Quality Management and Outcomes Team

MEETING SUMMARY

MARCH 12, 2015
12:30 PM – 4:00 PM (EST)

MEETING CALLED	Hope Barrett
TYPE OF MEETING	Quarterly Informational, Planning and Implementing Meeting
FACILITATOR	Hope Barrett Hope.Barrett@ky.gov 502-782-6147
NOTE TAKER	David U. Smith
ATTENDEES	**KDBHDID**: **Commissioner's Office:** Wendy Morris Vestena "Tina" Robbins **Behavioral Health:** Hope Barrett Lou Kurtz Chris Duckworth PK Sims (host) David U. Smith **Developmental & Intellectual Disabilities:** Claudia Johnson Cathy Lerza **Administration & Financial Management:** ---------- **Program Integrity:** Sandra Davis Lea Taylor **Regional MH/MR Boards** **1. Four Rivers:** ---------- **2. Pennyroyal:** Jami Ivey **3. River Valley:** ---------- **4. Lifeskills:** Doug Bradley **5. Communicare:** Missy Brown **6. Seven Counties:** Caroline Fink (conference-call) **7. NorthKey:** Nan Genther (conference-call) **8. Comprehend:** ---------- **9. /10. Pathways:** Betsey Jackson (conference-call) **11. Mountain:** Dorian Moe (webinar/conference-call) **12. Kentucky River** Sarah Prokopchuk (conference-call) **13. Cumberland River** ---------- **14. Adanta:** Dr. Dan Luchtefeld (webinar/call) **15. Bluegrass:** Joachim Knuf **KARP** ---------- **UK- Institute for Pharmaceutical Outcomes and Policy (IPOP)** Diane Daugherty

Agenda topics

12:40 – 12:50 PM **1. WELCOME & INTRODUCTIONS** **BHDID STAFF FACILITATOR (Hope Barrett)**

12:50 – 1:30 PM **2. REGIONAL QUALITY IMPROVEMENT UPDATES** **REGIONAL REPRESENTATIVES**

DISCUSSION

There was a round-robin sharing by each present Regional MH/MR Boards giving up an update on at least one QI activity, e.g., tool, strategy, technique, etc. on which they are currently working.

Highlights included:

- Region 1 – No report
- Region 2 – Many changes; EMR pushed back due to billing issues; interim CEO
- Region 3 – No report
- Region 4 – Outcome measures in all services; EMR, trying to get back to original default state, i.e., auto-filling documents in treatment process.
- Region 5 – MWMA Training being streamlined to work with EMR.
- Region 6 – Tish Geftos, Director of Quality Improvement, is no longer with SCS. However, before leaving, Tish met with the Department and gave valuable input. Caroline Fink, SCS, to follow-up.
- Region 7 – Same QI Projects, i.e., SMI – Medication Management; SA – Reduction of health risk behaviors; Integrated care – hired a new primary care physician, and; New SAMHSA Grant – Implementation plan.
- Region 8 – No report
- Region 9/10 – Pursuing CARF Accreditation. Using an accreditation specialist to assist.
- Region 11 – Person-Centered Recovery Planning Trainer hired to train all staff. Also working on Fidelity Scales in ACT, Therapeutic Rehabilitation and Boston-model SMI. Also, the Second Home Place is about to open (May 1, 2015), a medical health clinic for the homeless in the outpatient clinics in Johnson and Floyd Counties. Plans are for one also in Pike County. In addition, Safe Haven has also opened, for non-custodial parents to visit children in a highly monitored environment (through the court system). Lastly, all 14 facilities have been

	damaged by the snow. • Region 12 – They are also pursuing CARF accreditation. Also, Person-Centered Recovery Planning training to all staff. Working on updating EMR to use ICD-10 and DSM-5 by 7/1/15. • Region 13 – Jill West will fill in for the retired Kathy Tremaine. • Region 14 – Started their EHR one week ago, Monday. 2-3 months before reports can be generated from it. Will allow the tracking of many things, among them medication patterns. • Region 15 – Person-Centered Recovery Planning Trainers at all the hubs. They also applied for the SAMHSA Grant. "Net Smart" rollout/go-live has been pushed back to July 2015. SA treatment is expanding with new staff. Scheduling at the Phone Center is to be enhanced. There is a "productivity push".

1:30 – 3:15 PM **4. <u>OUTCOMES</u>**

● **<u>Review of CMHC-Contract Performance Indicators</u>** **BHDID STAFF (Hope Barrett)**

DISCUSSION	Because of a need to set up the projector for Doug Bradley's presentation, Hope moved to the next agenda item and opened a discussion, along with BHDID Staff, on the Proposed Performance Indicators for the 2016 CMHC Contract (see handout). • The following bullets were formed to represent comments, concerns and follow-up: o Some are still focused on getting accurate data, but moving away from just "counting widgets" in other areas to real outcomes ▪ Crisis – Having difficulty tracking because of Level of Care changes. ▪ SMI – Not changed at all. Wendy Morris, Deputy Commissioner, is getting a team together with CMHC and state hospital representatives to aid in continuity of care. The "summit" is planned for May or June. ▪ DIVERTS – One measure has been added to the existing one from last year (aligned with ISA). ▪ SED – Pretty much the same as last year. ▪ SA Prevention – NA ▪ SA Treatment – From five (5) to four (4) indicators. The increase of 5% of TEDS is coming out. ▪ DUI – Eliminated ▪ AI – NA ▪ DID – Not changed, but risk is spread out.

2:56 – 3:15 PM **BREAK**

3:15 – 3:41 PM **3. <u>TRAINING / DISCUSSION</u>**

● **<u>The Four Disciplines of Execution</u>** **Doug Bradley, Lifeskills**

DISCUSSION	Doug Bradley, Region 4, presented Lifeskills' implementation of "The Four Disciplines of Execution" (or 4DX) by Sean Covey. It included: o Focusing on the Wildly Important Goals (WIGs) o Acting on Lead Measures o Keeping a Compelling Scoreboard o Creating a Cadence of Accountability (see handout) Joachim Knuf, Bluegrass, volunteered to give the next meeting's training/discussion on "Hoshin Planning", a Total Quality Management (TQM) methodology based on a concept popularized in Japan in the late 1950s by Professor Yoji Akao. It started in the production, i.e., automotive, industry, then progressed into the service industry, finally reaching healthcare and thereupon behavioral health.

3:41 – 3:45 PM **4. <u>OUTCOMES</u>**

● **<u>Quality Improvement Plan Requirements – I/DD</u>** **Claudia Johnson**

DISCUSSION	Claudia Johnson, DDID Assistant Director, presented the Quality Improvement Plan Requirements – I/DD, including: o Conducting a comprehensive review of their Crisis Contact Database, and; o Developing a Quality Improvement Plan

3:45 – 4:06 PM **5. <u>BHDID PROGRAM UPDATES & ANNOUNCEMENTS</u>** **SEE BELOW**

	• **P & A Interim Settlement Agreement** — **Wendy Morris**
DISCUSSION	Wendy Morris gave an update on the progress of Individuals with SMI Transitioning from Personal Care Homes to supportive independent living. At the end of February, there were 123. There is a goal of 200 this annual cycle combined with 100 last year for a combined of 300 by October 1, 2015. However, the average is now twenty (20) per month. Plans are to add FAQs to the Department's website. There is still some cleanup in the web-based app's database.
	• **Consumer Satisfaction Survey Status** — **Diane Daugherty**
DISCUSSION	Diane Daugherty gave an update on the status of Consumer Satisfaction Survey. Had been sending out results by email, but Diane can drop them in the regions' IPOP folders instead. 2015 has been sent out without any significant changes. There are four (4) fatal error fields: Region Number; Site Code; Date, and; CMHC Identifier. Caroline Fink, SCS, will send out instructions on how to populate bubbles.
	• **BHDID Monitoring Program** — **Wendy Morris**
DISCUSSION	Wendy Morris gave an update on the progress of the Department's Contract Monitoring Program. The monitoring of independent contracts has already started. But before the CMHC Contract Monitoring starts, the Monitoring Tool will be sent out to the regions' senior staff, in its entirety.
	• **Grant Updates and New Grant Announcements** — **All Participants**
DISCUSSION	Because of lack of time, the grant updates will take place at the next meeting.

NEXT MEETING DATES

DATE: May 28, 2015
TIME: 12:30 p.m. - 4:00 p.m. EST
LOCATION:

- Option A) in person - KBHDID, 275 Main Street 4th floor, Frankfort, KY
- Option B) Webinar Conferencing - To join the QMOT Webinar, please click the link below and enter as a guest: http://chfs.adobeconnect.com/qmotmeeting/. In order to participate in the Webinar, you may need to update your Adobe Flash Player. To test your computer, please click this link: http://admin.adobeconnect.com/common/help/en/support/meeting_test.htm
- Option C) teleconference (audio only)
  1. Dial 866-754-7476
  You will hear a voice prompt asking you to enter a passcode followed by the # sign.
  2. Enter "2119371775#"
  3. You will be automatically joined into the conference.

The Quarterly schedule for 2015 is: (quarterly on the 4th Thursday at 12:30-4:00 EST).

- ☑ March 12
- ☐ May 28
- ☐ Aug 27
- ☐ Nov 19 (1-week early due to Thanksgiving Day)

Performance Indicators in the 2015 CMHC Contract

Funding Pool	Performance Indicator	Incentive Amount
Crisis	The DBHDID shall assess the utilization of crisis services for adults (Clients/1,000 Census – Adult) and for children (Clients/1,000 Census – Children). The performance indicator is defined as the number of adult or child clients at each center who received a crisis service (Residential Crisis Stabilization – MH Adult, MH Child, MH Non-Residential Crisis Response, or I/DD Crisis Prevention) during the quarter. The client count is divided by the regions' total adult or child population (per 2010 U.S. Census). That result is then multiplied by 1,000 to show clients per 1,000 people. Goal is to increase emergency response and crisis services over the previous fiscal year by 5%. **Goal is to increase access to crisis services**	1% of allocated crisis funding
DIVERTS	DBHDID shall count the number of persons in each region who previously resided in Personal Care Homes and who have received in-reach, developed Person Centered Plans and have successfully transitioned into integrated affordable housing. The number of persons previously living in Personal Care Homes who have successfully transitioned into affordable housing during SFY 2015 shall be 5% greater than the number of persons who have previously resided in Personal Care Homes who have successfully transitioned into affordable housing during SFY 2014. This shall be consistent with the terms of the Interim Settlement Agreement. **Goal: Increase community integration**	1% of allocated DIVERTS funding
SMI	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. The percentage of thirty (30) day readmissions for SFY 2015 must be 5% less than the thirty (30) day readmission rate for SFY 2014, for each respective center. This measure will be listed as a report under each respective CMHC secure login page. **Goal: Decrease the Regional re-admission rate**	1% of allocated SMI funding
SED	**2.**--DBHDID shall assess the percentage of all children entered into the IMPACT Outcomes System and who have a Service Coordinator Checklist and age specific Baseline entered in the system within 60 days of admission in the IMPACT Program, and also have a required Follow-Up Interview completed and entered into the IMPACT Outcomes System or an Exit Form completed and entered into the system if the child has been formally exited from the IMPACT Program. The standard of performance is 80% for SFY 2015 **Goal: Ensure that follow-up occurs for children in the IMPACT Program**	1% of allocated SED funding

Performance Indicators in the 2015 CMHC Contract

SA Prevention	No performance indicator identified.	NA
SA Treatment	1. The DBHDID shall assess regional performance for achieving or exceeding established SUD benchmarks for access and retention. (Reference: Substance Abuse Access & Retention Report available under the CMHC secure login page.) Benchmarks include: **Goal: to increase penetration rate** a.--Seven percent (7%) penetration rate for access **Goal: to increase engagement rate** b.--Three (3) services in the first 30 days post admission for engagement **Goal: to increase retention** c.--Seven (7) services per client and 50% of clients with treatment episodes of greater than 30 days for retention.	½ % of allocated SA Treatment funding (for attainment of at least one of the three access and retention goals (a., b. or c.).
	2. The DBHDID shall assess the number of substance abuse admissions for both adults and children. The indicator is defined as the number of TEDS Substance Abuse Admissions during the quarter as a percent of the number of TEDS Substance Abuse Admissions during the same quarter of the prior year. The number of admissions must be at least 5% greater in SFY 15 than in SFY 14 (based on at least two quarters where the number of admissions had increased by 5% compared to the same quarter in the previous year). This indicator is aligned with the DBHDID Commissioner's Dashboard. **Goal is to increase TEDS admissions.**	½ % of allocated SA Treatment funding.
Driving Under the Influence (DUI) Services	No performance indicator identified.	NA
Alcohol Intoxication Services (AI)	No performance indicator identified.	NA
Developmental and/or Intellectual Disabilities (DID)	The DBHDID shall assess the number of individuals with an Intellectual or Developmental Disability who experience repeated (two or more times in 6 months) psychiatric hospitalizations. The number of individuals who experience repeated hospitalizations in SFY 15 must be less than the number in SFY14. **Goal: to reduce the number of individuals who experience psychiatric hospital re-admissions**	1% of allocated I/DD funding

Performance Indicators in the 2015 CMHC Contract

	Numerator: DBHDID Facilities data; (the number of those in the denominator who had two (2) or more admissions to any state owned or state operated psychiatric hospital in a 6 months period). Denominator: DBHDID Client file; (the number of clients who have an Intellectual Disabilities diagnosis coded in the diagnosis fields in the client data set or have Developmental Disabilities\Developmental Delay coded in field #46 "Developmental Disability\Developmental Delay" in the client file according to the BHDID Data Implementation Guide. NOTE: this definition is based solely on Client data set information and NOT on services provided.)	
Pre-Admission Screening and Resident Review (PASRR) Services	No performance indicator identified.	NA
Projects for Assistance in Transition from Homelessness (PATH) Services	No performance indicator identified.	NA
Deaf or Hard of Hearing Services	No performance indicator identified.	NA
Other Services – Medication Access and Quality Coordinator (MAQC)	No performance indicator identified.	NA
Other Services – Suicide Prevention Efforts for Adolescents in Kentucky (SPEAK)	No performance indicator identified.	NA
Other Services – Kentucky Adolescent Treatment Education Grant (KAT-ED)	No performance indicator identified.	NA
Administrative Services	No performance indicator identified.	NA

Funding Pool	Performance Indicator	Incentive Amount
Crisis	**Measure Name: Psychiatric Hospital Admissions for Adults and Children Who Received Crisis Stabilization Services** The DBHDID shall assess the psychiatric hospital admission rate for clients receiving crisis stabilization services. The performance indicator is defined as the percentage of adult clients who received a residential crisis stabilization service per CMHC during the reporting period who are admitted to a state-owned or state-contracted psychiatric hospital (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) in 30 days or less of the date of the last residential crisis stabilization service. Goal is to decrease by 5% the center's SFY2015 percentage. **Goal: Increase Effectiveness of Residential Crisis Services** **Risk: 1% of Crisis funding**	1% of allocated crisis funding
DIVERTS	**1. Measure Name: Direct Intervention for Persons Living In Personal Care Homes** The DBHDID shall count the number of persons in each region who previously resided in Personal Care Homes and who have received in-reach, assigned to transition team, developed Person Centered Recovery Plans and have successfully transitioned into integrated affordable housing. The ISA Web Application will be the source of all data used to determine this measure. For each respective center, the number of persons previously living in Personal Care Homes who have successfully transitioned into affordable housing according to the ISA Web Application records during the SFY2016 monitoring period shall be 5% greater than the number of persons who have previously resided in Personal Care Homes who have successfully transitioned into affordable housing during the same period during SFY2015. **Goal: Increase community integration** **Risk: 2% of DIVERTS funding**	2% of allocated DIVERTS funding
	2. Measure Name: 14-Day Follow-up for Referrals Made for Persons Living In Personal Care Homes The DBHDID shall assess the percentage of new referrals made during the SFY2016 monitoring period for persons living in personal care homes in Kentucky. The CMHC must conduct an in-reach service within fourteen (14) days of the referral date for 90% of the referrals made during the monitoring period. **Goal: Follow-up on New referrals** **Risk: 3% of DIVERTS funding**	3% of allocated DIVERTS funding

SMI	**Measure Name: 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. The percentage of thirty (30) day readmissions for the SFY 2016 monitoring period must be 5% less than the thirty (30) day readmission rate for the same period during SFY 2015, for each respective center. **Goal: Decrease the regional re-admission rate** **Risk: 1% of SMI funding**	1% of allocated SMI funding
SED	**1. Measure Name: IMPACT Clients Entered into IMPACT Outcomes Management System** DBHDID shall assess the percentage of all children with an SED/IMPACT marker who are entered into the IMPACT Outcomes Management System (IMPACT Outcomes) within thirty (30) days of the first service date. The standard of performance is 80% for the SFY2016 monitoring period. The SED/IMPACT marker is defined as answer option 2 "SED/IMPACT" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. This measure excludes any SED/IMPACT clients who are in the IMPACT Outcomes Management System and whose date of first service in Kentucky IMPACT is prior to the beginning of the SFY2016 monitoring period. **Goal: Increase the percentage of children entered into the IMPACT Outcomes System** **Risk: 1% of IMPACT High-Fidelity funding (TBBA)**	1% of IMPACT High-Fidelity funding (TBBA)
	2. Measure Name: IMPACT Surveys Completed DBHDID shall assess the percentage of all children entered into the IMPACT Outcomes Management System and who have a Service Coordinator Checklist and age specific Baseline entered in the system within 60 days of entry into the IMPACT Program, and also have a required Follow-Up Interview completed and entered into the IMPACT Outcomes System or an Exit Form completed and entered into the system if the child has been formally exited from the IMPACT Program. The standard of performance is 80% for the SFY2016 monitoring period. **Goal: Ensure that follow-up occurs for children in the IMPACT Program** **Risk: 1% of IMPACT High-Fidelity funding (TBBA)**	1% of IMPACT High-Fidelity funding (TBBA)

	3. Measure Name: Clients Receiving Targeted Case Management and Having SED DBHDID shall assess the percentage of all records for children and youth receiving Targeted Case Management who also have an SED marker. The standard of performance is 80% for the SFY2016 monitoring period. The Targeted Case Management service is defined as 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. The SED marker is defined as answer options 1 "Yes (SED)"" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. **Goal: Increase the percentage of children who receive Targeted Case Management that also are marked SED.** **Risk: 3% of SED funding (TBBA/TBAA)**	3% of SED funding (TBBA/TBAA)
	4. Measure Name: Child Population with SED Who Receive Targeted Case Management DBHDID shall assess the percentage of the region's SED population that are served as SED clients and receive Targeted Case Management service. The standard of performance is 5% for the SFY2016 monitoring period. The region's 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 SED/IMPACT marker is defined as answer options 1 "Yes (SED)" 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** **Risk: 0% of SED funding**	0% of SED funding
SA Prevention	No performance indicator identified.	NA
SA Treatment	**1. Percent of Census Population Served** This measure calculates the percentage of the census population served who are estimated in need of treatment. **Goal: Increase penetration rate** **Risk: 1% of SUD funding**	1 % of allocated SA Treatment funding.

	2. 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. **Goal: Increase engagement rate** **Risk: 1% of SUD funding**	1 % of allocated SA Treatment funding.
	3. 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. **Goal: Increase treatment retention** **Risk: 1% of SUD funding**	1 % of allocated SA Treatment funding.
	4. 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. **Goal: Increase treatment retention** **Risk: 1% of SUD funding**	1 % of allocated SA Treatment funding.
Driving Under the Influence (DUI) Services	No performance indicator identified.	NA
Alcohol Intoxication Services (AI)	No performance indicator identified.	NA
Developmental and/or Intellectual Disabilities (DID)	**1. DDID Clients with Multiple Hospital Admissions** The DBHDID shall assess the number of individuals with an Intellectual or other Developmental Disability who experience repeated (two or more times in 6 months) hospitalizations at a state-owned or operated psychiatric hospital. The number of individuals who experience repeated hospitalizations in the SFY2016 monitoring period will be less than the number for the same period in SFY15. **Goal: Reduce the number of individuals who experience psychiatric hospital re-admissions** **Risk: 1/2% of DID funding**	1/2% of allocated I/DD funding

	2. Data Accuracy The DBHDID shall review the submission of Form 140-I/DD Financial Implementation Report. The standard for performance is that the report Form 140 shall be submitted unaltered, complete and accurate with no more than 5% inaccuracies found. Distinct clients and units provided will match the data reported to the IPOP client and event data sets. **Goal: Improve data quality** **Risk: 1/2% of DID funding**	1/2% of allocated I/DD funding
Pre-Admission Screening and Resident Review (PASRR) Services	No performance indicator identified.	NA
Projects for Assistance in Transition from Homelessness (PATH) Services	No performance indicator identified.	NA
Deaf or Hard of Hearing Services	No performance indicator identified.	NA
Other Services – Medication Access and Quality Coordinator (MAQC)	No performance indicator identified.	NA
Other Services – Suicide Prevention Efforts for Adolescents in Kentucky (SPEAK)	No performance indicator identified.	NA
Other Services – Kentucky Adolescent	No performance indicator identified.	NA

Treatment Education Grant (KAT-ED)		
Administrative Services	No performance indicator identified.	NA

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

Measure Name: Psychiatric Hospital Admissions for Adults and Children Who Received Crisis Stabilization Services

The DBHDID shall assess the psychiatric hospital admission rate for clients receiving crisis stabilization services. The performance indicator is defined as the percentage of adult clients who received a residential crisis stabilization service per CMHC during the reporting period who are admitted to a state-owned or state-contracted psychiatric hospital (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) in 30 days or less of the date of the last residential crisis stabilization service. Goal is to decrease by 5% the center's SFY2015 percentage.

Goal: Increase Effectiveness of Residential Crisis Services

Risk: 1% of Crisis funding

Numerator: Of the clients counted in the denominator, the unduplicated number of clients who had at least one admission to a any State-owned or state-contracted psychiatric hospital (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital in 30 days or less of the last date of the residential crisis stabilization service.

Denominator: the unduplicated count of adult clients at each center who received at least one Residential Crisis Stabilization Service (Service Code 138 (MH Adult).

Service Name	Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) "BHDID Service Code"
Residential Crisis Stabilization	138 (MH Adults)

The client counts for each of these services are displayed in report "M-1D: CMHC Service Mix/Utilization" which is posted to the CMHC Secure login page for each CMHC.

Benchmark: The percent calculated during state fiscal year 2016 will be an decrease of 5% from the percentage calculated for state fiscal year 2015.

Data Sources:

Numerator Source: Client & Event Data; Facilities Data

Denominator Source: Client & Event Data

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

1. Measure Name: Direct Intervention for Persons Living In Personal Care Homes

The DBHDID shall count the number of persons in each region who previously resided in Personal Care Homes and who have received in-reach, assigned to transition team, developed Person Centered Recovery Plans and have successfully transitioned into integrated affordable housing. The ISA Web Application will be the source of all data used to determine this measure. For each respective center, the number of persons previously living in Personal Care Homes who have successfully transitioned into affordable housing according to the ISA Web Application records during the SFY2016 monitoring period shall be 5% greater than the number of persons who have previously resided in Personal Care Homes who have successfully transitioned into affordable housing during the same period during SFY2015.

Goal: Increase community integration

Risk: 2% of DIVERTS funding

Methodology

This measure is determined by comparing two numbers: the number of persons who have transitioned out of personal care homes and into affordable housing where the CMHC region is the "Transitioning Agency" during:

T2) the SFY2016 monitoring period (April 1, 2015 through March 31, 2016) and

T1) April 1, 2014 through March 31, 2015.

To determine the numbers of clients transitioned per CMHC, the BHDID will count the clients whose ISA Web Application record contains accurate dates for the following fields. For T1, these will be determined from the information relayed to the BHDID from the CMCH in the electronic reporting method that was used at that time.

- "In-Reach",
- "Assigned to Transition Team",
- "Person Centered Recovery Plan completed", and
- "Transitioned" date.

Records having a completed and valid "Transitioned" date will be grouped by CMHC according to the "Transitioning Agency" field. Per Transitioning Agency, the records with transitioned dates will be further grouped according to one of the following two "Type of Housing" according to the contents of the "Type of Housing" field. Definitions for housing types are provided in the ISA Web Application Manual located on the application web site:

A. Community-Based Supported Housing

B. NOT Community-Based Supported Housing

Benchmark: For each respective center, the number of persons previously living in Personal Care Homes who have successfully transitioned into affordable housing according to the ISA Web Application records during the SFY2016 monitoring period shall be 5% greater than the number of persons who have previously resided in Personal Care Homes who have successfully transitioned into affordable housing during the same period during SFY2015.

If no assignments from the interim settlement agreement are made to a CMHC as of April 1, the measure does not apply to that CMHC.

Data Sources:

T1: To determine this measure, the BHDID will use data reported under both the database reporting process that was used during part of the year and the ISA Web Application data which began January, 19 2015.

T2: To determine this measure, the BHDID will use the data reported in the ISA Web Application data which began January, 19 2015.

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

2. Measure Name: 14-Day Follow-up for Referrals Made for Persons Living In Personal Care Homes

The DBHDID shall assess the percentage of new referrals made during the SFY2016 monitoring period for persons living in personal care homes in Kentucky. The CMHC must conduct an in-reach service within fourteen (14) days of the referral date for 90% of the referrals made during the monitoring period.

Goal: Follow-up on New referrals

Risk: 3% of DIVERTS funding

Numerator: the number of referrals made during the SFY2016 monitoring period for persons living in personal care homes in Kentucky for which a valid in-reach date occurred within fourteen (14) calendar days of the referral date and for which this valid in-reach date has been recorded in the "In-Reach" field in the ISA Web Application.

Denominator: the number of referrals made during the SFY2016 monitoring period for persons living in personal care homes in Kentucky. Referrals will be grouped by CMHCs according to the county of the personal care home where the person resides or the hospital discharged location as specified in the referral form.

Benchmark: The CMHC must conduct an in-reach service within fourteen (14) days of the referral date for 90% of the referrals made during the monitoring period which are assigned to the CMHC according to the location specified on the referral form.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: the ISA Web Application records as reported by CMHC staff

Denominator Source: Referral forms entered into the ISA Web Application referral form

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

Risk: 1% of SMI funding

Measure Name: 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. The percentage of thirty (30) day readmissions for the SFY 2016 monitoring period must be 5% less than the thirty (30) day readmission rate for the same period during SFY 2015, for each respective center.

Goal: Decrease the regional re-admission rate

Numerator: The count 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.

Denominator: The count 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

Benchmark: The percentage of thirty (30) day readmissions for the SFY 2016 monitoring period must be 5% less than the thirty (30) day readmission rate for the same period during SFY 2015, for each respective center.

Monitoring Period: July 1, 2015 through March 31, 2016

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

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

1. Measure Name: IMPACT Clients Entered into IMPACT Outcomes Management System

DBHDID shall assess the percentage of all children with an SED/IMPACT marker who are entered into the IMPACT Outcomes Management System (IMPACT Outcomes) within thirty (30) days of the first service date. The standard of performance is 80% for the SFY2016 monitoring period. The SED/IMPACT marker is defined as answer option 2 "SED/IMPACT" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. This measure excludes any SED/IMPACT clients who are in the IMPACT Outcomes Management System and whose date of first service in Kentucky IMPACT is prior to the beginning of the SFY2016 monitoring period.

Goal: Increase the percentage of children entered into the IMPACT Outcomes System

Risk: 1% of IMPACT High-Fidelity funding (TBBA)

Numerator: The count of children with an SED/IMPACT marker in field #41 of the client file as submitted according to the BHDID Data Implementation Guide and who have valid identifying information in the IMPACT Outcomes Management System (IMPACT Outcomes) within thirty (30) days of the first service date.

Denominator: The count of children/youth that are marked SED/IMPACT in field #41 of the client file as submitted according to the BHDID Data Implementation Guide.

Benchmark: The standard of performance is 80% for the SFY2016 monitoring period.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: client data (field #41, answer option 2) and Ky IMPACT Outcomes Management System data

Denominator Source: client data (field #41, answer option 2). This number is also monitored on report SED Clients by Program on the Department's public webpage http://dbhdid.ky.gov/DBHDIDReports/cmhcdatareports.aspx

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

2. Measure Name: IMPACT Surveys Completed

DBHDID shall assess the percentage of all children entered into the IMPACT Outcomes Management System and who have a Service Coordinator Checklist and age specific Baseline entered in the system within 60 days of entry into the IMPACT Program, and also have a required Follow-Up Interview completed and entered into the IMPACT Outcomes System or an Exit Form completed and entered into the system if the child has been formally exited from the IMPACT Program. The standard of performance is 80% for the SFY2016 monitoring period.

Goal: Ensure that follow-up occurs for children in the IMPACT Program

Risk: 1% of IMPACT High-Fidelity funding (TBBA)

Numerator: The count of children ages birth through twenty one (21) who are enrolled in the IMPACT Program and who have identifying information in the IMPACT Outcomes Management System (IMPACT Outcomes) and who had a Baseline Service Coordinator Checklist (SCC), an age specific Baseline Survey (two baselines if client is an adolescent) entered into IMPACT Outcomes within 60 days of entry into the IMPACT Program, and a Follow-Up

interview/survey (two baselines if client is an adolescent) completed and entered into IMPACT Outcomes within the appropriate time window. Clients for whom a Baseline SCC and Baseline Survey(s) were completed but who exited the IMPACT Program prior to the due date of the Follow-Up Survey(s) are included in the numerator.

Denominator: The count of children ages birth through twenty one (21) who are enrolled in the IMPACT Program and who have identifying information in the IMPACT Outcomes Management System. This measure excludes clients who exited the IMPACT Program during ninety (90) days following the admission into the KY IMPACT Program as evidenced by a completed Exit Form entered into IMPACT Outcomes.

Benchmark: The standard of performance is 80% for the SFY2016 monitoring period.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: Ky IMPACT Outcomes Management System data

Denominator Source: Ky IMPACT Outcomes Management System 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".

3. Measure Name: Clients Receiving Targeted Case Management and Having SED

DBHDID shall assess the percentage of all records for children and youth receiving Targeted Case Management who also have an SED marker. The standard of performance is 80% for the SFY2016 monitoring period. The Targeted Case Management service is defined as 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. The SED marker is defined as answer options 1 "Yes (SED)"" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

Goal: Increase the percentage of children who receive Targeted Case Management that also are marked SED.

Risk: 3% of SED funding (TBBA/TBAA)

Numerator: The count of SED children and youth as defined by answer options 1 "Yes (SED)" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide

Denominator: The count of children receiving 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.

Benchmark: The standard of performance is 80% for the SFY2016 monitoring period.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: client data (field #41, answer option 1).

Denominator Source: event data (field "NTE02 DMHMRS_Modifier_1, answer option "061").

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

4. Measure Name: Child Population with SED Who Receive Targeted Case Management

DBHDID shall assess the percentage of the region's SED population that are served as SED clients and receive Targeted Case Management service. The standard of performance is 5% for the SFY2016 monitoring period. The region's 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 SED/IMPACT marker is defined as answer options 1 "Yes (SED)" 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

Risk: 0% of SED funding

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. SED is defined by answer options 1 "Yes (SED)" Program Client" in field #41 "Severe Emotional Disability (SED)" in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. Targeted Case Management is defined as 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).

Benchmark: The standard of performance is 8% for the SFY2016 monitoring period.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: client data (field #41, answer option 1) 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).

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 2.005.3–Reporting PREVENTION SERVICES

1. Measure Name: Reporting Standards

DBHDID shall assess the timeliness, accuracy, and validity of reports submitted by Regional Prevention Centers. Each Regional Prevention Center will submit timely and accurate reports of valid activities and intermediate outcomes achieved by RPC staff and/or coalition members. The standard of performance is 95% for each category of timeliness, accuracy and validity within 30 days of receipt by BHDID Prevention Branch staff.

Goal: To meet reporting standards; Regional Prevention Center's reports will have no more than 5% error rate in each of the categories of timeliness, accuracy and validity.

Risk: 0% of Prevention funding

Timeliness Error Rate:

A timeliness error is counted when any report is more than 30 days overdue.

Numerator: The number of reports submitted by the Regional Prevention Center during the monitoring period which had a timeliness error

Denominator: The number of reports submitted by the Regional Prevention Center during the monitoring period

Accuracy Error Rate:

An accuracy error is counted when BHDID Prevention Branch staff identify that a report submitted contains an error in the report contents or calculations which is not corrected within 30 days of receipt by BHDID Prevention Branch staff.

Numerator: The number of reports submitted by the Regional Prevention Center during the monitoring period which had an accuracy error

Denominator: The number of reports submitted by the Regional Prevention Center during the monitoring period

Validity Error Rate:

A validity error is counted when BHDID Prevention Branch staff identify a report during on-site review that contains different information than what was submitted electronically and the identified information is not corrected with 30 days of the site visit date.

Numerator: The number of reports submitted by the Regional Prevention Center during the monitoring period which had a validity error

Denominator: The number of reports submitted by the Regional Prevention Center during the monitoring period

Benchmark: The standard of performance is overall 95% for the SFY2016 monitoring period.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Reports submitted by Regional Prevention Centers to BHDID Prevention Branch Staff

Site reviews conducted at the Regional Prevention Centers by the BHDID Prevention Branch Staff

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 2.06–SUBSTANCE ABUSE TREATMENT

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

SUD Measure #1 Percent of Census Population Served - Risk is 1% of SA funding

SUD Measure #2 Number of Services per Treatment Episode - Risk is 1% of SA funding

SUD Measure #3 Percent of Treatment Episodes Lasting Thirty (30) Days or Longer – Risk is 1% of SA funding

SUD Measure #4 Number of Services in the First Thirty (30) Days - Risk is 1% of SA funding

1. Percent of Census Population Served

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

Goal: Increase penetration rate

Risk: 1% of SUD funding

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+

Benchmark: While the funding source for Kentucky's SAPT Block Grant has a goal of 10% of the at risk population, Kentucky's benchmark penetration rate is 7%.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: Client & Event data

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

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.

2. 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.

Goal: Increase engagement rate

Risk: 1% of SUD funding

Numerator: the count of mental health and substance abuse 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 reporting period

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

Monitoring Period: July 1, 2015 through March 31, 2016

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".

3. 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.

Goal: Increase treatment retention

Risk: 1% of SUD funding

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 reporting period

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

Monitoring Period: July 1, 2015 through March 31, 2016

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".

4. 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.

Goal: Increase treatment retention

Risk: 1% of SUD funding

Numerator: the count of mental health and substance abuse 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 reporting period

Benchmark: 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: July 1, 2015 through March 31, 2016

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".

SECTION 2.07–Driving Under the Influence (DUI) Services

1.—Maintain Certified Staff

The DBHDID shall assess the number of staff that are certified by the BHDID as DUI Assessors. The indicator is defined as the number of certified DUI assessors with an active log-in account with the Kentucky DUI Assessment Instrument (KDAI) system. The CMHC must have at least one (1) staff member who meets both of the criteria outlined in the benchmark during all months of the SFY2016 monitoring period.

Goal: Maintain at least one DUI certified staff member

Risk: 1/3% of DUI funding

Benchmark: For all months during the monitoring period, the CMHC will maintain one (1) staff member who meets both of the following criteria during all months of the SFY2016 monitoring period.

a) is certified by the BHDID as a DUI Assessor and
b) has an active log-in account with the Kentucky DUI Assessment Instrument (KDAI) system.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

The BHDID will monitor the criteria monthly by reviewing certification records, off site monitoring of assessment records and activity of log-in accounts with the Kentucky DUI Assessment Instrument (KDAI) system.

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

2.—Acceptance of Indigent DUI Clients

The DBHDID shall assess the number of indigent clients served by the CMHC. The indicator is defined as the number of clients served with an assessment, education or treatment services at no charge to the clients who are determined indigent by the court or means test.

Goal: At least 25% of total clients served will be indigent clients

Risk: 1/3% of DUI funding

Benchmark: During the monitoring period, at least 25% of the clients served with a DUI assessment, education or treatment services at no cost to the client will be indigent as determined by the court or means test.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

The BHDID will use the Kentucky DUI Assessment Instrument (KDAI) system to monitor the number of indigent clients served and the total number of clients served during the monitoring period.

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

3.—Record Maintenance

The DBHDID shall assess for the maintenance of a copy of a means test or affidavit of indigence in the CMHC client record. The indicator is defined as the number of indigent clients served with an assessment, education or treatment services at no charge to the clients who are determined indigent by the court or means test whose CMHC client record contains a means test or affidavit of indigence.

Goal: At least 80% of indigent client records will have a stored copy of a means test or affidavit of indigence.

Risk: 1/3% of DUI funding

Benchmark: At any time during the monitoring period, at least 80% of indigent client records that are sampled during on-site reviews will have a stored copy of a means test or affidavit of indigence.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

The BHDID will use the Kentucky DUI Assessment Instrument (KDAI) system to monitor the number of indigent clients served and the total number of clients served during the monitoring period. The client records reviewed during on-site periodic program reviews will be randomly selected based on the information attained from the KDAI system.

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 2.09–DEVELOPMENTAL AND OTHER INTELLECTUAL DISABILITIES (DID)

Risk: 1 – 1/2% of DID funding

Risk: 2 – 1/2% of DID funding

1. DDID Clients with Multiple Hospital Admissions

The DBHDID shall assess the number of individuals with an Intellectual or other Developmental Disability who experience repeated (two or more times in 6 months) hospitalizations at a state-owned or operated psychiatric hospital. The number of individuals who experience repeated hospitalizations in the SFY2016 monitoring period will be less than the number for the same period in SFY15.

Goal: Reduce the number of individuals who experience psychiatric hospital re-admissions

Risk: 1/2% of DID funding

Numerator: the count of those in the denominator who had 2 or more admissions to any state-owned or operated psychiatric hospital within any 180 day period during the monitoring period.

Denominator: the count of clients who have an Intellectual Disabilities diagnosis coded in the diagnosis fields in the client data set or have Developmental Disabilities\Developmental Delay coded in field #46 "Developmental Disability\Developmental Delay" in the client file according to the DBHDID Data Implementation Guide. NOTE: this definition is based solely on Client data set information and NOT on services provided.)

Benchmark: The number of individuals who experience 2 or more hospitalizations within a 180 day period during the SFY2016 monitoring period must be less than the number of individuals who experience 2 or more hospitalizations for the CMHC during the same period in SFY2015.

Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Numerator Source: Facilities (psychiatric hospital) admissions data

Denominator Source: Client & Event data, and Facilities (psychiatric hospital) admissions 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".

2. Data Accuracy

The DBHDID shall review the submission of Form 140-I/DD Financial Implementation Report. The standard for performance is that the report Form 140 shall be submitted unaltered, complete and accurate with no more than 5% inaccuracies found. Distinct clients and units provided will match the data reported to the IPOP client and event data sets.

Goal: Improve data quality

Risk: 1/2% of DID funding

This measure is determined by reviewing form 140 as submitted by the CMHC in comparison to the electronic Client & Event data submitted by the CMHC for the same time period. An inaccuracy is determined by reporting no data (blanks) in a field where data is expected and when the number reported on form 140 does not match the number reported in the client and event data set. The latter can be monitored through Report "CMHC_D73 -

ID Clients & Events - ID Program by Code/Payer DBHDID" which is posted to the Department's public webpage http://dbhdid.ky.gov/DBHDIDReports/cmhcdatareports.aspx.

Report D73 number: The number of items on client/event web-based report #D73 which do not match the distinct client counts and units of service reported on form 140

Form 140 number: The sixty six (66) items requiring data on form 140. (There are 33 rows which each require an accurate report of distinct client count and unit of service for a total of 66 items.) Specifically, the numbers will be used for this measure which are reported on the third quarter Form 140 which covers January 1 – March 31, 2016.

Benchmark: The standard for performance is that the form 140 shall be submitted on time, unaltered, complete and accurate. Regarding accuracy, there will be four (4) or less items having significant differences found between reports D73 and the fourth quarter report Form 140.

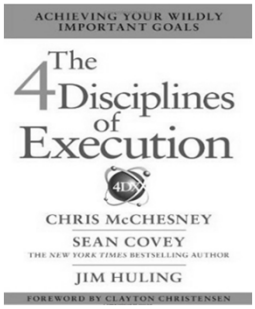
Monitoring Period: July 1, 2015 through March 31, 2016

Data Sources:

Report D73 number: Client & Event data, specifically "CMHC_D73 - ID Clients & Events - ID Program by Code/Payer DBHDID" which is posted to the Department's public webpage http://dbhdid.ky.gov/DBHDIDReports/cmhcdatareports.aspx.

Form 140 number: Plan & Budget form 140 as submitted for the year in the fourth quarter

Reports Available: Regional reports for this measure will be posted under each respective CMHC secure login page within the section "CMHC Contract Compliance Reports". For data submitted in the client and event data, see Report "CMHC_D73 - ID Clients & Events - ID Program by Code/Payer DBHDID" which is posted to the Department's public webpage http://dbhdid.ky.gov/DBHDIDReports/cmhcdatareports.aspx. Form 140 is submitted to the BHDID by CMHCs.



Orientation to

THE 4 DISCIPLINES OF EXECUTION

CHRIS MCCHESNEY, SEAN COVEY & JIM HULING

THE WHIRLWIND

- "It's the massive amount of energy that's necessary just to keep your operation going on a day-to-day basis; and, ironically, it's also the thing that makes it so hard to execute anything new."

4 DISCIPLINES

- Discipline 1: Focus on the Wildly Important.
- Discipline 2: Act on the Lead Measures.
- Discipline 3: Keep a Compelling Scoreboard.
- Discipline 4: Create a Cadence of Accountability.

FOCUS ON THE WILDLY IMPORTANT

Why is it so difficult?

- Leaders see so much potential!
- Other people's agendas
- Hedging your bets

FOCUS ON THE WILDLY IMPORTANT

Why is it so important?

- The more you try to do, the less you actually accomplish
- When an organization has 5+ goals…

–There will always be more good ideas than there is capacity to execute- p 29

Act on the Lead Measures

INSTALLING DISCIPLINE 2

LEAD MEASURES HAVE TWO CHARACTERISTICS:

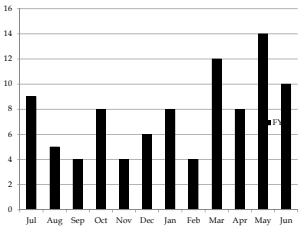
- They are ***predictive***. This means that if the lead measure changes, you can predict that the lag measure will also change
- They are ***influenceable.*** They involve behaviors that team members can control and can do something about.

CREATE LEAD MEASURES

- Movement on them will drive achievement of your WIG
- Focusing on them will give staff more of a sense that they are in control

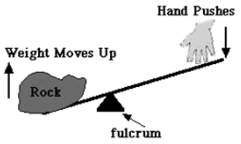
A REAL WORLD EXAMPLE: 30 DAY READMISSIONS

"Managing by lag measures is the equivalent of driving a car by looking in the rearview mirror"
W. Edwards Deming



LEAD MEASURES PROVIDE LEVERAGE

- You can't move the rock but you CAN move the lever
- When you move the lever the rock moves



30 DAY READMISSION EXAMPLE

- WIG: Reduce 30 Day Readmissions 30% by December 31st
- Lag Measure: 30 Day Readmission Rate
- Possible Lead Measures:
  - Have a psychiatrist appointment within 7 days
  - Reach out by telephone prior to appointment
  - See all d/c at least weekly for three months
  - Provide TCM to all discharge clients

ACTING ON LEAD MEASURES IS THE MOST DIFFICULT PART OF 4DX

- Lead measures can be counterintuitive. People want to stay focused on lag measures
- Lead measures are hard to track. Usually lead measures involve behaviors and there may be nothing in the existing data system to measure them
- Lead measures often look too simple. It can feel like your are focusing on something insignificant

Discipline 3: Keep a Compelling Scoreboard

THE 4 DISCIPLINES OF EXECUTION

The third discipline is to make sure everyone knows the score at all times, so they can tell whether or not they are winning.

This is the discipline of engagement

If the lead and lag measures are not captured on a visual scoreboard and updated regularly, they will disappear into the whirlwind.

- People disengage when they don't know the score.

A compelling scoreboard provides information essential to team problem solving and decision making. Tells the team:

- Where they are.
- Where they should be.

For maximum engagement and performance you need a player's scoreboard to make it a team game.

- It motivates the players to win.
- People play differently when they are keeping score.

They understand the connection between their performance and reaching their goal, and this changes the level at which they play.

All team members should be able to see it and watch it change moment by moment, day by day, or week by week.

CHARACTERISTICS OF COMPELLING PLAYERS' SCOREBOARD

- Is it simple? It has to be simple
- Can I see it easily? It has to be visible to the ream so they can tell who is winning. Otherwise your WIG and lead measures could be forgotten

People are most satisfied with their jobs (most motivated) when those jobs provide the opportunity to experience achievement.

4DX enables you to set up a winnable game.

- Discipline 1 = narrows your focus to a wildly important goal and establishes a clear finish line.
- Discipline 2 = Creates lead measures that give your team leverage to achieve the goal.

- Discipline 3 = Provides a compelling players scoreboard without which the game would be lost and no one would care.

CREATING A CADENCE OF ACCOUNTABILITY

"Ah, those were great days, The Pre-Accountabilty Era."

WIG SESSIONS

- Weekly
  - 20-30 minutes
- Avoiding outside distraction
  - AKA: The whirlwind
- WIG Agenda
  - Account – "What did I do?"
  - Review – "How effective was I?"
  - Plan - "What will I do this week?"
- Commitment
  - to supervisor, but also to colleagues

Quality Improvement Plan Requirements – I/DD

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

2.01.3 Reporting

4.--CMHC shall conduct a comprehensive review of their submitted crisis data available from the Crisis Contact Database, and department data submissions, noting trends in such areas as individuals seeking support, agencies making referrals, age, diagnosis and involvement in services, and develop continuous quality improvement goals with action steps to address gaps in the service array and to improve services. These continuous quality improvement goals shall be integrated into the CMHC's overall continuous quality improvement plan and shall be available for review by DBHDID staff upon request.

SECTION 2.09–DEVELOPMENTAL AND OTHER INTELLECTUAL DISABILITIES (I/DD)

2.09.2 Deliverables

3.--Develop a quality improvement plan that includes updated findings and corrective actions as a result of department quality assurance monitoring, which includes evidence of continuous improvement of utilizing best practice standards toward meeting program goals and the critical strategic areas identified in the annual report released by the Kentucky National Core Indicators available at the Kentucky National Core Indicators