Kentucky Department for Behavioral Health,
Developmental and Intellectual Disabilities

BHDID Performance Indicator Implementation Guide

Applicable to State Fiscal Year 2023 Contracts

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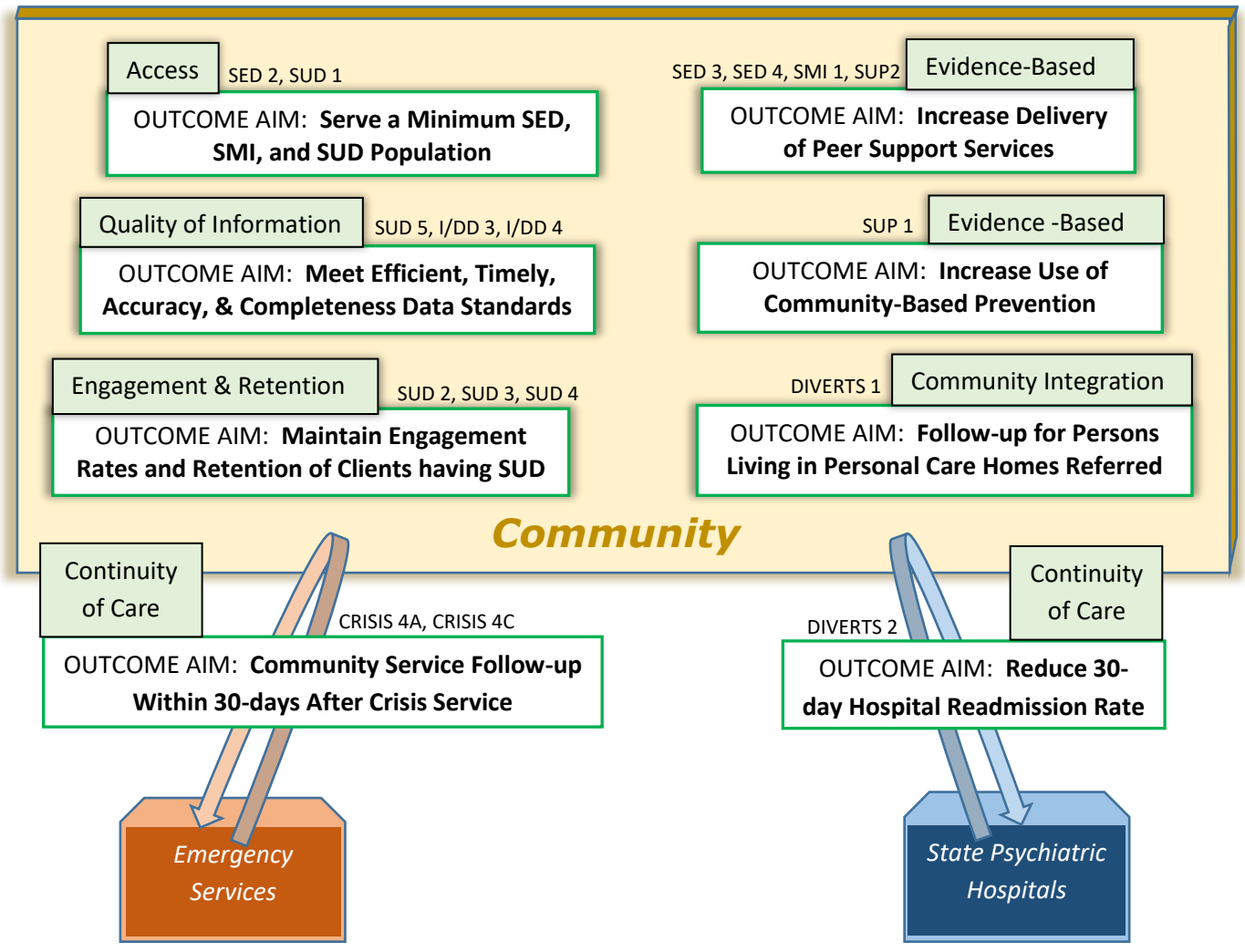
KENTUCKY DBHDID CONTRACTUAL PERFORMANCE INDICATORS OVERVIEW 2023

Annually, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracting processes are becoming more performance-based. The CMHC Payments section of the CMHC contract describes the accountability associated with Performance Indicators (PIs). This guide describes the PIs associated with the SFY23 Contracts and is posted at http://dbhdid.ky.gov/cmhc/documents/dpr/Performance%20Indicator%20Implementation%20Guide.pdf

Performance Indicators (PIs) focus on systemic outcomes of services provided by Kentucky's Community Mental Health Centers and other providers. As shown in Figure 1, the PIs are categorized into domains of measure including Access, Evidence-Based Services, Quality of Information, Engagement and Retention, Community Integration, and Continuity of Care. Within these domains, outcome aims are designed to improve the system of care and the integration of services provided in the community, residential crisis stabilization, and psychiatric hospitals.

Figure 1: Performance Indicators associated with SFY23 contracts



Funding Source	Performance Indicator
Emergency Services: two measures place at risk a total of 2% of the total Emergency Services funding	**Domain: Continuity of Care** **CRISIS4A: Continuing Care Engagement Following Crisis Services for Adults** **Measure #4 applies to all CMHCs.** The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. Toward this intent, the DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential crisis stabilization, or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%. **Risk: 1% of total emergency services funding** **Domain: Continuity of Care** **CRISIS4C: Continuing Care Engagement Following Crisis Services for Children** **Measure #4 applies to all CMHCs.** The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. The DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential crisis stabilization, or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%. **Risk: 1% of total emergency services funding**

DIVERTS Total of 6% allocated DIVERTS funding	**DIVERTS1: 14-Day Follow-up for Accessible Referrals Made to the Settlement Agreement Data Tracking Tool** The DBHDID shall assess the percentage of accessible referrals made during the monitoring period which received an InReach service. The CMHC must conduct an InReach service within fourteen (14) days of the referral date for 90% of the accessible referrals made during the monitoring period. **Risk: 3% of DIVERTS funding** **DIVERTS2: Hospital Readmissions for CMHC Referrals – 30 Days** The DBHDID shall assess the percentage of individuals discharged from state owned or state-operated psychiatric hospitals with a referral for treatment to the CMHC as a provider of community behavioral health services and were subsequently readmitted to any Kentucky state-owned or state operated psychiatric hospital within thirty (30) days of the previous discharge date. **Risk: 3% of DIVERTS funding**
SMI Total of 1% allocated SMI funding	**SMI1: Peer Services for Adults with SMI** The DBHDID shall assess the percentage of individuals receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of adults having SMI who receive Adult Mental Health Peer Support Services. **Risk: 1% of SMI funding**
SED Total of 2.5% allocated SED funding	**SED2: Child Population with SED Who Receive Targeted Case Management** The DBHDID shall assess the percentage of the region's estimated SED population that are served as SED clients and receive Targeted Case Management service. The region's estimated SED population is defined as the estimated number of children and youth with SED in the region (5.0% of total child population per 2010 census). The expected standard of performance is 8% for the current monitoring period. That is, Regions serve 8% of the estimated 5% of the population under age 18. **Risk: 2% of SED funding** **SED3: Peer Services for Children and Youth** The DBHDID shall assess the percentage of children and youth receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of children and youth who receive Peer Support Services. **Risk: 0.5% of SED funding**

KENTUCKY HIGH FIDELITY WRAPAROUND Total of 3% allocated IMPACT funding	**SED4: Caseloads for High Fidelity Wraparound Facilitators Serving Children/Youth** **SED4 Measure applies to all CMHC regions except regions 2 and 3.** The CMHC contract requires a specific number of High Fidelity Wraparound (HFW) facilitators to serve children/youth under age 21. The DBHDID will assess the caseload maintained by High Fidelity Wraparound (HFW) facilitators. While full caseload is defined as no more than ten (10) persons per HFW facilitator per month, this measure expects that 50% of a full caseload will be maintained. **Risk: 3% of total IMPACT allocation**
~~SA~~ SU Prevention Total of 1% allocated Block Grant Prevention funding	~~**SAP1**~~ **SUP1: Regional Prevention Centers Use of Community-Based Process Strategy** **Measure #1 applies to all CMHC regions operating a Regional Prevention Center** The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy "Community-Based Process". The BHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the "Community-Based Process" CSAP Strategy. 70% of all activities delivered by all Regional Prevention Centers must be within the community-based process category of activities. **Risk: 1% of Block Grant Prevention funding** ~~**SAP12**~~ **SUP2:** Regional Prevention Centers Total Time of Prevention Activities Entered in the Prevention Data System **Measure #2 applies to all CMHC regions operating a Regional Prevention Center** The DBHDID's evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS in order to accurately and completely articulate the prevention efforts delivered, as required by the Substance Abuse Prevention and Treatment Block Grant and prevention-focused discretionary grants. The expected standard of performance for each respective center is entry of a minimum of ~~40%~~ 45% of available time, as measured on the 110D as submitted during the Plan & Budget process. **Risk: 0% of Block Grant Prevention funding**
~~SA~~ SU Treatment Total of 4% allocated ~~SA~~ SU Treatment funding	**SUD1: Percent of Census Population Served** This measure calculates the percentage of the census population served that are estimated in need of treatment. **Risk: 0% of SUD funding** **SUD2: Number of Services per Treatment Episode** This measure calculates the average number of outpatient services provided for Treatment

	Episodes Data Set (TEDS) episodes which lasted for thirty (30) days or longer. **Risk: 1% of SUD funding** **SUD3: Percent of Treatment Episodes Lasting Thirty (30) Days or Longer** This measure calculates the percent of outpatient TEDS Episodes which lasted thirty (30) days or longer. **Risk: 1% of SUD funding** **SUD4: Number of Services in the First Thirty (30) Days** This measure calculates the number of outpatient services provided during the first thirty (30) days post admission. **Risk: 1% of SUD funding** **SUD5: TEDS Data Accuracy** This measure monitors the accuracy of client fields reported in the Treatment Episode Data Set (TEDS). **Risk: 1% of SUD funding**
Kentucky Moms Mater	No performance indicator identified.
Driving Under the Influence (DUI) Services	No performance indicator.
Alcohol Intoxication Services (AI)	No performance indicator.
Developmental and/or Intellectual Disabilities (DDID) Total of 2% allocated I/DD general funds	**I/DD3: Consistency and Accuracy of Client's Reported Receiving SGF Services.** The DBHDID shall assess the accuracy and consistency of information reported via the Form 140 with the client listing report as due through the Department Periodic Report processes. The form is due by the end of the calendar month following the end of each quarter. Consistency and accuracy of information reported will be determined by the review of form 140 with the client listing to verify that the number of clients reported receiving each SGF service is the same on both reports for the same period. **Risk: 1% of DDID funding** **I/DD4: Crisis Initial Response and Reporting** The DBHDID must ensure that all individuals who are identified as having an intellectual or developmental disability and seeking crisis services are referred to on-call, qualified I/DD

	crisis responders for appropriate and timely intervention. CMHCs are required to submit documentation of all crisis events via the Crisis Contact Data Sheet (CCDS) system. Crisis sheets are reviewed monthly and approved if contract requirements for crisis responses are met. DBHDID shall assess the rate of approved crisis sheets for the monitoring period. The expected standard of performance is that ~~60%~~ 75% of all CCDS are submitted timely and indicate that the appropriate response was provided per contract requirements. **Risk: 1% of DDID funding**

SECTION 2.01–KENTUCKY EMERGENCY RESPONSE AND CRISIS PREVENTION SYSTEM (CRISIS)

Domain: Continuity of Care

CRISIS4A: Continuing Care Engagement Following Crisis Services for Adults

CRISIS4A applies to all CMHCs.

The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential crisis stabilization, or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%.

Evidence of an episode of crisis care is defined by one or more of the following two circumstances:

1) The occurrence of one or more days of consecutive residential crisis service events in the event file as specified in the table below.

2) The occurrence of Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service in the event file as specified in the table below.

Service Name	SFY14 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"	SFY215, SFY16, SFY17, SFY18, SFY19, SFY20, SFY21, SFY22 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
Mobile Crisis Response	076	176
I/DD Crisis Prevention	091	191
Crisis Intervention	n/a	200, 210, 211
Residential Crisis Stabilization (MH Adults)	138	138*
Residential Crisis Stabilization (MH Children & Youth)	139	139*

** Service Codes 138 and 139 will not apply to providers that do not have a CMHC-operated Crisis Stabilization Unit for adults or children.*

Risk: 1% of total emergency services funding

Rationale: Engagement is critical for treatment success and foundational for a recovery-oriented system. This measure demonstrates a high performance gap area; evidence shows that follow-up is a significant problem for individuals having mental illness compared to the general population. Guidelines of the National Institute of Mental Health and the Centers for Mental Health Services indicate that outcomes are poorer when follow up does not occur. An outpatient visit with a mental health practitioner after discharge from crisis care is recommended to make sure that patients' transitions to the home or work environment is supported and that gains made while in crisis care are not lost. This helps health care providers detect early post-hospitalization reactions or medication problems while providing continuing care. This contract performance measure is adapted from NCQA Guidelines to involve Kentucky's billable crisis services.

Numerator: Of the clients counted in the denominator, the number of clients receiving at least one (1) service within thirty (30) calendar days following the last day of a residential crisis stabilization or a mobile crisis response, crisis intervention, or I/DD crisis prevention service(s). The service must be a valid service code according to the DBHDID Data Implementation Guide (specifically Appendix E) and reported in the Event file. The follow-up service does not have to be provided by the same CMHC that delivered the crisis service(s). Clients receiving only an episode of crisis care within the thirty days is not included in the numerator. Services that occur on the same day as the crisis service do not apply.

Denominator: The number of the region's clients that are age 18 or older having an episode of residential crisis stabilization lasting one (1) or more calendar days or receiving a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention Service. "Region's client" is defined by clients having "client status" 1 in the client file and by the occurrence of a non-crisis service within ninety (90) calendar days prior to the current episode of crisis care. The service delivered 90 days prior to the current episode of crisis care are to be delivered by the same provider and will be followed by a gap in crisis events. The service delivered 90 days prior to the current crisis episode will not include the five crisis services in the table above (Residential Crisis Stabilization-MH Children & Youth, Residential Crisis Stabilization- Adults, Mobile Crisis Response, Crisis Intervention, and I/DD Crisis Prevention Service).

Benchmark: The expected standard of performance is that clients must receive a service within thirty (30) days after an episode of crisis care. The last completed three (3) years of data were used to determine the target.

Target: The 30-day rate of follow-up must be at or above 45%.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Event Data Set (field "NTE02 DMHMRS_Modifier_1")

Denominator Source: Client Data Set (fields "Client Status" and diagnoses); Event Data Set (field "NTE02 DMHMRS_Modifier_1")

Baseline: The statewide median value for the last completed four (4) years of data.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

References:

The National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) 2015 technical specifications for Accountable Care Organization (ACO) measurement. Washington (DC): National Committee for Quality Assurance (*NCQA); 2014. Measure #0576 (FUH-AD) which measures follow-up for persons having schizophrenia discharged from psychiatric hospital. This contract performance measure is adapted to involve Kentucky's system of Crisis Residential Service and billable crisis services.

Domain: Continuity of Care

Proposed CRISIS4C: Continuing Care Engagement Following Crisis Services for Children

CRISIS4C applies to all CMHCs.

The DBHDID must ensure that clients receive ongoing engagement of services following an episode of crisis care. The DBHDID shall assess the rate of follow-up for the region's clients who experienced an episode of residential

crisis stabilization or received a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service. The expected standard of performance is that clients must receive a service within thirty (30) calendar days after an episode of crisis care. The measure includes only services that occur between the first day of the monitoring period and thirty (30) or more calendar days before the end of the monitoring period. The rate of follow-up must be at or above 45%.

Evidence of an episode of crisis care is defined by one or more of the following two circumstances:

1) The occurrence of three or more days of consecutive residential crisis service events in the event file as specified in the table below.

2) The occurrence of Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention service in the event file as specified in the table below.

Service Name	SFY14 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"	SFY15, SFY16, SFY17, SFY18, SFY19, SFY20, SFY21, SFY22 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
Mobile Crisis Response	076	176
I/DD Crisis Prevention	091	191
Crisis Intervention	n/a	200, 210, 211
Residential Crisis Stabilization (MH Adults)	138	138*
Residential Crisis Stabilization (MH Children & Youth)	139	139*

** Service Codes 138 and 139 will not apply to providers that do not have a CMHC-operated Crisis Stabilization Unit for adults or children.*

Risk: 1% of total emergency services funding

Rationale: Engagement is critical for treatment success and foundational for a recovery-oriented system. This measure demonstrates a high performance gap area; evidence shows that follow-up is a significant problem for individuals having mental illness compared to the general population. Guidelines of the National Institute of Mental Health and the Centers for Mental Health Services indicate that outcomes are poorer when follow up does not occur. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that patients' transitions to the home or work environment is supported and that gains made during hospitalizations are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. This contract performance measure is adapted from NCQA Guidelines to involve Kentucky's billable crisis services.

Numerator: Of the clients counted in the denominator, the number of clients receiving at least one (1) service within thirty (30) calendar days following the last day of a residential crisis stabilization episode of care or a mobile crisis response, crisis intervention, or I/DD crisis prevention service(s). The service must be a valid service code according to the DBHDID Data Implementation Guide (specifically Appendix E) and reported in the Event file. The follow-up service does not have to be provided by the same CMHC that delivered the crisis service(s). Clients receiving another episode of crisis care within the thirty days is not included in the numerator. Services that occur on the same day as the crisis service do not apply.

Denominator: The number of the region's clients that are under age 18 having an episode of residential crisis stabilization lasting three (3) or more calendar days or receiving a Mobile Crisis Response, Crisis Intervention, or I/DD Crisis Prevention Service. "Region's client" is defined by clients having "client status" 1 in the client file and

by the occurrence of a non-crisis service within ninety (90) calendar days prior to the current episode of crisis care. The service delivered 90 days prior to the current episode of crisis care are to be delivered by the same provider and will be followed by a gap in crisis events. The service delivered 90 days prior to the current crisis episode will not include the five crisis services in the table above (Residential Crisis Stabilization-MH Children & Youth, Residential Crisis Stabilization- Adults, Mobile Crisis Response, Crisis Intervention, and I/DD Crisis Prevention Service).

Benchmark: The expected standard of performance is that clients must receive a service within thirty (30) days after an episode of crisis care as defined above. For current contracts, the last completed three (3) years of data were used to determine the target.

Target: The 30-day rate of follow-up must be at or above 45%.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Event Data Set (field "NTE02 DMHMRS_Modifier_1")

Denominator Source: Client Data Set (fields "Client Status" and diagnoses); Event Data Set (field "NTE02 DMHMRS_Modifier_1")

Baseline: The statewide median value for the last completed four (4) years of data.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

References:

The National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) 2015 technical specifications for Accountable Care Organization (ACO) measurement. Washington (DC): National Committee for Quality Assurance (*NCQA); 2014. Measure #0576 (FUH-CH) which measures follow-up for persons having schizophrenia discharged from psychiatric hospital. This contract performance measure is adapted to involve Kentucky's system of billable crisis services and Crisis Residential Service since no psychiatric hospitals operate for children in the state. The children's version of this measure (CRISIS4C) is modeled after the Centers for Medicare & Medicaid Services Core Set of Children's Health Care Quality Measures (Child Core Set) which includes only ages 6 to 20 which is an adaption from the HEDIS measure of ages 6 and older.

Regarding the denominator used for the children's measure (CRISIS04C), the three-day length of stay is included to intentionally exclude children and youth in Crisis Stabilization Units (CSUs) as an indirect consequence of legislation-driven system of care changes. For example, instead of children going into detention, they may be cared for in a CMHC-Operated CSU for a few days.

SECTION 2.02–DIRECT INTERVENTION: VITAL EARLY RESPONSIVE TREATMENT SYSTEM (DIVERTS)

Domain: Community Integration

DIVERTS1: 14-Day Follow-up for Accessible Referrals Made to the Settlement Agreement Data Tracking Tool

The DBHDID shall assess the percentage of accessible referrals made during the monitoring period which received an InReach service. The CMHC must conduct an InReach service within fourteen (14) days of the referral date for 90% of the accessible referrals made during the monitoring period.

Goal: Follow-up on Accessible Referrals

Risk: 3% of DIVERTS funding

Rationale: The Amended Settlement Agreement (ASA) between the Cabinet for Health and Family Services and the Department for Public Advocacy was effective December 2, 2015 through September 30, 2018. The Second Amended Settlement Agreement (SASA) became effective on October 1, 2018. Embedded in these agreements are expected efforts to support adults with serious mental illness who desire to live in the community instead of a personal care home. Per the agreements, an InReach service is expected to be provided within 14 days of the referral date for persons referred to the Settlement Agreement Data Tracking Tool.

Numerator: the number of accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period for which a valid InReach service occurred within fourteen (14) calendar days of the referral date and for which this valid InReach service has a valid date recorded in the Data Tracking Tool.

Denominator: the number of accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period. Referrals will be grouped by CMHCs according to the county where the person resides or the hospital discharge location as specified in the referral form.

Target: The CMHC must conduct an InReach service within fourteen (14) days of the referral date for 90% of the accessible referrals made to the Settlement Agreement Data Tracking Tool during the monitoring period which are assigned to the CMHC according to the location specified on the referral form.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: CMHC staff updates made to the referrals in the ISA ASA SASA Data Tracking Tool

Denominator Source: Referral forms entered into the ISA ASA SASA Data Tracking Tool

Baseline: The original expectation was developed within the initial Interim Settlement Agreement (ISA) (2013) and was carried over into the Amended Settlement Agreement (ASA) in 2015 and then into the Second Amended Settlement Agreement (SASA) effective October 1, 2018. This measure has remained constant throughout the life of ISA, ASA, and SASA.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section “CMHC Contract Compliance Reports”.

Reference: The Second Amended Settlement Agreement (SASA) between the Department for Public Advocacy and the Cabinet for Health and Family Services.

Domain: Continuity of Care

DIVERTS2: Hospital Readmissions for CMHC Referrals – 30 Days

The DBHDID shall assess the percentage of individuals discharged from state-owned or state-operated psychiatric hospitals with a referral for treatment to the CMHC as a provider of community behavioral health services that were subsequently readmitted to any Kentucky state-owned or state-operated psychiatric hospital within thirty (30) days of the previous discharge date.

Risk: 3% of DIVERTS funding

Rationale: Expectations and deliverables in section 2.02 DIVERTS of the contract intend to build into the adult system of care transitions from acute care setting into the community. Additional expectations include attending Continuity of Care Committee meetings and working collaboratively with state psychiatric hospitals toward community integration and continuity of care. This performance indicator focuses on the transition from inpatient to outpatient care by monitoring the 30-day state psychiatric hospital readmission rate. The National Committee for Quality Assurance (NCQA) recognizes that lack of outpatient follow-up within a week of discharge from a 24-hour inpatient facility is associated with hospital readmissions. For persons with Serious Mental Illness, the period directly following hospitalization carries many risks. These include a relapse of their symptoms and the need for hospital readmission, an increased risk of homelessness and the possibility of violent behavior or suicide.

Numerator: Of the clients counted in the denominator, the number of individuals that were subsequently readmitted to any Kentucky state-owned or state-operated psychiatric hospital within thirty (30) days of the previous discharge date. Kentucky state-owned or state-operated hospitals related to this measure include ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital and Western State Hospital.

Denominator: The count of individuals discharged from state-owned or state-operated psychiatric hospitals (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) with a referral for treatment to the CMHC as a provider of community behavioral health services. The discharge referral must be to the same CMHC who provided a service within forty-five (45) days prior to the psychiatric hospital admission. "Client Status 1" as indicated in Client field #6 and "Severe Mental Illness" as indicated in Client field #40 "SMI" (answer value 1 = yes) must apply to the client during the monitoring period.

Target: The CMHC's rate for the monitoring period must be equal to or less than the 75th quantile mark of the CMHC's rate calculated over the past five monitoring periods.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Facility (psychiatric hospital) admission data

Denominator Source: Facility (psychiatric hospital) discharge data which have a treatment for referral to the CMHC. Client Data Set: field #6 (Client Status Code) = 1 and field #40 (SMI=1).

Baseline: The last five completed years of data are used to determine the target for each CMHC's rate.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Reference:

The Healthcare Effectiveness Data and Information Set (HEDIS), National Committee for Quality Assurance (NCQA).

National Association of State Mental Health Program Directors (NASMHPD), Assessment #3, Care Transition Interventions to Reduce Psychiatric Re-Hospitalizations. Study supported by the Center for Mental Health Services

(CMHS)/Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (HHS).

Cuffel B.J., Held M., and Goldman W., Predictive Models and the Effectiveness of Strategies for Improving Outpatient Follow-Up under Managed Care. *Psych Serv* 2002;53:1438 – 1443 (November 2002).

Nelson E.A., Maruish M.E., and Axler J.L., Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. *Psych Serv* 2000; 51(7):885 – 889 (July 2002).

Olfson M., Gameroff M.J., Marcus S.C., *et al*, Emergency Treatment of Young People Following Deliberate Self-Harm, *Arch Gen Psychiatry* 2005;62(10):1122 – 1128 (October 2005).

SECTION 2.03–SERVICES FOR ADULTS WITH A SERIOUS MENTAL ILLNESS (SMI)

SMI1: Peer Services for Adults with SMI who meet criteria for the service

The DBHDID shall assess the percentage of individuals receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of adults having SMI who receive Adult Mental Health Peer Services.

Risk: 1% of SMI funding

Rationale: Deliverables in section 2.02 DIVERTS of the contract include 2.0 FTE Adult Certified Peer Support Specialists targeted to serve individuals transitioning from an institutional setting which is in addition to the 0.50 FTE requirement for Assertive Community Treatment (ACT) teams. This performance indicator is intended to coordinate with the expectation that Peer Services are provided to persons having Serious Mental Illness outside of ACT. It is also the intention of the DBHDID to align priority areas of federal reporting requirements and deliverables within provider contracts. This Indicator design is parallel to that for multiple populations served by DBHDID (SED and SMI).

Time 1 (T1) The count of adult individuals having SMI who received any one of the following Peer Support Services from the CMHC as a provider of community behavioral health services during the last completed monitoring period. Persons having SMI are to be reported in the Client File field 40 (Serious Mental Illness) with the value "1 = yes".

Service Name	BHDID Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
Peer Support	145 (Individual); 146 (Group)

Time 2 (T2) The same calculation used to determine T1 is applied to the current monitoring period.

Target: T2 will show an increase in the total number of adults with SMI who receive Adult Mental Health Peer Services in the last completed monitoring period (T1). An expectation of percentage increase will be distributed across quartiles that indicate low to high previous performance. Low previous performance is assigned a minimum expectation of 20% increase and higher previous performance is assigned a quarter fraction of 20%. The following describes how previous performance is assigned to a quartile:

The number served will be placed in ordered row from lowest to highest. If the highest numbers served are statistically determined to be outliers, they will be removed from the remaining calculation. The four interquartile ranges will be determined using the median values. A flat percent of expected increase will be assigned to each of the four quartiles as described below.

The % increase over previous year's performance will be assigned in the following manner according to the number served in the previous monitoring period.	
If the region is in this Quartile Range	This is the expected % increase in number served from the previous monitoring period
Q1 (previously low performance)	20%
Q2 (previously median performance)	10%
Q3 (previously higher performance)	5%
Q4 (previously highest performance)	2.5%

Monitoring Period:

T1 Previous monitoring period = April 1, 2021 through March 31, 2022

T2 Current Monitoring Period = April 1, 2022 through March 31, 2023

Data Sources:

SMI Data Source: value "1 = yes" is recorded in the Client File field 40 (Serious Mental Illness).

Service Data Source: one of the values "145" or "146" is recorded in the Event File field NTE02 (FA0-12) – DMHMRS Modifier 1 (Service Code).

Baseline: Previous performance determines the percent of expected increase; see chart above.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

SECTION 2.04–BEHAVIORAL HEALTH SERVICES FOR CHILDREN/YOUTH AND FAMILIES

Domain: Evidence-Based Care

SED2: Child Population with SED Who Receive Targeted Case Management

The DBHDID shall assess the percentage of the region's estimated SED population that are served as SED clients and receive Targeted Case Management service. The region's estimated SED population is defined as the estimated number of children and youth with SED in the region (5.0% of total child population per 2010 census). The expected standard of performance is 8% for the current monitoring period. Regions serve 8% of the estimated 5% of the population under age 18. The SED/High Fidelity Wraparound marker is defined as answer options 1 "Yes (SED)" or 2 "SED - High Fidelity Wraparound" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. The Targeted Case Management service is defined as answer option "061" (Case Management Services Children with SED) in the field "NTE02 DMHMRS_Modifier_1 (DBHDID Service code)" in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

Goal: Increase the percentage of child population served with SED who Receive Targeted Case Management (TCM)

Risk: 2% of SED funding

Rationale: Deliverables in section 2.04.2–Children/Youth and Families Deliverables section of the contract include provision of a Basic Benefit Package for children/youth with SED who are deemed eligible for DBHDID funded services. Targeted Case Management for SED is part of an appropriate array of services that are aligned with the current Medicaid State Plan and are expected to be available. This performance indicator is intended to coordinate with the expectation that Targeted Case Management Services (an evidence based practice) are provided to children/youth having Severe Emotional Disorder.

Numerator: The unduplicated count of SED children less than 18 years of age at the end of the monitoring period who received Targeted Case Management service. Specifically, the count of SED children and youth as defined by answer options 1 "Yes (SED)" or 2 "SED - High Fidelity Wraparound" in field #41 "Severe Emotional Disability (SED)" in the client file and have received Targeted Case Management as indicated by answer option "061" (Case Management Services Children or Youth with SED) in the field "NTE02 DMHMRS_Modifier_1 (DBHDID Service code)" in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

Denominator: The estimated number of children and youth with SED in the region (5.0% of total child population per 2010 census).

Target: The expected standard of performance is 8% for the current monitoring period.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: client data (field #41, answer option 1 "Yes (SED)" or 2 "SED - High Fidelity Wraparound") and event data (field NTE02 DMHMRS_Modifier_1, answer option 061)

Denominator Source: 2010 census data (5.0% of total child population per 2010 census).

Baseline: The last five completed monitoring periods of data are used to determine the target for each CMHC and the statewide rate.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Reference: The Kentucky Department of Medicaid Services State Plan
https://chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf

Domain: Evidence-Based Care

SED3: Peer Services for Children who Meet Criteria for the Service

The DBHDID shall assess the percentage of children and youth receiving Peer Support Services from the CMHC as a provider of community behavioral health services. The assessment will compare the measure across two subsequent monitoring periods. The expected standard of performance is an increase in the percent of children and youth who receive Peer Support Services.

Risk: one half percent (0.5%) of SED funding

Rationale: Deliverables in section 2.04.2–Children/Youth and Families Deliverables section of the contract include provision of a Basic Benefit Package, for children/youth who are deemed eligible for DBHDID funded services. This performance indicator is intended to coordinate with the expectation that Peer Services (an evidence based practice) are provided to children/youth. It is also the intention of the DBHDID to align priority areas of federal reporting requirements and deliverables within provider contracts.

Time 1 (T1) The unduplicated count of children and youth who received any one of the following Peer Support Services from the CMHC as a provider of community behavioral health services during the last completed monitoring period.

Service Name	BHDID Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
*Parent/Family Peer Support - Individual	147
*Parent/Family Peer Support – Group	148
Youth Peer Support - Individual	149
Youth Peer Support - Group	150

Time 2 (T2) The same calculation used to determine T1 is applied to the current monitoring period.

Target: T2 will show an increase in the total number of children/youth who receive Peer Support Services in the last completed monitoring period (T1). An expectation of 2.5% increase will be distributed across quartiles that indicate low to high previous performance. Low previous performance is assigned a minimum expectation of 2.5% increase and higher previous performance is assigned a quarter fraction of 2.5%. The following describes how previous performance is assigned to a quartile:

> The number served will be placed in ordered row from lowest to highest. If the highest numbers served are statistically determined to be outliers, they will be removed from the remaining calculation. The four interquartile ranges will be determined using the median values. A flat percent of expected increase will be assigned to each of the four quartiles as described below.

The % increase over previous year's performance will be assigned in the following manner according to the number served in the previous monitoring period.	
If the region is in this Quartile Range	This is the expected % increase in number served from the previous monitoring period
Q1 (previously low performance)	2.500%
Q2 (previously median performance)	1.875%
Q3 (previously higher performance)	1.250%
Q4 (previously highest performance)	0.625%

Monitoring Period:

T1 Previous monitoring period = April 1, 2021 through March 31, 2022

T2 Current Monitoring Period = April 1, 2022 through March 31, 2023

Data Sources:

Service Data Source: one of the values "147", "148", "149" or "150" is recorded in the Event File field NTE02 (FA0-12) – DMHMRS Modifier 1 (Service Code).

Baseline: Previous performance determines the percent of expected increase; see chart above.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Reference:

** Special note about the Parent/Family Peer Support Service:*
In the system of care, Parent/Family Peer Support services may be provided for children and youth regardless of SED designation. At times, Parent/Family Peer Support services may be provided for family members of the child client. For the purposes of this measure, only services that are billed for the child client are included. For more information about the Peer Support Services, see the Service Standard at http://dbhdid.ky.gov/kdbhdid/standards.aspx.

Domain: Evidence-Based Care

SED4: Caseloads for High Fidelity Wraparound Facilitators Serving Children/Youth

SED4 applies to all CMHCs except Regions 2 and 3.

The CMHC contract requires a specific number of High Fidelity Wraparound (HFW) facilitators to serve children/youth under age 21. The DBHDID will assess the caseload maintained by High Fidelity Wraparound (HFW) facilitators. While full caseload is defined as no more than ten (10) persons per HFW facilitator per month, this measure expects that 50% of a full caseload will be maintained.

Risk: 3% of total IMPACT allocation

Rationale
The DBHDID supports High Fidelity Wraparound (HFW) as an evidence based practice. Using this practice, the DBHDID expects CMHC regions to serve children/youth that meet criteria for SED, are involved with multiple child serving agencies/services, and may benefit from coordinated care offered through HFW.
Fidelity to the HFW model dictates that each HFW facilitator serve a caseload of no more than ten (10) clients. This performance indicator will monitor for maintenance of at least 50% of full caseload per facilitator. For example, CMHC xx is contractually obligated to employ 2 HFW facilitators. The expected full caseload for a CMHC region required to employ 2 HFW facilitators is 20 clients/month (10 per facilitator). In this example, the target for this performance indicator is the maintenance of a caseload of 10 clients/month (5 per facilitator) which is 50% of the full caseload for 2 facilitators.

Numerator: *the actual number of active clients*
The total number of active clients under age 21 (at any time during the year) entered into the IMPACT Outcomes Management System (IOMS) during the monitoring period.

Denominator: *the number that equates to 50% of the expected full caseload per HFW facilitator*
The expected number of active clients under age 21 (at any time during the year) that should be entered into the IMPACT Outcomes Management System (IOMS) during the monitoring period as determined by the number of contractually required HFW facilitators. The following table describes the method used to define the denominator - 50% of full caseload. The region-specific denominator is displayed in the last column titled "Performance Indicator Denominator".

CMHC Region	Number of HFW Facilitators Supported per CMHC Contract	Expected Full Caseload per HFW Facilitator (10 per facilitator)	PERFORMANCE INDICATOR DENOMINATOR Expected monthly average of active clients (50% of full caseload)
Four Rivers	3	30	15
Pennyroyal Center	not applicable	not applicable	not applicable
River Valley	not applicable	not applicable	not applicable
LifeSkills	3	30	15
Communicare	3	30	15
Centerstone	3	30	15
NorthKey	2	20	10
Comprehend	2	20	10
Pathways	2	20	10
Mountain	2	20	10
Kentucky River	2	20	10
Cumberland River	3	30	15
Adanta	2	20	10
New Vista	3	30	15

Definitions

- An "**Active**" client is one who is entered in the IMPACT Outcomes Management System (IOMS) with an "Exit Date" during or after the monitoring period. Clients having Exit Dates before the monitoring period are not excluded from becoming active during the monitoring period.
- A "**HFW facilitator caseload**" is defined as the expected number of active clients under age 21 (at any time during the year) entered into the IMPACT Outcomes Management System (IOMS) per HFW facilitator.
- "**full HFW facilitator caseload**" for a HFW facilitator is 10 persons.
- "**50% of a full HFW facilitator caseload**" for a HFW facilitator is 5 persons.

Benchmark: A full caseload is defined as 10 persons per HFW facilitator per month. Since this is a new measure starting April 1, 2020, the measure of performance is reduced to 50% of full caseload. This expectation may increase in future monitoring periods. For the current monitoring period, the expected standard of performance is the maintenance of 50% caseload per HFW facilitator on the average over the 12-month monitoring period. The number of HFW facilitators required varies per CMHC and is defined in each CMHC Region's contract.

Target: *The target rate is 50%.*
The expected standard of performance is the maintenance of 50% of a full caseload per facilitator as averaged over the 12 month monitoring period.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Source(s): IMPACT Outcomes Management System (IOMS) and the CMHC contract

Reference(s):
Refer to specific CMHC contract for the required minimum number of HFW facilitators for each region.
Wraparound Implementation Standards – Program. University of Maryland School of Social Work, The Institute for Innovation and Implementation & The National Wraparound Implementation Center. 2020. https://nwi.pdx.edu/pdf/Wraparound-implementation-and-practice-quality-standards.pdf).

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

SECTION 2.07 –SUBSTANCE ~~ABUSE~~ USE PREVENTION

Domain: Evidence-Based Strategies

~~SAP1~~ SUP1: Regional Prevention Centers (RPCs) Use of Community-Based Process Strategy

Measure #1 applies to all CMHC regions operating a Regional Prevention Center (RPC)

The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy "Community-Based Process". The BHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the "Community-Based Process" CSAP Strategy. 70% of all activities delivered by all Regional Prevention Centers must be within the community-based process category of activities

Risk: 1% of Block Grant Prevention funding

Rationale: The DBHDID's evaluation of data reported on the utilization of Center for Substance Abuse Prevention (CSAP) strategies indicated that our state was in need of a focus on Community-Based Process. This performance indicator is intended to emphasize the focus and align with the DBHDID's RPC training and development plan which is built on using the Strategic Prevention Framework (SPF).

Numerator: of the activities in the denominator, the number of activities that are appropriately associated with the CSAP Strategy "Community-Based Process".

Denominator: the number of the Center's activities completed during the monitoring period and which are reported in the Prevention Data System.

Target: 70% of all activities delivered by all Regional Prevention Centers must be within the community-based process category of activities

Monitoring Period:

Previous = April 1, 2021 through March 31, 2022
Current = April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Prevention Data System

Denominator Source: Prevention Data System

Baseline: Performance as reported in the Prevention Data System.

Reports Available: Regional Center reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Domain: Evidence-Based Strategies

~~**SAP1**~~ **SUP2:** Regional Prevention Centers Total Time of Prevention Activities Entered in the Prevention Data System (PDS)

Measure #2 applies to all CMHC regions operating a Regional Prevention Center

The DBHDID's evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS in order to accurately and completely articulate the prevention efforts delivered, as required by the Substance Abuse Prevention and Treatment Block Grant and prevention-focused discretionary grants. The expected standard of performance for each respective center is entry of a minimum of ~~40%~~ 45% of available time, as measured on the 110D as submitted during the Plan & Budget process.

Risk: 0% of Block Grant Prevention funding

Rationale: The Prevention Data System (PDS) is the primary data collection system and source of information available for evaluating quantity of the types of prevention activities delivered to Kentucky's communities. This system is used to evaluate impact of prevention work in Kentucky and to account for funding received. The DBHDID's evaluation of data submitted to the Prevention Data System indicated that our state needs to focus on ensuring that all activities are reported in the PDS in order to accurately report these activities to funders and articulate the value of prevention services to key stakeholders. This performance indicator is intended to emphasize the importance of inputting all prevention activities delivered into the PDS in order to accurately and completely articulate the prevention efforts delivered, as required by the Substance Abuse Prevention and Treatment Block Grant and prevention-focused discretionary grants.

Numerator: The total time for all activities reported in the Prevention Data System

Denominator: The available time for prevention service delivery in the reporting period based on the number of hours available for prevention weekly and Full Time Equivalencies (FTE) as reported on the 110D Line 43, Column H.

Target: The percent calculated for the current monitoring period will be at least ~~34%~~ 45% of available time reported in the Prevention Data System. The PI is based on ~~34%~~ 45% of a 52-week total. The table below indicates how the target is calculated.

A	B	C	D	E	To be Monitored	To be Monitored
CMHC RPC Name	**Hours available per week** **Col J (lines 6-20)** **Source P&B Form 110D (Col J)**	**DENOMINATOR: Hours available to prevention per 110D (Column H, Row 43)** **(Col B*52)** **Source P&B Form 110D FY 23 Initial Submission; Sum of Col I, lines 6-20; Does not include agency supervision, administration, KMM, Girls/Boys Clubs, or PES**	**TARGET PERCENT: The % of required hours to total hours**	**TARGET NUMERATOR: The number of hours required to meet the PI** **45% of Col C**	**ACHIEVED #: The total time for all activities reported in the Prevention Data System** **Source: PDS**	**ACHIEVED %: The total percentage of available time for all activities reported in the Prevention Data System** **Source: PDS**
Four Rivers	172	8,944	45%	4,025		
Pennyroyal	146	7,605	45%	3,422		
River Valley	120	6,240	45%	2,808		
Lifeskills	196	10,192	45%	4,586		
Communicare	190	9,880	45%	4,446		
Seven Counties	293	15,262	45%	6,868		
NorthKey	230	11,960	45%	5,382		
Comprehend	139	7,215	45%	3,247		
Pathways	187	9,730	45%	4,379		
Mountain	156	9,984	45%	4,493		
Kentucky River	206	9,672	45%	4,352		
Cumberland River	187	9,750	45%	4,388		
Adanta	195	10,140	45%	4,563		
New Vista	320	16,640	45%	7,488		

Monitoring Period:

Previous = ~~not applicable; SUP2 PI first applies to SFY22~~ April 1, 2021 through March 31, 2022
Current = April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Prevention Data System

Denominator Source: DBHDID Plan and Budget Form 110D Line 43, Column H

Baseline: 2020 PDS time entry data was tested to determine the initial target used in SFY22.

Reports Available: Regional Center reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

SECTION 2.08–SUBSTANCE ~~ABUSE~~ USE TREATMENT

The DBHDID shall assess regional performance for achieving or exceeding established SUD benchmarks for access and retention.

SUD1 Percent of Census Population Served - Risk is 0% of SUD funding

SUD2 Number of Services per Treatment Episode - Risk is 1% of SUD funding

SUD3 Percent of Treatment Episodes Lasting Thirty (30) Days or Longer – Risk is 1% of SUD funding

SUD4 Number of Services in the First Thirty (30) Days - Risk is 1% of SUD funding

SUD5 TEDS Data Accuracy - Risk is 1% of SUD funding

SUD1: Percent of Census Population Served

This measure calculates the percentage of the census population served that are estimated in need of treatment.

The DBHDID shall assess the percentage of the region's estimated population in need of Substance Use Disorder (SUD) treatment that are served by the center during the monitoring period. The region's estimated population in need of SUD Treatment is defined as 5% of the number of individuals age 12 and older in the region per the 2010 census. The expected standard of performance is 7% for the current monitoring period. Regions serve 7% of the estimated 5% of the census population age 12 and older in need of SUD treatment.

Goal: to serve a minimum of 7% of the estimated population age 12 and over that are estimated in need of Substance Use Disorder Treatment.

Risk: 0% of SUD funding

Rationale: Expectations outlined in section 2.07.01 – SA Treatment Services includes the provision of serving clients having Substance Use Disorder (SUD). This includes the provision of SUD-specific services that are part of an appropriate array of services that are aligned with the current Medicaid State Plan and are expected to be available. This performance indicator is intended to coordinate with the expectations and deliverables in this section of the contract and the expectation of serving clients with Federal Block Grant funds.

Numerator: the count of clients age 12+ receiving outpatient SA treatment services

Denominator: the percentage of persons age 12+ in the region estimated to need treatment as determined by the National Survey on Drug and Health (NSDUH)) multiplied by (the region's 2010 census population of ages 12+)

Target: While the funding source for Kentucky's SAPT Block Grant has a goal of 10% of the at risk population, Kentucky's expected standard of performance for this penetration rate is 7%.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Client & Event data

Denominator Source: NSDUH and the region's 2010 county census population of ages 12 or older

Baseline: Kentucky's expected standard of performance for this penetration rate is 7%.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports". Also, reference the Substance Abuse Access & Retention Report available under the CMHC secure login page.

Domain: Treatment Engagement

SUD2: Number of Services per Treatment Episode

This measure calculates the average number of outpatient services provided for Treatment Episodes Data Set (TEDS) episodes which lasted for thirty (30) days or longer.

Risk: 1% of SUD funding

Rationale: Through this performance indicator, the DBHDID intends to measure engagement in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: the count of mental health and substance ~~abuse~~ use outpatient services provided between admission and discharge

Denominator: the count of outpatient Treatment Episodes Data Set (TEDS) episodes which lasted thirty (30) days or longer where the discharge date is during the current monitoring period

Target: at minimum, an average of seven (7) services during the first thirty days of post admission for engagement

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: Client and Event data, TEDS

Denominator Source: Client and Event data, TEDS

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Domain: Treatment Retention

SUD3: Percent of Treatment Episodes Lasting Thirty (30) Days or Longer

This measure calculates the percent of outpatient TEDS Episodes which lasted thirty (30) days or longer.

Risk: 1% of SUD funding

Rationale: Through this performance indicator, the DBHDID intends to measure retention in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: the count of outpatient Treatment Episodes Data Set (TEDS) episodes which lasted thirty (30) days or longer.

Denominator: the count of outpatient Treatment Episodes Data Set (TEDS) episodes where the discharge date is during the current monitoring period

Target: at minimum, an average of 50% of all outpatient substance ~~abuse~~ use treatment episodes will last more than thirty (30) days.

Monitoring Period: January 1, 2022 through December 31, 2022

Data Sources:

Numerator Source: Client & Event data, TEDS

Denominator Source: Client & Event data, TEDS

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Domain: Treatment Engagement

SUD4: Number of Services in the First Thirty (30) Days

This measure calculates the number of outpatient services provided during the first thirty (30) days post admission.

Risk: 1% of SUD funding

Rationale: Through this performance indicator, the DBHDID intends to measure engagement in treatment for clients reported in the TEDS data as part of the federal reporting requirement.

Numerator: the count of mental health and substance ~~abuse~~ use outpatient services provided during the first thirty (30) days of the Treatment Episode Data Set (TEDS) episode.

Denominator: the count of outpatient Treatment Episodes Data Set (TEDS) episodes where the discharge date is during the current monitoring period

Target: at minimum, an average of three (3) outpatient services will be provided during the first thirty (30) days of a Treatment Episode Data Set (TEDS) episode.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: TEDS Admissions data; Client & Event data

Denominator Source: TEDS Admissions data; Client & Event data

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

Domain: Quality of Information

SUD5: TEDS Data Fields Accuracy

This measure focuses on Treatment Episode Data Set (TEDS) data accuracy. The SUD5 PI target is that the TEDS Client data set pass the data standards for 3 of the 4 entire quarters during the Incentive Bond Year (April 1 – March 31). The TEDS file data standard defines the threshold of missing, unknown, or invalid codes. These thresholds are described in detail in the report "PI_SA_T11" which is posted to the Central Login "Block Grants" section of pre-defined reports. The bullets below outline the thresholds for new and old fields.

- New fields (fields in their first year of data collection) may have up to and no more than 20% missing, unknown, or invalid codes.
- Old fields (fields in existence for more than one year) may have up to and no more than 5% missing, unknown, or invalid codes.

Risk: 1% of SUD funding

Rationale: Deliverables in section 2.07.02 – SA Treatment Deliverables includes the requirement of submitting data which follows data quality standards as outlined in the guidance document "DBHDID Data Implementation Guide". The data submitted is the source data for the Treatment Episodes Data Set (TEDS) and is related to the access and retention performance indicators described under Reporting. This performance indicator is intended to coordinate with the data quality standards expectations in this section of the contract and the expectation of federal data quality standards associated with the use of Federal Block Grant funds.

TEDS is a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance ~~abuse~~ use and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. The state role in submitting TEDS to SAMHSA is critical, since TEDS is the only national data source for client-level information on persons who use substance ~~abuse~~ use treatment services. This reporting framework supports SAMHSA's initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance ~~abuse~~ use and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA's program, performance measurement, and management goals.

Section 505 (a) of the Public Health Service Act (42 U.S.C. 290aa-4) directs the SAMHSA Administrator to collect data on the number of public and private behavioral health treatment programs and the number and characteristics of individuals seeking treatment through such programs. As specified in SAMHSA's instructions, states should develop procedures to ensure that the data they submit to TEDS are accurate and in the correct format.

Numerator: Of the records in the denominator, the number of unknown, missing or invalid values.

Denominator: The number of CMHC submission records in the Client file during the quarter for TEDS Substance ~~abuse~~ use clients.

Target:
The target is to, at the end of the monitoring period, pass compliance on the Client File as defined in the PI_SA_T11 report for a minimum 3 of the 4 Incentive Bond Year (IBY) quarters. The target is determined at the end of the monitoring period to ensure inclusion of data that may have been resubmitted during the year in effort to correct data errors in original file submissions.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

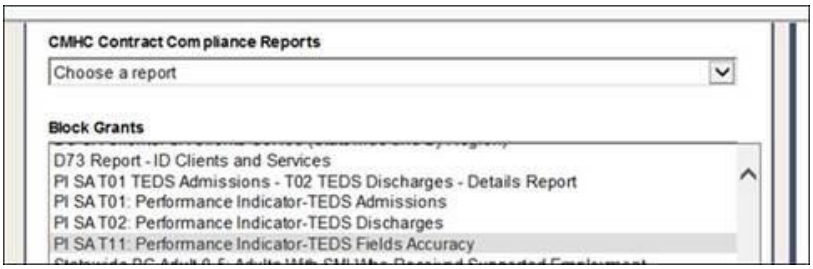
Numerator Source: Client, Event, and Discharge data sets received from CMHCs.

Denominator Source: Client, Event, and Discharge data sets received from CMHCs.

Baseline: Rates over the last 3 completed calendar years were used to determine the target.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports" as well as within the section "Block Grants". Below is a snapshot of the Block Grant reports section showing these reports in the dropdown menu. Additional details will be summarized on monthly summary reports and discussed at the Joint Committee for Information Continuity (JCIC) committee meetings.

Location of "PI SA T11" Report



Reference: Treatment Episode Data Set (TEDS) State Instruction Manual with Data Submission System (DSS) Guide Version 4.2.1. *Prepared for:* Center for Behavioral Health Statistics and Quality Substance Abuse and Mental Health Services Administration. *Prepared by:* Eagle Technologies, Inc.

SECTION 2.12–DEVELOPMENTAL AND OTHER INTELLECTUAL DISABILITIES (DID)

Domain: Quality of Information

I/DD3: Consistency and accuracy of client's reported receiving SGF services.

The DBHDID shall assess the accuracy and consistency of information reported via the Form 140 with client listing report as due through the Department Periodic Report processes. The form is due by the end of the calendar month following the end of each quarter.

Consistency and accuracy of information reported will be determined by review of form 140 with client listing to verify that number of clients reported receiving each SGF service is the same on both reports for the same period.

Risk: 1% of DDID funding

Rationale: Consistency and accuracy of information reported on form 140 with client listing are essential to division monitoring and planning for services.

Numerator: The total number of complete Form 140 with client listing reports submitted during the monitoring period in which number of clients reported receiving each SGF service is the same on both reports.

Denominator: The total number of complete reports due during the monitoring period which is four (4).

Benchmark: The expected standard of performance is that three (3) of the four (4) quarterly submissions will be received and determined to be reporting consistent information by DBHDID by the end of the calendar month following the end of each quarter.

Target: 75% of quarterly report submissions must be complete and timely.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: DPR Form 140 with SGF client listing submitted to the BHDID with consistent reporting of clients receiving services.

Denominator Source: The number of required DPR Form 140s with SGF client listing reports that are due during the 12-month (4 quarter) monitoring period.

Baseline: The performance indicator monitoring process over the last three contract periods have been evaluated in order to set the target minimum of 75%.

Reports Available: Quarterly communications on successful receipt of complete quarterly reporting documents will be relayed from the Division of Developmental & Intellectual Disabilities CMHC liaison staff during scheduled meetings between the liaisons and CMHC I/DD staff. Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports".

References:

- Department Periodic Reporting (DPR) process http://dbhdid.ky.gov/cmhc/dpr.aspx
- Detailed instructions for completion of form 140 and client listing are included within the form 140.

Domain: Accuracy of Information

~~DID4~~ I/DD4: Crisis initial response and reporting

I/DD4 applies to all CMHCs.

The DBHDID must ensure that all individuals seeking crisis services who are identified as having an intellectual or developmental disability are referred to on-call, qualified I/DD crisis responders for appropriate and timely intervention. CMHCs are required to submit documentation of all crisis events via the Crisis Contact Data Sheet (CCDS) system. Crisis sheets are reviewed monthly and approved if contract requirements for crisis response are met. Toward this intent, the DBHDID shall assess the rate of approved crisis sheets for the monitoring period. The expected standard of performance is that ~~60%~~ 75% of all CCDS are submitted timely and indicate that appropriate response was provided per contract requirements.

Risk: 1% of DID funds

Rationale: The goal of I/DD crisis services is to provide timely support and intervention to prevent institutionalization and allow the individual to remain in community setting. A lack of timely referral to I/DD crisis team or a failure to appropriately triage and respond may result in an unnecessary loss of current placement or institutionalization.

Numerator: The number of CCDS submitted by CMHC and approved by DBHDID for the monitoring period.

Denominator: The total number of CCDS submitted by the CMHC. When monitoring by DBHDID identifies that a crisis event occurred but CCDS was not submitted, these will be included.

Benchmark: The expected standard of performance is that clients must be referred timely to I/DD crisis responder, properly triaged, and receive appropriate response based on triage level.

Target: The percentage of crisis events receiving response meeting contract requirements must be at or above 60%.

Monitoring Period: April 1, 2022 through March 31, 2023

Data Sources:

Numerator Source: CCDS database. Report of number of approved crisis sheets for CMHC for monitoring period.

Denominator Source: CCDS database. Report of number of submitted crisis sheets for CMHC for monitoring.

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section “CMHC Contract Compliance Reports”.