REVIEW OF PERFORMANCE DATA INDICATORS AND OUTCOMES MEASUREMENT FOR MENTAL HEALTH SYSTEMS FOR CHILDREN

FINAL REPORT

Prepared for the
Joint Legislative Audit and Review Committee (JLARC)
by
Dougherty Management Associates, Inc.

May 20, 2002

DOUGHERTY MANAGEMENT ASSOCIATES, INC.

EXECUTIVE SUMMARY

Background and Project Summary

Dougherty Management Associates, Inc. (DMA) was retained by the State of Washington's Joint Legislative Audit and Review Committee (JLARC) to conduct a review of performance indicators and outcomes measurement for mental health systems for children as part of the Children's Mental Health Study. DMA, a research and consulting firm in Lexington, Massachusetts, has extensive experience working with state and county health and human service organizations. DMA's work involves strategic planning, procurement consulting, and conducting national research on quality and cost effectiveness in publicly funded systems. One current national project is gathering, comparing, and disseminating indicators on financial, utilization, and quality performance of children's public mental health systems throughout the country.

For JLARC, DMA has reviewed performance and outcomes measurement systems to provide models for Washington and has assessed the current data and reporting by the Washington State Department of Social and Health Services, Mental Health Division (MHD), Regional Support Networks (RSNs), and providers to determine its adequacy for use in performance and outcomes measurement. In addition, DMA reviewed the measurement framework laid out in the December 13, 2000 JLARC Performance Audit of the Mental Health System and developed recommendations for modifications to this framework. DMA's recommendations are aimed at assisting stakeholders to improve Washington's performance and outcomes measurement system so that it ultimately allows reporting of data to the Legislature that can inform their decision-making. In addition, the recommendations seek to provide information to MHD on ways to make the data more useful for their decision-making as well as to increase the comparability of data to allow comparisons among RSNs and comparisons with other states.

Major Findings

The findings below result from DMA's review of not only the collection and reporting of data within Washington State but also initiatives outside the state. Reviewing other initiatives enables states and counties to better understand and assess their own systems. In addition, availability of data can assist stakeholders to evaluate the children's mental health system and also is likely to prompt valuable quality improvement efforts.

Review of Statewide and National Initiatives

- Successful implementation of performance and outcomes measurement systems requires state agency resources as well as buy-in from state leadership.
- Systems utilize data in a variety of ways including legislative reporting, quality improvement, performance incentives, and for clinical tools and provider practice profiles. Of the systems reviewed, one state currently utilizes financial incentives.

MHD Statewide Measurement and Reporting

- MHD does not currently report expenditure or cost data by age. Therefore, critical cost indicators such as cost per individual served or cost per unit cannot be reported separately for children. (MHD reports they can calculate RSN direct expenditures

per individual served and per unit for broad service categories such as crisis, residential and inpatient; they just cannot report children and adults separately.)

- MHD currently collects individual point-in-time data such as current living situation. MHD does not yet have the algorithms in place to report individual change scores although MHD reports they are working on implementing the programming that will allow for tracking change at the individual client level. This is an area where MHD is obtaining technical assistance to implement the tracking system.
- MHD has made progress by improving the data requirements and data specifications in response to the December 2000 JLARC report. Many RSN representatives and providers believe additional improvements must be made to permit data comparisons across the state.

RSN Measurement and Reporting

- RSNs vary in sophistication and in type of outcomes measurement used for children; some collect data on numerous measures while others do not monitor or require any clinical outcomes data from the providers.
- RSNs are expecting leadership and guidance from MHD regarding clinical outcomes measures. Specifically, a number of RSNs report they have not yet implemented clinical outcomes measures because they are 'waiting on the state' to require specific measures.
- Administration of the Child Global Assessment Scale (CGAS) instrument appears inconsistent across RSNs. Some RSNs are not administering the CGAS even though results are a required element in the revised MHD data dictionary, effective January 1, 2002.

Recommendations

One of the goals of the DMA recommendations listed below is to help Washington develop a successful performance and outcomes measurement project. Such a project will enable the Legislature, MHD, RSNs and providers to monitor performance by using data to identify trends and make comparisons with like organizations. Implementing any performance and outcomes measurement system entails challenges; however, other initiatives demonstrate that the likelihood of success is far higher in systems with regular stakeholder collaboration and in those that embrace continuous quality improvement. Implementation of these general recommendations should lead to an improved performance and outcomes measurement system with an increased level of data comparability and reliability.

Recommendation 1:

Begin by collecting and monitoring a core set of measures from the Measurement Framework in the December 2000 JLARC Report.

Rationale

A core measurement set will reduce provider burden and give stakeholders a focused way to monitor system performance. The current framework properly reflects many of the data collection recommendations that national initiatives have made; however, it should be reduced in size to provide a more focused set of measures for Washington's children's mental health system. Beginning with a core data set will also allow MHD, the RSNs and providers to identify areas

where data need improving and to work together to increase data reliability and validity. In the future, MHD may want to include additional measures from the Framework or other 'developmental' measures as the need arises to monitor other areas of the children's mental health system.

Recommendation 2:

Encourage MHD to distribute statewide and RSN comparison data in a regular and timely way.

Rationale

Regular feedback should increase provider reporting and accuracy. Other systems implementing performance and outcomes measurement systems have found that distributing and publishing data regularly, even without actual consequences, can increase compliance with data reporting merely by creating a 'peer pressure' effect. Organizations do not want to be singled out among their peers for being non-compliant or error prone in data reporting. Regular reporting also can reduce organizations' sensitivity to being measured by making the practice commonplace. MHD should work on creating standards for frequency of the reporting of specific measures. Depending on the measure, reporting may be monthly, quarterly, or annually. For example, cost measures may only be reasonable to report annually, while measures such as penetration can and should be reported more frequently.

Recommendation 3:

Continue to increase the level of specificity for data definitions.

Rationale

Detailed data specifications should increase data consistency and comparability. MHD has been working with a performance improvement workgroup to define the measures currently being reported; however, many performance measurement initiatives have found that multiple iterations are necessary to ensure that data can be compared across regions within a state or across states.

Recommendation 4:

Provide training to RSNs and providers in data collection and reporting.

Rationale

Training, coupled with increased definitional specificity, will increase data reliability and data quality. Training can reduce some differing interpretations among those individuals collecting and reporting the data.

Recommendation 5:

Link desired system goals more directly to measures.

Rationale

System goals help to provide clearer expectations and a rationale for data use. Providers and other stakeholders may become more invested in the performance measurement program if the goals are clearly understood. In addition, financial incentives for reporting might be considered to encourage RSN reporting.

Recommendation 6:

Collect and analyze data to separate child and adolescent costs from adult costs. This will permit MHD to track RSN direct service expenditures per child served and per unit of service for children served.

Rationale

Because expenditure data provide an indication of the level of resources used by the mental health service system, they are central to any public reporting system. Understanding the reasons for differences in spending per client and the types of services funded will be enormously useful for the policy debates on new initiatives or policy changes.

The following recommended measures are a sub-set of the JLARC Framework Measures and what DMA considers a 'core' set. We excluded some Framework measures from the core set because there was no current data source, the measure was not directly relevant to children, or the measure would be overly burdensome to collect. Implementation of a core measurement set will reduce provider burden in the short-term and give stakeholders a focused way to monitor system performance. Once the core set is established, if the need arises to monitor other areas of the children's mental health system, MHD may want to consider adding measures.

REVIEW OF PERFORMANCE DATA INDICATORS AND OUTCOMES MEASUREMENT FOR MENTAL HEALTH SYSTEMS FOR CHILDREN

RECOMMENDED PERFORMANCE AND OUTCOMES MEASURES

Access:

1. **Penetration rate**
2. **Utilization rate for specific service types**
3. **Consumer/family perception of access**

Quality/Appropriateness:

1. **Consumer/family perception of quality/appropriateness**
2. **Consumer/family perception of participation in decision-making**
3. **Follow up after hospital discharge within 7 days**
4. **30 day readmission rate**

Outcomes:

1. **Consumer change as a result of services**
2. **Living situation or community tenure**
3. **Juvenile justice involvement rate**
4. **Substance abuse services rate**

Structure/Plan Management (Financial):

1. **RSN service expenditures per child served**
2. **RSN service expenditures per unit of service (for specific service types)**

Dougherty Management Associates, Inc.

Conclusion

In order to make informed budget and policy decisions, during this period of scarce resources for public mental health services, purchasers need data on the impact of services on consumers as well as the overall system performance. Increasingly, public mental health systems are finding it useful and necessary to systematically collect and report measurement data that can be benchmarked with other systems. Collecting, analyzing, and benchmarking performance and outcomes data within public mental health systems serving children can enable stakeholders to identify areas for improvement and thus ultimately lead to improved quality and accountability.

In recent years, Washington State has made good progress toward implementing a performance measurement program for the public mental health system. However, as the findings indicate, stakeholders in Washington need to implement new or refocused efforts, such as those outlined in this report's recommendations, aimed at developing a consistent and comparable performance and outcomes management system to ensure data are valid, reliable and useful for decision-making. In addition, public reporting of data also needs to become more frequent, systematic, and widely distributed. Investment in properly implementing performance and outcomes measures that are common to those used by other systems should provide a corresponding 'return on investment' in the form of trend data that will enable effective oversight while providing reasonable comparisons between RSNs and between Washington and other states.

REVIEW OF PERFORMANCE DATA INDICATORS AND OUTCOMES MEASUREMENT FOR MENTAL HEALTH SYSTEMS FOR CHILDREN

TABLE OF CONTENTS

INTRODUCTION AND BACKGROUND

Dougherty Management Associates, Inc. (DMA) was retained by the State of Washington's Joint Legislative Audit and Review Committee (JLARC) to conduct a review of performance indicators and outcomes measurement for mental health systems for children as part of the Children's Mental Health Study. DMA, a research and consulting firm in Lexington, Massachusetts, has extensive experience working with state and county health and human service organizations. DMA's work involves strategic planning, procurement consulting, and conducting national research on quality and cost effectiveness in publicly funded systems. One current national project is gathering, comparing, and disseminating indicators on financial, utilization, and quality performance of children's public mental health systems throughout the country.

For JLARC, DMA reviewed state and national performance and outcomes measurement initiatives for children and assessed the performance and outcomes measurement data currently being collected by the Washington State Department of Social and Health Services, Mental Health Division (MHD), Regional Support Networks (RSNs) and providers. In addition, the project scope included a review of the measurement framework laid out in the December 13, 2000 JLARC Performance Audit of the Mental Health System and the development of recommendations for modifications to this framework. DMA's review, assessment, findings, and recommendations are described in the sections below.

Throughout the project, DMA sought to combine the perspectives of key stakeholders from Washington State with the work that is being done on children's performance and outcomes measurement on a state and national level outside of Washington. This project builds upon what JLARC and others have previously done to move the public children's mental health system in Washington toward a more uniform and focused approach of measuring the performance and outcomes.

Many Washington State stakeholders were contacted to obtain information for this project, including representatives from the 14 RSNs; MHD staff; staff and members of the Washington Community Mental Health Council, including the Council's Chief Executive Officer and Board of Directors; and the Senior Research Analyst from the Children and Family Services Committee of the House of Representatives. (Refer to Appendix 1 for a complete listing of stakeholders.)

REVIEW OF STATE AND NATIONAL INITIATIVES

Performance indicator and outcomes measurement systems in both the private and public sectors were reviewed. Specifically, initiatives and states were chosen based on their potential relevance to Washington; for example, states with a regional or county-based mental health system or a legislative performance reporting system were selected.

National measurement initiatives that were included in the review are:

- Substance Abuse and Mental Health Services Administration (SAMHSA) Outcomes Roundtable for Children and Families;
- Sixteen State Study on Mental Health Agency Performance Measures;
- Children's Mental Health Benchmarking Project;
- National Association of Psychiatric Health Systems (NAPHS), Lessons Learned from the Pilot Testing of NAPHS Benchmarking Indicators; and
- Center for Clinical Informatics: PacifiCare Behavioral Health Care Alert System.

In addition, a number of state projects were reviewed or state representatives contacted; the states are:

- California: Department of Mental Health;
- Colorado: Medicaid Mental Health Capitation Program;
- Florida: Department of Children and Families;
- New Mexico: Children, Youth and Families Department;
- New York: Office of Mental Health;
- Oregon: Office of Mental Health and Addictions Services; and
- Pennsylvania: Early Warning System.

The purpose of this review was two fold: first, to identify systems and organizations that stand out in the field with exemplary performance and outcomes measurement and second, to identify the 'lessons learned' so that JLARC and state officials can learn from what others have done and use the information to guide the decisions made in Washington.

Data Uses in Other Systems

A review of public and private sector performance measurement initiatives demonstrated that systems utilize data in a variety of ways. A summary of these uses is outlined below.

- *Legislative Reporting:* Both California and Florida require that the responsible state agency submit an annual report on the performance of the public sector children's mental health system to the state legislature. These reports contain data on indicators such as number of children receiving a mental health service each year and change in level of functioning for children receiving services. In addition, New Mexico reports one behavioral health measure, in a set of measures related to child well being, to their state legislature.
- *Quality Improvement:* The performance measurement programs in Oregon and Pennsylvania focus on utilizing the data for quality improvement purposes within their service systems. Data are reported and compared by county or regional entity.

In both cases, data are publicly reported, made available to stakeholders, and used to identify areas that need improvement.

- *Performance Incentives:* Colorado uses performance measurement data for quality improvement and to compare the performance of their regional managed care entities. The state also ties financial incentives to specific performance indicators.
- *Clinical Tool and Provider Practice Profiles:* PacifiCare's Behavioral HealthCare ALERT System utilizes outcomes data primarily as a clinical tool to notify providers when an individual exhibits particular risk factors, and also to provide provider practices with comparative profiles.

For a more detailed description of programs in other states and private systems, please refer to Appendix 2**.**

Commonly Utilized Children's Outcomes Measurement Instruments

In addition to reviewing utilization/access and financial measures, DMA's review of children's clinical outcomes measurement efforts both within and outside of Washington State revealed that many different instruments are utilized to measure behavioral outcomes and level of functioning for children. Listed below are some commonly utilized instruments and some of the mental health system utilizing them.

- Child and Adolescent Functional Assessment Scale (CAFAS) – California (one of the five core instruments utilized)
- Ohio Youth Problem, Functioning and Satisfaction Scale (Ohio Scales) – Ohio and Pierce RSN
- Children's Functional Assessment Rating Scale (CFARS) – New Mexico
- Children's Global Assessment Scale (CGAS) – Oregon and Washington State
- Child and Adolescent Needs and Strengths (CANS) – New York State
- Treatment Outcomes Package (TOP) – Washington Community Mental Health Council and other provider groups in states such as Massachusetts

Other researchers[1] have identified a number of key issues that MHD and other stakeholders should consider in choosing and implementing any new outcomes measurement system in Washington State. These issues are: time; cost; reliability and validity; family burden; training; and utility. Regardless of the particular system implemented within Washington State, the wide range of instruments used outside the State may make it difficult to benchmark Washington's outcome data with the performance of other children's mental health systems.

Lessons Learned

Reviewing information from other initiatives can enable Washington to better understand and improve its own system. The review of state and national initiatives revealed a number of *lessons learned* from systems of mental health care implementing large-scale performance and outcomes measurement initiatives. Key issues to consider when implementing a measurement system include:

[1] Walrath, Christine, 'Behavioral and Functioning Presentation', 14th Annual Research Conference for Children's Mental Health, Tampa, Florida. 2001.

- State agency administrative resources are necessary to devote to improving initially low submission rates of performance data by providers and reducing initially high error rates.
- State leadership must demonstrate a strong commitment to outcomes measurement in order to successfully implement a measurement program.
- Begin with the best data available and then strive to improve data reliability and validity rather than getting caught up trying to start with 'perfect' data.
- Stakeholders should recognize and value that a performance project is not only a way to monitor and improve quality but it is also a way to improve data collection efforts.
- Even just the *process* of collecting data can help to identify areas that require improvement, such as interagency collaboration.
- Measurement programs should strive to provide data quickly, as close to 'real time' as possible. Long lag times following the reporting period reduce the utility of the data.
- Regional data should only be displayed when they are sufficient to allow for regional comparisons; otherwise, only statewide data should be reported publicly.
- Measurement definitions must be clear and precise to ensure comparability.
- Clinical outcomes data are difficult to collect at "discharge" from outpatient care; many clients 'just stop coming'. Most, if not all, outpatient programs report collecting substantially less data at discharge than at intake.
- Copyrighted outcomes measurement tools lack flexibility.
- Financial data and service data may be handled by different units or data systems, thus making it difficult to report on financial performance measures.
- Measurement programs require several years to implement.

  (One program offered the following timeline: First year-data may not be very usable, focus on compliance with program and data specifications; second year-begin to have more confidence in the data and act as if the program matters to encourage participation; and third year-start to see benefits.)
- Collecting a sufficient sample size of family/youth satisfaction data in order to compare entities at the local or regional level can be difficult.

Findings: Review of State and National Initiatives

Reviewing other initiatives highlights the types of measurement efforts that have been implemented and provides a context for the current JLARC efforts and our recommendations. Even though measurement systems differ from one another there is an emerging consensus on the types of measures and indicators that states should track. The support of so many states for DMA's Children's Mental Health Benchmarking Project and the recent recommendations of the Children's Outcomes Roundtable are examples of this emerging consensus. A summary of the specific findings from the review of state and national initiatives is described below.

- Successful implementation of performance and outcomes measurement systems requires state agency resources as well as buy-in from state leadership.

- Of the systems reviewed, one state currently utilizes financial incentives related to performance and outcomes measurement and another is considering them.
- State and national initiatives are using many different types of children's outcomes measurement instruments. This will make it difficult for Washington to compare itself to others in the children's outcomes domain.
- Establishing a high quality performance and outcomes measurement system is an iterative process. For example, many times in the process of implementing a measurement program, data specifications need to be clarified and measures need to be refined.

REVIEW OF WASHINGTON STATE MEASUREMENT & REPORTING

The following sections describe DMA's review of Washington State's current measurement and reporting at both MHD and RSNs; summarizes our findings; and identifies some barriers to data collection.

MHD: Statewide Data Collection and Reporting

MHD currently collects a substantial amount of data from the RSNs; the data originates primarily at the provider level and then are reported to the RSN, which in turn reports the data to MHD. Recently, MHD has structured much of its data collection, reporting, and measurement to reflect the JLARC Measurement Framework outlined in the December 2000 JLARC Audit Report. This framework includes measures for both adults and children; it categorizes 23 measures into four domains: access; service quality / appropriateness; outcomes; and system structure / plan management.

MHD requires RSNs to report results from the CGAS instrument (a children's outcomes measurement instrument) as part of the data dictionary; however, MHD recently issued a request for proposals to develop and implement an automated mental health outcomes management system. This procurement is in response to the Washington State Legislature's mandate for MHD to implement a statewide mental health outcomes system. It is expected that the selected vendor, who is estimated to begin its contract with MHD in May 2002, will include children's mental health outcomes as a component of the system.

Findings

DMA held numerous discussions with MHD staff to collect information regarding the agency's current data collection and measurement initiatives. These discussions focused on gathering information regarding the recently implemented, revised 'data dictionary' and the draft Performance Indicator Framework in development. In addition, some specific challenges MHD faces related to the collection and reporting of specific data elements and performance measures were identified. The information obtained from these discussions and reviews are summarized as follows:

- *Overall*: MHD has made progress by improving the data requirements and data specifications in response to the December 2000 JLARC report. Many RSN representatives and providers believe additional improvements must be made to permit data comparisons across the state.
- *'Process vs. Outcomes' Measurement*: MHD has increased collection of outcomes-related data. However, there does not appear to be a corresponding decrease in process-related data elements.
- *Fiscal*: MHD does not currently report expenditure or cost data by age. Therefore, critical cost indicators such as cost per individual served or cost per unit cannot be reported separately for children. (MHD reports they can calculate RSN direct expenditures per individual served and per unit for broad service categories such as crisis, residential and inpatient; they just cannot report children and adults separately.)

- *Individual Client Outcomes:* MHD currently collects individual point-in-time data such as current living situation. MHD does not yet have the algorithms in place to report individual change scores, although MHD reports they are working on implementing programming that will allow for tracking change at the client level. This is an area in which MHD is obtaining technical assistance to implement the tracking system.
- *Inpatient Data:* RSN-specific reporting of inpatient data needs to be improved and used more reliably; approximately 13% of the data cannot properly identify the client's RSN of origin but are reported by location of the facility. MHD can report aggregate statewide inpatient data.
- *Additional Framework Measures:* There are no current data sources for some of the measures recommended in the JLARC Performance Measurement Framework such as 'average time from first contact to first service'.

(Refer to Appendix 4 for a detailed assessment of the current status of MHD data collection as it relates to the JLARC Performance Measurement Framework from the December 2000 JLARC report.)

RSN: Performance and Outcomes Measurement

Representatives from all 14 of the Regional Support Networks were interviewed using a standard interview guide. The topics covered during the interviews were related to the current status of data collection and monitoring specific to children/families including the RSN's use of performance measurement data, level of functioning instruments, clinical outcomes data, and satisfaction survey data. These RSN interviews provided a wealth of information regarding the status of performance and outcomes measurement for children. The major interview findings are described below. (Refer to Appendix 3 for RSN-specific interview information.)

- RSNs vary in sophistication and in type of outcomes measurement used for children; some collect data on numerous measures while others do not monitor or require any clinical outcomes data from the providers.
- A few RSNs are moving away from attaching financial penalties and incentives to the data and moving toward utilizing the data for quality improvement purposes. Several RSNs specifically stated that they find it more useful to publish the data and rely on 'peer pressure' to motivate providers rather than to institute financial penalties and incentives.
- RSNs are expecting leadership and guidance from MHD regarding clinical outcomes measures. Specifically, a number of RSNs report they have not yet implemented clinical outcomes measures because they are 'waiting on the state' to require specific measures.
- Administration of the Child Global Assessment Scale (CGAS) instrument appears inconsistent across RSNs. Some RSNs are not administering the CGAS even though results are a required element in the revised MHD data dictionary, effective January 1, 2002.
- RSNs have different information systems for reporting data to the state. However, six RSNs have recently joined together to procure new information systems from a single vendor.
- Only one RSN systematically collects and reviews provider-level Treatment Outcomes Package (TOP) data. (TOP is the outcomes system utilized by

approximately half of the Washington Community Mental Health Council membership.) Some RSNs do view individual TOP data during on-site chart reviews. However, the TOP is clearly a provider-level tool at this point; the data are not widely distributed or utilized at the RSN or state level.

RSN 'Best' Practices

Washington State does not need to rely only on other states for examples of best practices. There are a number of data collection and measurement systems implemented in the state that can provide good models. During interviews with RSN staff, a number of exemplary or 'best' practices in data collection, reporting and collaboration were identified. Some of these include:

- *Regularly scheduled RSN/provider meetings and data feedback to providers from the RSN*. Providers receive agency-specific reports that allow them to compare themselves to other agencies. (Pierce County RSN)
- *Interagency collaboration and data sharing for high need children*. The RSN receives daily reports from juvenile detention; the juvenile detention data are matched to the RSN client list and shared with providers. (Southwest RSN)
- *Publicly available reporting of utilization, financial, and client outcomes data in the form of a Quarterly Report and clear system goals that relate to relevant outcomes measures.* For example, the RSN specifically couples questions with measurement descriptions and the results: 'Are we able to reduce the number of homeless clients?, measured by comparing the homeless status of clients from the beginning of the benefit to the status at the end of the benefit for benefits expired year to date and reporting the percent of clients who stayed homeless, the percent who found housing, and the ratio of homeless clients who found housing to clients who became homeless. (King County RSN)

This should not be viewed as an exhaustive list but rather as examples of some exemplary practices within Washington State. There may be additional RSNs implementing similar or other practices; however, these were clearly identified during interviews.

Barriers and Summary

Barriers to Data Collection and Reporting

Challenges exist in any performance and outcomes measurement system, particularly one that involves multiple data sets. However, other initiatives' successes demonstrate that with continual collaboration among stakeholders many of these obstacles can be overcome. During interviews and review of key documents, some specific barriers to data collection and reporting in Washington were identified. These are:

- *Training* on the newly implemented data dictionary has not occurred.
- RSNs and providers interpret data elements differently, even though MHD has worked on increasing the level of detail in the data definitions and measure specifications. For example, interpretations and therefore reporting appear to differ for terms such as 'family-like', 'natural settings' and 'stable environments'.
- Discussions with providers and RSNs indicated that funding to procure an outcomes management vendor *might* not be sufficient to support consistent implementation at the provider level. The level of support available will probably also depend on the

scope of work submitted by the selected vendor and the vendor's plans for implementation and training.

- Though obvious to most stakeholders, the regional structure of Washington's mental health system has led to differing information systems and data collection methods.

Summary

DMA has reviewed performance and outcomes measurement systems to provide models for Washington and has assessed the current data and reporting by MHD and the RSNs to determine its adequacy for use in performance and outcomes measurement. The following section makes recommendations based on the synthesis of this knowledge of Washington's current data and reporting systems with information about national initiatives. These recommendations are aimed at assisting stakeholders to improve Washington's performance and outcomes measurement system so that it ultimately allows reporting of data to the Legislature that can inform their decision-making. In addition, the recommendations seek to provide information to MHD on ways to make the data more useful for their decision-making as well as to increase the comparability of data to allow comparisons among RSNs and comparisons with other states.

RECOMMENDATIONS

Overall

These overall recommendations are intended to assist Washington State's children's mental health system in its development of a reliable measurement system that provides critical data to stakeholders. Implementation of these recommendations should lead to an increased level of data comparability and value.

Recommendation 1:

Begin by collecting and monitoring a core set of measures from the Measurement Framework in the December 2000 JLARC Report.

Rationale

A core measurement set will reduce provider burden and give stakeholders a focused way to monitor system performance. The current framework properly reflects many of the data collection recommendations that national initiatives have made; however, it should be reduced in size to provide a more focused set of measures for Washington's children's mental health system. Beginning with a core data set will also allow MHD, the RSNs and providers to identify areas where data need improving and to work together to increase data reliability and validity. In the future, MHD may want to include additional measures from the Framework or other 'developmental' measures as the need arises to monitor other areas of the children's mental health system.

Recommendation 2:

Encourage MHD to distribute statewide and RSN comparison data in a regular and timely way.

Rationale

Regular feedback should increase provider reporting and accuracy. Other systems implementing performance and outcomes measurement systems have found that distributing and publishing data regularly, even without actual consequences, can increase compliance with data reporting merely by creating a 'peer pressure' effect. Organizations do not want to be singled out among their peers for being non-compliant or error prone in data reporting. Regular reporting also can reduce organizations' sensitivity to being measured by making the practice commonplace. MHD should work on creating standards for frequency of the reporting of specific measures. Depending on the measure, reporting may be monthly, quarterly, or annually. For example, cost measures may only be reasonable to report annually, while measures such as penetration can and should be reported more frequently.

Recommendation 3:

Continue to increase the level of specificity for data definitions.

Rationale

Detailed data specifications should increase data consistency and comparability. MHD has been working with a performance improvement workgroup to define the measures currently being reported; however, many performance measurement initiatives have found that multiple iterations are necessary to ensure that data can be compared across regions within a state or across states.

Recommendation 4:

Provide training to RSNs and providers in data collection and reporting.

Rationale

Training, coupled with increased definitional specificity, will increase data reliability and data quality. Training can reduce some differing interpretations among those individuals collecting and reporting the data.

Recommendation 5:

Link desired system goals more directly to measures.

Rationale

System goals help to provide clearer expectations and a rationale for data use. Providers and other stakeholders may become more invested in the performance measurement program if the goals are clearly understood. In addition, financial incentives for reporting might be considered to encourage RSN reporting.

Recommendation 6:

Collect and analyze data to separate child and adolescent costs from adult costs. This will permit MHD to track RSN direct service expenditures per child served and per unit of service for children served.

Rationale

Because expenditure data provide an indication of the level of resources used by the mental health service system, they are central to any public reporting system. Understanding the reasons for differences in spending per client and the types of services funded will be enormously useful for the policy debates on new initiatives or policy changes.

Specific Performance Measures

A successful performance and outcomes measurement project should enable RSNs and providers to monitor their performance by using data to identify trends and to make comparisons with like organizations. In addition, any performance and outcomes measurement project implemented in Washington should supply state administrators and purchasers with data that can inform their decision-making. In order to accomplish these goals, selected measures should at the very least address the following three basic questions.

- How many children are being served?
- At what cost?
- Have the children improved while in service?

In addition to addressing the questions above, selected performance and outcomes measures were chosen based upon compatibility with the following criteria.

- Comparability,
- Reasonableness,
- Level of Provider Impact and Burden,
- Cost to Collect and Report, and
- Purchaser Usefulness.

In other words, performance projects should include measures that are useful and comparable. At the same time, these measures should be reasonable; they should be neither burdensome nor costly to collect and report.

Our recommendations build upon the JLARC Measurement Framework from the December 2000 JLARC Audit Report and take into account the above criteria. In addition, measures were chosen based upon their relevance to children's services; whether the data are currently collected or could be collected with minimal additional effort; and whether the measure is utilized or recommended by a recognized state or national performance measurement initiative. To accomplish this, the measures in the JLARC Measurement Framework were compared to the measures from a number of state and national initiatives (Appendix 5).

The following measures are recommended for monitoring and tracking the performance and outcomes of the children's public mental health system in Washington State. Details and recommendations for specific measures are provided in Appendix 6.

Access Measures

1. *Penetration rate* [2]
2. *Utilization rate*[3] *for specific service types*
3. *Consumer/family perception of access*

[2]Penetration rate is the proportion of a specified population that received a mental health service. It is calculated by dividing the unduplicated number of individuals who received a mental health service by the total covered population.

[3] Utilization rate measures the use of a single service or type of service, e.g. hospital care or outpatient services. It is usually expressed in rates per unit of population for a given period, e.g. total number of admissions (or discharges) to a hospital per 1,000 covered individuals per year.

Rationale

Many state and national performance measurement initiatives recommend and currently use penetration and utilization rates to measure access to care. As emphasized in the Sixteen State Study on Mental Health Agency Performance Measures, these indicators address "the fundamental issue of whether persons with mental illnesses are receiving mental health services and whether the system is responsive to various consumer populations".4 Because other initiatives frequently collect and report data on these measures, Washington State will have the opportunity to compare its system performance to that of other states.

The consumer perspective is critical in any measurement system and numerous groups also recommend utilizing a survey to capture consumer perception of timely and convenient access to services. MHD currently collects these data through the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. The MHSIP survey is widely administered in many states and there may be the opportunity for Washington to compare its performance to that of other states by using the MHSIP survey results.

Discussion

Penetration rates are usually calculated either for the general population or for a specific Medicaid population. Penetration should be calculated using an unduplicated count of the number of individuals who receive a publicly funded mental health service as the numerator. For the general population, the denominator should be the population count of children in Washington (or in a particular RSN's catchment area). The most common way to calculate Medicaid penetration is to use the total unduplicated number of children enrolled in Medicaid as the denominator (some systems use average monthly enrollment instead of the unduplicated number). Penetration rates are often broken out by age, ethnicity, gender and diagnostic categories.

Utilization rates for a specific service type can be calculated as a penetration rate (for instance, percent of individuals receiving any mental health services who received inpatient services) or as a standardized rate of units provided (for instance, number of inpatient discharges or inpatient days per 1,000 population or per 1,000 Medicaid enrollees). Ideally, both levels of analysis would be available. Utilization rates should be calculated and monitored for various service types, including inpatient, outpatient (or another general category of community-based service) and residential care.

Consumer/family access to care is collected using self-report or family completed surveys. As previously mentioned, the MHSIP consumer survey is an instrument commonly used in public sector mental health systems to capture consumer perception of access and other key aspects of care. MHSIP has also developed a survey specific to youth that can be completed by family members of young children or by older adolescent consumers. MHSIP data are usually reported as the percentage of respondents' average ratings on a set of access questions. (For instance, on the current 5-point scale data can be reported as the percentage of respondents with an average score greater than 3.5 on the access-related questions.) Washington should continue to utilize the MHSIP survey to capture these data. However, Washington may want to consider moving to the Experience of Care and Health Outcomes (ECHO) instrument if and when this instrument replaces the MHSIP survey as the standard for public mental health systems. The ECHO is a relatively new instrument that incorporates features of both the MHSIP survey and the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS is a survey designed to

[4] Sixteen State Pilot Study, State Mental Health Agency Performance Measures, Draft Operational Measures, Prepared by the National Association of State Mental Health Program Directors Research Institute, Inc., February 27, 2001, (www.mhsip.org).

evaluate comprehensive managed care plans and incorporates supplemental questions for plans that include behavioral health in their benefits. Other factors to consider in collecting consumer data are the methods of survey administration, sample selection, frequency of administration, and whether to modify the standardized instrument to make it state-specific.

Quality/Appropriateness Measures

1. *Consumer/family perception of quality/appropriateness*
2. *Consumer/family perception of participation in decision-making*
3. *Follow up after hospital discharge within 7 days*
4. *30 day readmission rate*

Rationale

Like the 'consumer perception of access' measure described above, consumer perception of quality / appropriateness and consumer perception of participation in decision-making are recommended and collected by numerous groups. Moreover, MHD is already collecting these data through administration of the MHSIP survey.

Inpatient care is a restrictive and costly form of care that should be monitored closely. It is important to ensure that children are appropriately placed and that they are appropriately discharged to a less restrictive type of service. The two measures most commonly utilized to track discharge decisions and continuity of care are probably: follow up after discharge and readmission. Tracking follow up after hospital discharge documents whether children are properly receiving care in the community after discharge. 30-day readmission rates are frequently used to indicate the appropriateness of discharge and to suggest the availability or absence of community-based services. Benchmarking Washington's performance on these indicators may be possible since both are frequently used in other states and systems of care. In addition, many of the RSNs collect and regularly monitor data on follow up after hospital discharge.

Discussion

Like consumer / family perception of access described in the previous discussion section, consumer / family perception of quality / appropriateness and perception of participation in decision-making are collected via self-report survey instruments. The MHSIP survey addresses both of these areas in its instrument for youth / families.

Individual discharge and admission data from all inpatient facilities providing publicly funded psychiatric care are needed to properly calculate and track follow up after discharge and readmission. Tracking individuals across facilities provides a more accurate view of the service system by including those children that may receive services from different inpatient facilities or different community providers. Individuals receiving both long-term and short-term psychiatric inpatient care should be included in these measures. Follow up after discharge should be calculated as the percentage of children discharged from the hospital who have a follow-up visit with a publicly funded community provider within 7 days of the discharge. Readmission rate is most often calculated by dividing the total number of children readmitted to an inpatient facility for psychiatric care within 30 days of discharge from an inpatient facility for psychiatric care divided by the total number of inpatient discharges for children receiving psychiatric care.

Outcomes Measures

1. *Consumer change as a result of services*
2. *Living situation or community tenure*
3. *Juvenile justice involvement rate*
4. *Substance abuse services rate*

Rationale

One of the key questions that any system of mental health care should want to answer is whether consumers getting better as a result of the services they receive. MHD can now collect these data from some of the RSNs through the CGAS scores or consumer/family perception of change from the MHSIP survey; the new outcomes management system should capture these data in the future.

Many systems try to track a child's living situation based upon the generally agreed upon belief that children are better off in the least restrictive setting possible, that is, not in an institutional setting but in the community with a primary caretaker.

There is general agreement in the field that children and adolescents with serious emotional disturbances who are receiving public mental health services often also need and receive services from other child-serving agencies such as juvenile justice and substance abuse agencies. Many researchers and clinicians emphasize that higher levels of integration among these agencies can have a positive impact on the quality of services children receive. Monitoring children's rate of involvement with the juvenile justice system and rate of receiving substance abuse services can increase awareness and collaboration among other agencies providing services to children with a serious emotional disturbance.

Discussion

Consumer change as a result of services can be measured by either consumer/family perception of change in a self-report survey such as the MHSIP survey or by utilizing an instrument that is completed by a clinician or consumer/family member. As described earlier, there are numerous children's outcomes instruments that can measure change in a child's level of functioning, behaviors, or problem severity. These instruments are frequently administered at intake, at set intervals while a child is receiving services and then at discharge from services. In the future, Washington's new outcomes system should provide the necessary data to track consumer change as a result of services. In the meantime, MHD can track these data using either consumer perception data from the MHSIP survey or through CGAS data. (This assumes that there is increased collection of CGAS data from the RSNs.)

The status of a child's living situation is important but can be difficult to properly define and reliably measure. MHD's living situation measure in the current RSN contract is the 'percentage of children who live in family-like settings'. In defining the measure, MHD has equated 'family-like' with 'non-institutional'. Measuring the percentage of children who lived in non-institutional settings (or the reverse: 'lived in institutional settings') is a reasonable proxy for the extent to which children receiving mental health services are living in the community. However, these data can probably be more easily tracked by monitoring the penetration rates for inpatient and residential services, as recommended above. Instead, MHD may want to consider moving toward tracking the average number of days children are living in the community or 'community tenure'. For example, Florida's mental health system reports the 'projected annual days children spent in the community'. The measure is projected to an annualized statistic from the 30 days

prior to assessment. In addition, a figure of annual days in the community may be more meaningful to stakeholders than the percentage in a family-like setting.

Measures such as the rate of substance abuse treatment services or the rate of juvenile justice system involvement for those children / youth receiving mental health services are usually calculated by matching individual client files from the public mental health system with the client files of sister agencies to determine the overlap that occurred within the previous year. In Washington, the ability to match files is increased because the Department of Social and Health Services contains the Juvenile Rehabilitation Administration (JRA), the Division of Alcohol and Substance Abuse, and MHD. These measures are usually calculated as the percentage of children receiving a mental health service who also received a substance abuse treatment service, and the percentage of children receiving a mental health service who also had an 'encounter' with the juvenile justice system in the previous 12 months. The JLARC Framework states the juvenile justice measure as 'percentage of consumers without a jail / detention stay'. Either way of calculating the measure should provide the necessary data for monitoring. The juvenile justice involvement measure should specifically define what 'encounter(s)' to include. For example, the measure should specify whether only children / youth who received a mental health service(s) and had a juvenile detention stay are included or whether children / youth who received a mental health service(s) and had a juvenile detention stay or were on probation are included.

Structure/Plan Management (Financial) Measures

1. *RSN direct service expenditures per child served*
2. *RSN service expenditures per unit of service for specific service types (for children served)*

Rationale

The total amount of direct service money spent on children receiving services reflects the level of resources systems dedicate to children receiving treatment. For all purchasers of services in the mental health system, it is important to monitor not only aggregate expenditures per child served but also the variation in expenditures that occurs between local and regional entities. The review and comparison of fiscal data assists in holding public agencies accountable and enables more informed budget and policy decisions. In addition, dollars expended provides a common unit which comparisons can be made with other systems.

Discussion

The JLARC Framework includes the financial measure 'average annual cost per consumer served'. In place of this measure, 'RSN direct service expenditures per child served' is more precise because it includes only those dollars expended on direct mental health services, not any cost to operate RSNs. This measure may be calculated by dividing the total amount expended on mental health services for children in one year by the total number of children served in the year. These data can also be stratified to calculate measures such as inpatient expenditures per child hospitalized and outpatient expenditures per child receiving outpatient services.

Similarly, annual cost per unit of service might be replaced with 'RSN direct service expenditures per unit of service'. This measure is calculated by dividing the total amount expended on a particular type of service by the number of units of the service children received. For example, the average expenditures per day of inpatient services is calculated by dividing the total dollars spent on inpatient services by the total number of inpatient days for children. This measure should be calculated at least for inpatient and outpatient services. Outpatient services can be more difficult to compare and calculate than inpatient services because different types of

outpatient service programs count units differently; they may, for example, use hours, contacts, or half-days.

Calculating per unit expenditures is important; however, it can also be informative to look at the percentage of total mental health expenditures that are dedicated to different types of services. In a future phase of implementation of the performance measurement and outcomes system, Washington may want to look at how the RSNs compare in measures such as inpatient expenditures as a percentage of total mental health expenditures or inpatient and residential expenditures as a percentage of total mental health expenditures.

CONCLUSION

In order to make informed budget and policy decisions, during this period of scarce resources for public mental health services, purchasers need data on the impact of services on consumers as well as the overall system performance. Increasingly, public mental health systems are finding it useful and necessary to systematically collect and report measurement data that can be benchmarked with other systems. Collecting, analyzing, and benchmarking performance and outcomes data within public mental health systems serving children can enable stakeholders to identify areas for improvement and thus ultimately lead to improved quality and accountability.

In recent years, Washington State has made good progress toward implementing a performance measurement program for the public mental health system. However, as the findings indicate, stakeholders in Washington need to implement new or refocused efforts, such as those outlined in this report's recommendations, aimed at developing a consistent and comparable performance and outcomes management system to ensure data are valid, reliable and useful for decision-making. In addition, public reporting of data also needs to become more frequent, systematic, and widely distributed. Investment in properly implementing performance and outcomes measures that are common to those used by other systems should provide a corresponding 'return on investment' in the form of trend data that will enable effective oversight while providing reasonable comparisons between RSNs and between Washington and other states.

APPENDICES

1. **Listing of Stakeholders Contacted**
2. **Description of Data Uses in Other Systems**
3. **RSN Interview Summary**
4. **Assessment of MHD Data Collection and Reporting**
5. **Comparison of Current Framework to Other Initiatives**
6. **Recommendations**
7. **Acronyms and Glossary**

APPENDIX 1
LISTING OF STAKEHOLDERS CONTACTED

MENTAL HEALTH DIVISION

Judy Hall, Research Director
Susan Lucas, Chief of Finance
Richard Onizuka, Chief, Mental Health Services
Sabine Whipple, Children's Mental Health Specialist

RSN STAFF

Chelan-Douglas RSN:
Robin Lewellyn

Clark County RSN:
Cheri Dolezal

Grays Harbor RSN:
Becky Kellas

Greater Columbia Behavioral Health RSN:
Rene Ulam
Carrie Huie-Pascua

King County RSN:
Shelle Crosby
Karen Spoelman

North Central RSN:
Deborah Murray

Northeast RSN:
KarenVache

North Sound RSN:
Greg Long

Peninsula RSN:
Anders Edgerton
Stacey Smith

Pierce County RSN:
Doug Crandall

Southwest RSN:
Lesley Bombardier

Spokane County RSN:
Theresa Wright

Thurston-Mason RSN:
Mark Freedman

Timberlands RSN:
Ann Rockway

MENTAL HEALTH PROVIDERS

WA Community Mental Health Council: Cathy Gaylord, Chief Executive Officer
Rick Weaver, Past-President
Board of Directors

LEGISLATIVE STAFF

Children & Family Services Committee: Deborah Frazier, Senior Research Analyst

APPENDIX 2
DESCRIPTIONS OF DATA USES IN OTHER SYSTEMS

CALIFORNIA

California's Department of Mental Health reports annually to the Fiscal and Policy Committee of the state legislature regarding the Department's 'Children and Youth Performance Outcomes System'. This system collects data on children receiving public mental health services. Providers at the county level collect the data utilizing numerous child-specific assessment instruments.

The state requires providers to use five 'core' assessment instruments and designates an additional two instruments as optional. The five required instruments are:

- Child & Adolescent Functional Assessment Scale (CAFAS)
- Child Behavioral Checklist (CBCL)
- Youth Self Report (YSR)
- Client Living Environment Profile (CLEP)
- Client Satisfaction Questionnaire (CSQ-8)

The instruments are completed within 60 days of the client's involvement with county mental health; annually; and upon discharge.

The state reports the assessment data to the counties every 6 months and provides the counties with county-specific data, comparative data from their region, and statewide data. The state has recently begun to relate counties' data reporting compliance and accuracy to their eligibility for special project grants. Thus, if a county does not comply with data reporting requirements they will not receive special project grants.

CLINICAL INFORMATICS: PACIFICARE BEHAVIORAL HEALTH CARE ALERT SYSTEM

Now in its third year, the PacifiCare Behavioral Health's ALERT system is an outcomes project that is used both as a clinical tool for providers and for outcomes profiling. The system collects data for children and adolescents using a one page self report questionnaire that adolescents or family members (for younger children) complete during the first, third, and fifth session with a provider. Data are used to identify youth at risk of substance abuse or suicide. As soon as an at-risk consumer is identified, a notification letter is sent directly to the provider. In addition, PacifiCare utilizes the data to create case-mix-adjusted outcomes profiles for provider practices. The ALERT system has the ability to measure a client's actual change in comparison to an expected change score to determine whether the individual's outcome is better or worse than other individuals with similar characteristics.

COLORADO

Colorado's Performance Incentive Program was established to monitor the performance of the state's eight regional managed care organizations (MCOs), which provide public mental health services. The state applies financial incentives for the MCOs to ten specific indicators that include, for example, penetration rate and MHSIP survey results. In the first year of the program, Colorado used the median as the target; eventually however, they would like to use national benchmarks.

FLORIDA

Florida's Department of Children and Families must report data annually to the legislature on General Appropriations Measures. These measures are used in developing the annual state budget. The state requires that providers meet certain standards for each measure. If a provider does not meet the specified standards and does not comply with corrective action plans, it's contract can be revoked. The state also collects additional programmatic measures that are utilized internally for quality improvement.

General Appropriations Measures related to children's mental health include: the annual days children spend in the community; the number of children served within specific service types; and the percent of children with emotional disturbances who improve their level of functioning.

NEW MEXICO

The New Mexico Child, Youth and Families Department reports only one behavioral health measure as part of the General Appropriations Act Measures that are reported annually to the state legislature regarding overall child well being. The one children's behavioral health measure is "Percent of Children in Families receiving behavioral health services who experience an improved level of functioning at discharge", measured with the Children's Functional Assessment Rating Scale (CFARS) instrument.

NEW YORK

New York State uses performance and outcomes measurement to monitor a number of pilot programs. In addition, the state recently implemented the use of the Child and Adolescent Needs and Strengths (CANS) instrument in 26 of 52 counties. However, there are no full-scale statewide performance or outcomes measurement programs in place and the state is awaiting results from the counties utilizing CANS before it extends the program.

OREGON

Oregon's Office of Mental Health and Addiction Services developed a comprehensive Performance Indicators Project in Fiscal Year 1999 to monitor and improve the performance of the state's Mental Health Organizations (MHOs). Oregon prepares a comprehensive annual public report on this project; the report describes the performance goals, specifies each indicator, displays the data, and describes the data sources and any data limitations. Wherever possible,

the project reports data individually for the 12 MHOs and also provides statewide data on each indicator for comparison purposes. The project focuses on utilizing the data for quality improvement purposes; no financial penalties or incentives are associated with the indicators.

The Oregon Performance Indicators Project categorizes performance measures into the following five domains: access; quality; integration and coordination; prevention, education, and outreach; and outcomes. Indicators include, for example: percentage of consumers discharged from an acute care facility or state-run psychiatric facility who receive outpatient services within 7 days; amount spent on mental health services per member served; and percentage of positive responses to 'as a result of the treatment your child has received so far, do you believe things have improved for you and your child?'

PENNSYLVANIA

Pennsylvania operates an Early Warning Program (EWP) to monitor the state's Medicaid managed care program for behavioral health. The EWP has now been implemented in all 25 Pennsylvania counties with Medicaid managed care. The EWP focuses on reporting data for a selected set of real-time, performance-based, clinical and operational measures related to service authorizations, inpatient readmission, claims payment, grievances and provider opinion surveys.

Pennsylvania found that it was able to identify and address particular system problems by closely monitoring the data. For example, service authorization data identified one participating county with a low rate of authorization for services, as compared to other counties. The state was able to encourage this county's managed care program to put in place additional systems to increase access to services such as modified intake procedures and monitored waiting lists. The EWP resulted from extensive collaboration with system stakeholders including consumers, families, advocates, managed care organizations, provider groups, and federal agencies. The data from the EWP were widely distributed to stakeholders and made publicly available via the web.

APPENDIX 3
RSN INTERVIEW SUMMARY

	Level of Functioning	Outcomes	Satisfaction	Additional Performance Measures	Data Uses	Data Validity/ Reliability	General Structure	Comments
King Co.	CGAS	Yes: such as homelessness, housing, incarceration, age appropriate activities, and level of functioning	Tried in past, not great reliability. Used CSQ-8 face-to-face but in future will use MHSIP survey	King has just begun to match Juv Detention data to client files	Quarterly report cards, QM, Moving toward provider-specific reporting, UM, support for case rate payment structure, cross-system reports, and needs assessments	Monitor data submission timeliness and completeness; verify data accuracy through clinical record audits	UBH ASO holds provider contracts	Have not found financial performance incentives useful
Greater Columbia (GCBH)	Had been in GCBH data dictionary but not as a required field. There are varying degrees of compliance. GCBH has begun analysis of level of functioning.	Do reviewTOP data during on-site provider chart reviews.	MHSIP survey, face-to-face interviews	Additional access indicators such as intensity of outpatient services prior to hospitalization, readmissions, and time from 1st contact to ongoing service.	Management of service utilization; program development; QM Oversight Committee analysis; trend identification; funding decisions.		Decentralized; RSN contracts with County then to provider or directly with provider	GCBH's data dictionary is very similar to MHD
Clark Co.	BERS	Yes	CSQ-8, Quarterly	Baseline for employment & homeless; next contract will incorporate	CQI to monitor system; incentive payments	Run data checks on submissions and return to providers to correct errors	Performance-based contracts with providers	

	Level of Functioning	Outcomes	Satisfaction	Additional Performance Measures	Data Uses	Data Validity/ Reliability	General Structure	Comments
Southwest	No	No	SW RSN-specific survey; Require providers to collect at least 25 surveys monthly	Receive daily juvenile detention report matched to client files then data shared with providers	Annual Report		Contract directly with 2 major providers, plus a few ancillary services	Good local collaboration with schools, child welfare etc.
Grays Harbor	No	No	Provider-specific survey; all consumer/ parents	No	Only look at # served and # Medicaid		Contract directly with 2 providers. Small RSN 2 staff.	Do addtl UM monitoring
Pierce	Ohio Scales / Assessment instrument	Ohio Scales / Assessment instrument	Used to perform own survey; now rely on state MHSIP survey	Hope & Recovery, social relations.	QI process, monitor trend data, look at outliers (typically 1 SD from mean)	Data quality checks for missing / incorrect data, freq reporting to provs.	Contract directly w/ 3 large CMHCs & 3 specialty provs.	Perf measures in contract such as penetration & community integration. In process of establishing specific targets and penalties/rewards.
Spokane	No	Not sure	Service specific surveys. Mostly collect at time of discharge from service	Yrly monitoring of consumer involvement & case management	Use for monitoring and to provide TA to providers.	Some concern on juvenile justice& child welfare data but working closely to improve this	Contract with providers. UBH is ASO for UM/auth.	Financial penalties & incentives are in contracts but have not been strongly enforced.
Peninsula	CGAS (Ages 6-18); DC-03/PIRS-GAS (Birth to 6)	No	Peninsula-specific survey in past. Stopped due to MHD MHSIP survey	No additional requirements	Monitor only; no penalties, incentives. Use Individual CGAS data for auth., reauth and at discharge.		Sub-capitate to 4 major CMHCs, at risk including for inpt. RSN integrated structure with provider network	Try not to add anything to state requirements.

	Level of Functioning	Outcomes	Satisfaction	Additional Performance Measures	Data Uses	Data Validity/ Reliability	General Structure	Comments
Chelan-Douglas	Yes, Chelan-Douglas specific strength of functioning scale	Yes, Chelan-Douglas specific strength of functioning scale	Chelan-Douglas specific survey. Prov contracts req a specific # per quarter to be completed.	Reqs beyond the MHD data dictionary. Ex: Access to care: 1st contact to screening to 1st srvcs and time frames	Functioning scale part of reauth of srvcs that is required every 180 days for all services		Sub-capitate to 3 providers	Good local collaboration; collect more data then MHD requires
North Central	GAF, use for kids, just not under 5 yrs	Yes, providers report TOP data to RSN	Stopped own survey administration due to MHD MHSIP survey; will rely on TOP satisfaction data	Monitor TOP data	Monitor / QM with providers; no financial penalties	Incorporate data validation into contract monitoring	Sub-capitate to 3 CMHCs	Providers are trying to re-program IS to correspond to new data dictionary; otherwise no problems collecting new data
Timberlands	Yes, Timberlands specific tool incorporated in assessment	Yes, monitor employment, residential status, and education	Timberlands specific survey last year, kids separated	Indivs in ongoing care must be seen at least 1x month, crisis response time frame	QI, no financial tie		"Block grant" to 3 providers	Not sure how meaningful educ data are; only a sub-group of RSNs seem to have consistent coding
North East	GAF, to determine level of care	Moving toward using provider TOP data in the future	NE specific survey last year. In future, will use TOP satisfaction data		Part of QM Plan	Plan to incorporate measurement of integrity of data into contract reqs.	4 CMHCs: 1 in each of 4 counties in catchment area	Monthly mtg of reps from child serving groups and Informal local collaboration

	Level of Functioning	Outcomes	Satisfaction	Additional Performance Measures	Data Uses	Data Validity/ Reliability	General Structure	Comments
Thurston-Mason	Hoosier instrument modified for Thurston-Mason; used for intake and reauthorization	No	No	Track client involvement with juvenile rehabilitation (JRA)	Track / monitor utilization such as hospitalization and hospital diversion program		Contract with 2 major providers and additional providers for specialty services	
North Sound	CGAS, to determine level of care	No	Require providers to perform consumer survey every 2 years. Use results for QI.	Monitor hospital alternative program. Providers must meet 85% bed utiliz rate and 95% respite utiliz rate. In past, RSN sanctioned providers financially for not meeting targets	QI and monitoring utilization of CLIP beds and alternative program.	Instituted QI process to reduce data errors. Now holding off on data quality checks as they move to install new IS system at RSN and provider level.	Contract for approx 90% of services with provider network. An additional 4 providers provide specialty services.	

ACRONYMS:

ASO – Administrative Services Organization
BERS- Behavioral and Emotional Rating Scale: an outcomes measurement/assessment instrument specific for children/youth
CGAS- Children's Global Assessment Scale: an outcomes measurement/assessment instrument specific for children/youth
CMHCs – Community mental health centers
CSQ-8- An 8 item Consumer Satisfaction Questionnaire used in the health field
GAF- Global Assessment of Functioning Scale: an outcomes measurement/assessment instrument primarily used for adults ages 18+
MHSIP survey – Mental Health Statistics Improvement Program Consumer Survey: consumer survey targeted toward individuals receiving public sector mental health services
QI- Quality Improvement
TOP- Treatment Outcome Package: an instrument used to measure individual outcomes. Approximately half of the Washington Community Mental Health Council membership utilize this outcomes system.
UBH – United Behavioral Health: A for-profit managed behavioral health care company. 2 RSNs in Washington State contract with UBH to perform administrative services.

APPENDIX 4
ASSESSMENT OF MHD DATA COLLECTION AND REPORTING

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Comments
Domain: Access						
1	Penetration rates	✓	✓			Contract specifies 'rates by age'.
2	Utilization rates	✓	✓			Contract specifies 'rates by age' but does not specify type of service.
3	Consumer perception of access	✓		✓		Annual MHSIP survey (#15/16) for children and families. MHD completes and can stratify by RSN.
4	Average time from first contact to first service				✓	MHD does not collect data on 1st contact; some RSNs do.
Domain: Quality/Appropriateness						
1	Consumer/family perception of quality/appropriateness	✓		✓		Annual MHSIP survey (#21, 23, 24,25) for children and families. MHD completes and can stratify by RSN.
2	Percentage of consumers/families who actively participate in decision making regarding treatment	✓		✓		Annual MHSIP survey (#8, 9) for children and families includes 'consumer perception' not 'percentage' as written in the framework. MHD completes and can stratify by RSN.
3	Percentage of consumers linked to physical health services	✓		✓		Included in DSHS contract as the developmental measure 'percent of consumers who access physical health care'. MHSIP Q: 'did your child see an MD/nurse because he/she was sick?' MHD working on getting data from Medicaid services database.
4	Follow up after hospital discharge within 7 days			✓		3 inpatient data sources: Eval/Tx cntrs-RSNs report directly to MHD, Community hospitals---MMIS Medicaid reports, State hospitals--directly reported to MHD. Can calculate readmission and f/u statewide BUT problematic to breakdown by RSNs~13% of data unable to correctly attribute to correct RSN

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Comments
Domain: Quality/Appropriateness (continued)						
5	30 day readmission rate			✓		3 inpatient data sources: Eval/Tx cntrs-RSNs report directly to MHD, Community hospitals---MMIS Medicaid reports, State hospitals--directly reported to MHD. Can calculate readmission and f/u statewide BUT problematic to breakdown by RSNs~13% of data unable to correctly attribute to correct RSN
6	Percentage of jailed/detained consumers receiving mental health services while in jail/detention				✓	MHD might be able to match files with JRA at the statewide level.
Domain: Outcomes						
1	Consumer change as a result of services: consumer/family self-report and clinical assessment		✓			CGAS scores required in new data dictionary. Clinician completed. Measures individual change. Scores can be aggregated.
2	Consumer perception of hope for the future and personal empowerment				?	Probably not relevant for kids; only older adolescents.
3	Percentage of adults employed for one or more days in the last 30 days	✓				DSHS contract states 'percent of consumers age 16 and above who are employed' but performance measure specs state only adults.
4	Percentage of available school days attended in the past 30 days			✓		Data dictionary captures whether consumer is in school or not; this may be a more practical way to measure level of school involvement.
5	Percentage of consumers who have safe and stable housing	✓			✓	Included in DSHS contract as a developmental measure as 'percent of consumers living in stable environments'.
6	Percentage of consumers without a jail/detention stay				✓	Some RSNs collect this at the local level. Not systematically collected at the MHD level.
7	Percentage of consumers without a psychiatric hospitalization	✓		✓		Included in DSHS contract as developmental measure 'percent of consumers who are maintained in the community without a psychiatric hospitalization during the last 12 months'.

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Comments
Domain: Structure/Plan Management						
1	Average annual cost per consumer served	✓			✓	Financial Data: MHD reports data are available to calculate RSN direct service expenditures per individual served. However, the data cannot currently be separated by age for a 'per child served' measure.
2	Average annual cost per unit of service	✓			✓	Financial Data: MHD reports data are available to calculate RSN direct service expenditures per unit of service for service categories such as crisis, residential and inpatient. However, the data cannot currently be separated by age to report units received by children.
3	Percentage of revenues spent on direct services	✓				Overall system measure; not directly relevant for children's services
4	Percentage of professional positions throughout the MH system held by people of color and ethnic groups the system serves				**n/a**	Overall system measure; not directly relevant for children's services
5	Percentage of consumers with dual diagnoses who have service plans coordinated with other systems				✓	
6	Overall community partner satisfaction				**n/a**	Overall system measure; not directly relevant for children's services
Additional Measures						
1	Percent of consumers who were homeless in the last 12 months by age and priority population	✓	✓			Homeless is a category under data element 'living situation'.
2	Percent of children who live in family-like settings	✓	✓			Perf measure specs specify 'children who lived in non-institutional settings' and separately 'who where living at home'.
3	Percent of children and adolescents receiving services in natural settings (e.g. out of clinician office)	✓	✓			Treatment setting is a data element.

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Comments
Additional Measures (continued)						
4	Percent of consumers who receive services by both MHD and Div of Alcohol and SA in the previous 12 months	✓		✓		Included in DSHS contract as a developmental measure. Source: DSHS Client Services Database to collect both DASA and MHD service utilization.

APPENDIX 5
COMPARISON OF CURRENT FRAMEWORK TO OTHER INITIATIVES

	JLARC Report - MH System Performance Audit Framework	NASMHPD 16-State Study	Children's Outcomes Roundtable 3/13/02	OR Perf. Project	FLA Legislative Measures	Children's MH Benchmarking Project	Comments
Domain: Access							
1	Penetration rates	✓	✓	✓	✓	✓	FLA: only report # served, not rate
2	Utilization rates	✓	✓			✓	
3	Consumer perception of access	✓	✓	✓	✓		FLA: family satisfaction with services
4	Average time from first contact to first service	✓					OR: average number of days between 1st assessment and follow-up services
Domain: Quality/Appropriateness							
1	Consumer / family perception of quality / appropriateness	✓	✓	✓			
2	Percentage of consumers / families who actively participate in decision making regarding treatment	✓	✓	✓			
3	Percentage of consumers linked to physical health services	✓	✓	✓			OR: no age breakdown for children
4	Follow up after hospital discharge within 7 days	✓	✓	✓			OR: no age breakdown for children
5	30 day readmission rate	✓	✓			✓	
6	Percentage of jailed / detained consumers receiving mental health services while in jail / detention						
Domain: Outcomes							
1	Consumer change as a result of services: consumer / family self-report and clinical assessment	✓	✓	✓	✓		Roundtable recommends change in LOF
2	Consumer perception of hope for the future and personal empowerment	✓					

	JLARC Report - MH System Performance Audit Framework	NASMHPD 16-State Study	Children's Outcomes Roundtable 3/13/02	OR Perf. Project	FLA Legislative Measures	Children's MH Benchmarking Project	Comments
Domain: Outcomes (continued)							
3	Percentage of adults employed for one or more days in the last 30 days		✓				OR: only adults surveyed
4	Percentage of available school days attended in the past 30 days	✓	✓		✓		Roundtable: '% of kids whose attendance improved while in treatment'
5	Percentage of consumers who have safe and stable housing						
6	Percentage of consumers without a jail / detention stay	✓	✓	✓	✓	✓	16 state: percent of consumers arrested; Roundtable: % of kids whose encounters with law enforcement decreased while receiving services
7	Percentage of consumers without a psychiatric hospitalization						
Domain: Structure/Plan Management							
1	Average annual cost per consumer served	✓		✓	✓	✓	OR: no age breakdown for children
2	Average annual cost per unit of service					✓	
3	Percentage of revenues spent on direct services						
4	Percentage of professional positions throughout the MH system held by people of color and ethnic groups the system serves						
5	Percentage of consumers with dual diagnoses who have service plans coordinated with other systems						
6	Overall community partner satisfaction				✓		
Additional Measures							
1	Percent of consumers who were homeless in the last 12 months by age and priority population	✓				✓	

	JLARC Report - MH System Performance Audit Framework	NASMHPD 16-State Study	Children's Outcomes Roundtable 3/13/02	OR Perf. Project	FLA Legislative Measures	Children's MH Benchmarking Project	Comments
Additional Measures (continued):							
2	Percent of children who live in family-like settings	✓	✓		✓		Roundtable: % of children in non-family like settings; 16-state: for SED only, FLA: 'community tenure' days in community
3	Percent of children and adolescents receiving services in natural settings (e.g. out of clinician office)	✓	✓				
4	Percent of consumers who receive services by both MHD and Div of Alcohol and SA in the previous 12 months			✓		✓	OR: no age breakdown for children

APPENDIX 6
RECOMMENDATIONS

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Preliminary Recommendations
Domain: Access						
1	Penetration rates	✓	✓			Yes: core measure
2	Utilization rates	✓	✓			Yes: core measure
3	Consumer perception of access	✓		✓		Yes: Use MHSIP youth/family survey or another statewide survey instrument
4	Average time from first contact to first service				✓	'1st contact' too difficult to measure
Domain: Quality/Appropriateness						
1	Consumer/family perception of quality/appropriateness	✓		✓		Yes: Use MHSIP youth/family survey or another statewide survey instrument
2	Percentage of consumers/families who actively participate in decision making regarding treatment	✓		✓		Yes: Use MHSIP youth/family survey or another statewide survey instrument
3	Percentage of consumers linked to physical health services	✓		✓		Consider as a secondary measure for future
4	Follow up after hospital discharge within 7 days			✓		Yes
5	30 day readmission rate			✓		Yes
6	Percentage of jailed/detained consumers receiving mental health services while in jail/detention				✓	focus on Outcomes #6 below instead.
Domain: Outcomes						
1	Consumer change as a result of services: consumer/family self-report and clinical assessment		✓			Yes: Use MHSIP survey initially; new outcomes system should capture this in the future.
2	Consumer perception of hope for the future and personal empowerment				?	Focus instead on other measures of consumer/family perception

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Preliminary Recommendations
Domain: Outcomes (continued)						
3	Percentage of adults employed for one or more days in the last 30 days	✓				Only relevant to portion of youth population
4	Percentage of available school days attended in the past 30 days			✓		Choose a different school-related measure; consider as a secondary measure
5	Percentage of consumers who have safe and stable housing	✓			✓	Instead use 'living situation' from Additional Measures #5/6 below
6	Percentage of consumers without a jail/detention stay				✓	Yes: encourage MHD to match files with JRA; won't be able to analyze by RSN
7	Percentage of consumers without a psychiatric hospitalization	✓		✓		Can be captured similarly with utilization and penetration rates by service
Domain: Structure/Plan Management						
1	Average annual cost per consumer served	✓			✓	Yes: core measure
2	Average annual cost per unit of service	✓			✓	Yes: core measure
3	Percentage of revenues spent on direct services	✓				It's an overall system measure
4	Percentage of professional positions throughout the MH system held by people of color and ethnic groups the system serves				**n/a**	It's an overall system measure
5	Percentage of consumers with dual diagnoses who have service plans coordinated with other systems				✓	Coordination difficult to measure; focus instead on measure of those receiving services from both DASA/M
6	Overall community partner satisfaction				**n/a**	It's an overall system measure
Additional Measures						
1	Percent of consumers who were homeless in the last 12 months by age and priority population	✓	✓			Important information but extremely difficult to capture with any reliability/confidence
2	Percent of children who live in family-like settings	✓	✓			Yes, but modify

	JLARC Report - MH System Performance Audit Framework	DSHS Contract with RSNs	Current Data Dictionary	Other Current Data Source	No Current Source	Preliminary Recommendations
Additional Measures (continued)						
3	Percent of children and adolescents receiving services in natural settings (e.g. out of clinician office)	✓	✓			Consider as a secondary measure for future
4	Percent of consumers who receive services by both MHD and Div of Alcohol and SA in the previous 12 months	✓		✓		Yes, but perhaps consider as a secondary measure.

APPENDIX 7
ACRONYMS AND GLOSSARY

ASO – Administrative Services Organization

A management entity that performs services under contract such as authorizations and utilization reviews but does not assume financial risk.

BERS - Behavioral and Emotional Rating Scale

An outcomes measurement / assessment instrument specific for children / youth.

CAFAS - Child and Adolescent Functional Assessment Scale

An outcomes measurement / assessment instrument specific for children / youth.

CAHPS - Consumer Assessment of Health Plans Survey

A consumer survey designed for use to assess satisfaction with comprehensive managed care plans, includes supplemental questions for plans that include behavioral health in the benefit plan.

CANS - Child and Adolescent Needs and Strengths

An outcomes measurement / assessment instrument specific for children / youth.

CFARS - Children's Functional Assessment Rating Scale

An outcomes measurement / assessment instrument specific for children / youth.

CGAS - Children's Global Assessment Scale

An outcomes measurement / assessment instrument specific for children / youth

CMHC – Community Mental Health Center

A facility that provides primarily outpatient mental health services.

CSQ-8

An 8 item Consumer Satisfaction Questionnaire used in the health field.

ECHO-Experience of Care and Health Outcomes

Consumer satisfaction instrument.

GAF- Global Assessment of Functioning Scale

An outcomes measurement / assessment instrument primarily used for adults ages 18+.

MHD-Mental Health Division

Entity responsible for the administration of Washington state's public mental health system. MHD is located within the Washington State Department of Social and Health Services (DSHS).

MHSIP Survey – Mental Health Statistics Improvement Program Consumer Survey

Consumer survey targeted toward individuals receiving public sector mental health services

Ohio Scales - Ohio Youth, Problem Functioning and Satisfaction Scale

An outcomes measurement/assessment instrument used for children/adolescents. There are three parallel versions completed by the child (12-18 years), parent/primary caretaker, and provider.

Penetration Rate (for Mental Health)

The proportion of a specified population that received a mental health service. Penetration rate is calculated by dividing the unduplicated number of individuals who received a mental health service by the total covered population (for example, state population or population of individuals enrolled on Medicaid)..

RSN-Regional Support Network

Regional entities in Washington State which have a contractual relationship with the Mental Health Division (MHD) to plan and administer the services provided in each region for persons eligible for publicly funded mental health services. The 14 RSNs contract with public and private agencies that provide the mental health services.

SAMHSA – Substance Abuse and Mental Health Services Administration

A federal government agency of the Department of Health and Human Services. SAMHSA houses the Centers for mental health service and substance abuse.

TOP- Treatment Outcome Package

An instrument used to measure individual outcomes. Approximately half of the Washington Community Mental Health Council membership utilize this outcomes system.

UBH – United Behavioral Health

A for-profit managed behavioral health care company. Two RSNs in Washington State contract with UBH to perform administrative services.

Utilization Rate

A rate measuring the use of a single service or type of service, e.g. hospital care or outpatient services. It is usually expressed in rates per unit of population for a given period, e.g. total number of admissions (or discharges) to a hospital per 1,000 covered individuals per year.