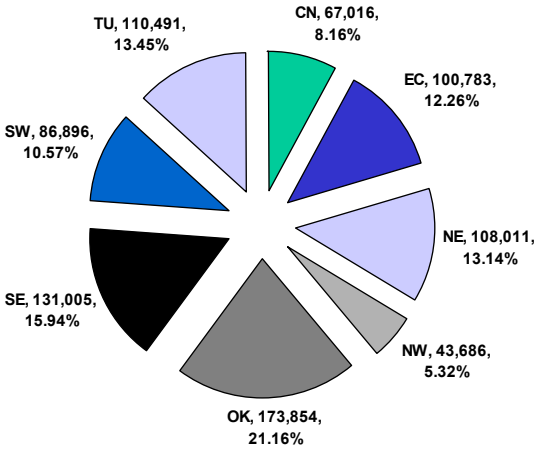
Future Development. System stakeholders were involved in previous indicator development processes, and as stakeholders express their perspectives regarding the utility of the selected RPM report indicators, or as system improvements make monitoring an indicator less important, it is likely other indicators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

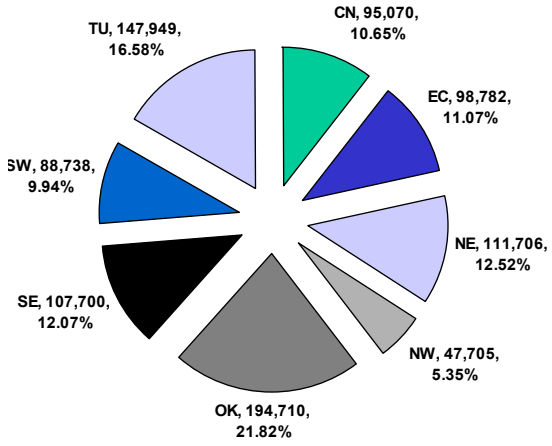
Appendix 2: RPM Report Indicator Definitions

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 100.

Denominator: Adult clients discharged from inpatient services during the quarter who are referred within the DMHSAS system or transferred within a single agency.

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 and Individual Rehabilitation Services for Adults with MMI – persons with MMI who received a case management or individual rehab service (ICIS service codes = 204, 225, or 226) in the quarter.

Numerator: Persons with MMI receiving a case management or individual rehab service during the quarter X 100.

Denominator: All persons identified as having MMI and are receiving services in the quarter studied.

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 3rd 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 3rd 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.

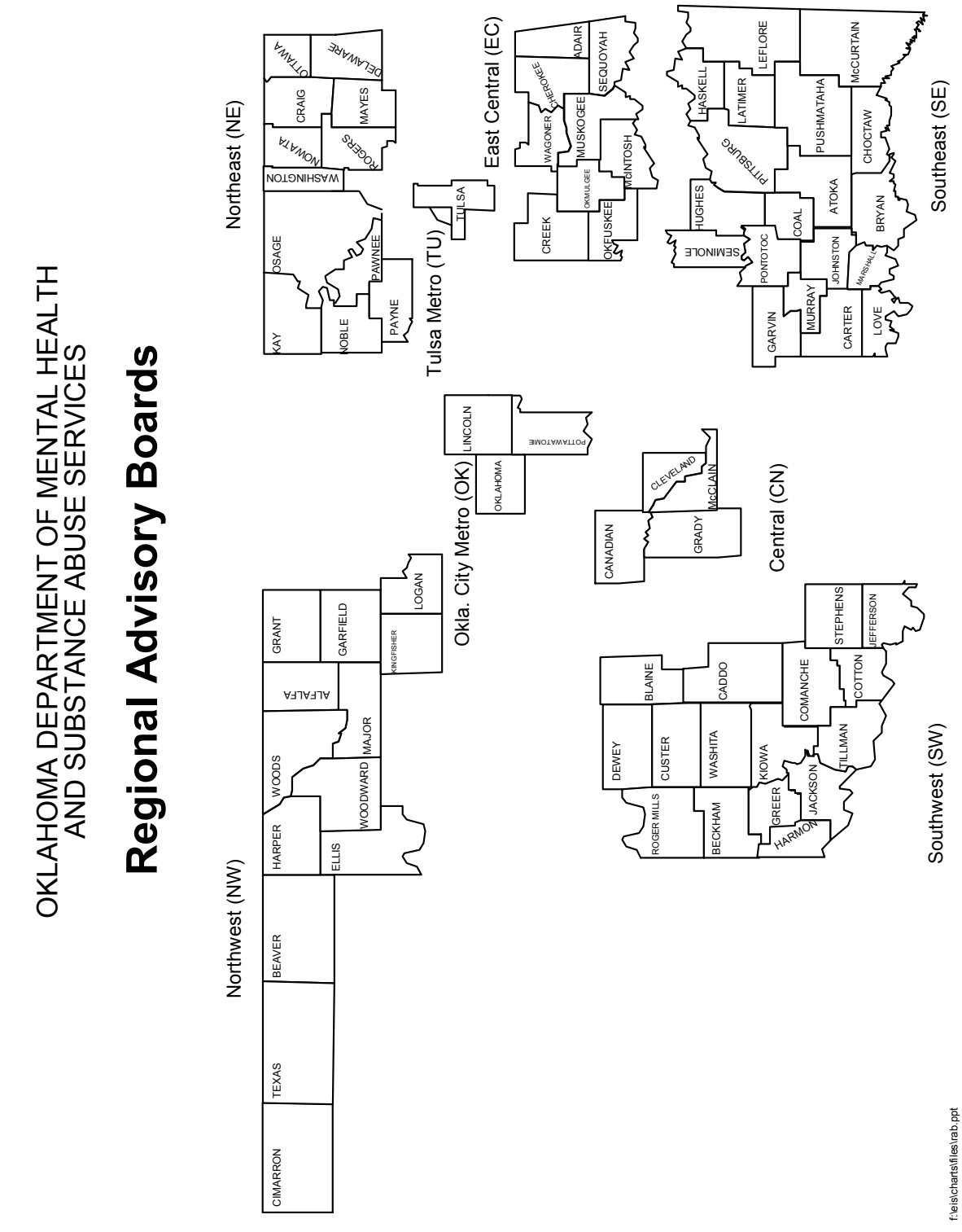
Denominator: Adults who initiated service following discharge from detox service during the quarter.

Measure SA3d: Engagement (Residential) – Of the persons, 18 years or older, who had a 3rd 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 3rd Quarter FY04

Mental Health Agencies

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
Associated Centers For Therapy, Inc.		5	2			3		898		908
Bill Willis Inpatient		38								38
Bill Willis Mental Health		871	10			1	1	14	14	911
Carl Albert C.M.H.C.		24			1	1247		1	4	1277
Center For Children & Families	56				15	1			2	74
Central Oklahoma CMHC	712			1	85	2				800
CREOKS Mental Health Services	1	521			19	3				544
Crossroads Incorporated			1		1			79		81
Divorce Visitation Arbitration			22		1					23
Edwin Fair CMHC			580	3		1	2	1		587
Family & Children's Services		3	5	1				1764		1773
Grand Lake M.H.C.		6	1154				1	11	6	1178
Green Country Behavioral Health Services, Inc.		310	1			1			1	313
Griffin Memorial Hospital	247	7	19	6	245	170	12	11	15	732
Hope Community Services, Inc.	3	1	1		686					691
Jim Taliaferro CMHC	23	2	1		3	3	1150		1	1183
M.H. Services Of Southern Oklahoma	2	4	2	2	5	1188	5		3	1211
North Care Center	3	1			1335	1				1340
Northwest Center for Behavioral Health	6	2	38	1275	44	13	80	6	7	1471
Oklahoma County Crisis Intervention Center	26	1	15	18	348	7	5	4	9	433
Oklahoma Forensic Center	16	16	20	8	56	32	22	33		203
Red Rock Behavioral Health Svc	487	3		9	885	4	461	113		1962
Safe Haven		1						47		48
Thunderbird Clubhouse	70				5					75
Transition House Inc.	11									11
Tulsa Center for Behavioral Health		6	8	2				335	2	353
Tulsa Metropolitan Ministry								264		264

Substance Abuse Agencies

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
12 & 12, Inc.	3	35	37	1	5	5	4	317	1	408
Ada Area Chemical Dependency Center						37				37
Alpha II, Inc.	1	8	14		2	2	2	1		30
Bill Willis Mental Health	1	155	6	1	2	3		5		173
Bridgeway			28			1				29
Broadway House, Inc.	2			1	1	20	4	1	2	31
CAA Turning Point	27				184		2			213
Care for Change Inc.					153		1			154
Community Alcoholism Services		16	45							61
Community Development Support Association				14						14
Cope, Inc.	1		2		100					103
Counseling Center Of S.E. Oklahoma			1	1		120				122
Domestic Violence Intervention Services, Inc.		5	1					15	1	22
Drug Recovery, Inc.	12	2	1	1	144	3	11	2		176
Eagle Ridge Institute	3	51	1	2	22	4	1	11		95
Edmond Family Services, Inc.					16					16
Edwin Fair CMHC			27		1		1			29
Family & Children's Services								33		33
Family Crisis Center, Inc.						48				48
Focus		36								36
Gateway To Prevention/Recovery	2	1			173	7				183
Hominy Health Services Center Inc.			55							55
House Of Hope Inc.	1	3	23		5	2	1	6		41
Human Skills & Resources		51	42	1	1			121		216
Indian Health Care Resource Center			3					44		47
Jim Taliaferro CMHC							24			24
Kiamichi Council On Alcoholism					1	218			1	220
Latino Community Dev. Agency					1					1
Logan County Youth & Family Services, Inc.	1		1	28	5					35
M.H. Services Of Southern Oklahoma	2	1	1		1	93	11		1	110
Metro Tulsa Substance Abuse Service	1	35	29		7	11	3	345	1	432
Monarch, Inc.	3	57	4		11	14	7	12		108
Moore Alcohol and Drug Center	15				7					22
Muskogee County Council of Youth Services		64						1		65
N.E. Ok Council on Alcoholism			140			9		1		150
Native American Center of Recovery				17	7	1				25
New Hope of Mangum	7			4	5	6	162	1		185
Norman Alcohol and Drug Treatment Center	25	5	6	2	70	18	8	1	1	136
Norman Alcohol Information Center	178	2			8	9				197
North Care Center					41					41
Northwest Center For Behavioral Health	5	1	3	22	23	7	30	3		94
NW Substance Treatment Center	3	3		4	3	2	8			23
Oklahoma Families First, Inc.						18				18
Opportunities, Inc., CDTC	11	1	6	11	27	3	40	1	1	101
Palmer Drug Abuse Program Inc.								3		3
Payne Co. Counseling Services, Inc.			29		1					30

Agency Name	CN	EC	NE	NW	OK	SE	SW	TU	UN	total
Payne County Drug Court, Inc.			25	2	1	5		1		34
People Incorporated		98	35	1			1			135
Red Rock Behavioral Health Svc	32		1	19	76	2	33			163
Riverside Counseling	14					4				18
Roadback, Inc.	3	1				7	64	1		76
ROCMND Area Youth Service			2							2
Rogers County Drug Abuse			93				1			94
S.W. Youth & Family Services	43						3			46
Shekinah Counseling Services						59	1		1	61
Specialized Outpatient Services, Inc.					39					39
Starting Point II, Inc.	1	6	50	7	21	4	2	5	1	97
Street School Inc.								4		4
The Brown Schools of Oklahoma, Inc.				1				20		21
The Next Step Network, Inc.		2	1	35	4	2	4		3	51
The Oaks Rehab. Services Center	3	60	5		2	143	4	2		219
The Referral Center	33	4	10	11	252	25	14		1	350
Total Life Counseling					116					116
Tri-City Substance Abuse Center					2	115				117
Tri-City Youth & Family Center	55	1			49	5	1	1	1	113
Tulsa Women And Children's Center	1	6	4	1	4			21		37
Turning Point			77						1	78
Vinita Al/Dg Treatment Center		30	37		4	4	3	9		87
Women In Safe Homes, Inc.		14			1	1				16
YWCA Crisis Center				4	1			1		6

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).