# Indiana Family and Social Services Administration
# Division of Mental Health and Addiction (DMHA)

## Performance Measure Definitions – Achieving Positive Outcomes

## SFY 2016

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# Introduction to Performance Measures and Definitions for State Fiscal Year 2016

Since State Fiscal Year (SFY) 2008, DMHA has maintained performance-based contracting with organizations responsible for ensuring a community-based continuum of care for adults and youth with mental illnesses or addictions who meet established criteria. These organizations "earn" a portion of their allocated funds based on degree to which performance measure targets are met. As originally intended, the system has evolved over the past seven years from an emphasis on process to a current emphasis on outcomes. This concept of accountability through performance has permeated DMHA's contracting process in the form of specified deliverables for which the contract pays and specific client outcome measures in many contracts.

## Required Assessments and Reassessments

The Performance Measures are designed around a service delivery system based on episodes of care. An episode of care is defined by an admission date and a discharge date. At the beginning of each episode of care for a consumer, an assessment is completed. This is the admission or initial assessment. Depending upon the length of services, one or more reassessments will be completed. If the episode of care extends for six or more months, a reassessment is recommended every six months and required before eight months. Providers may perform reassessments more frequently based on the needs of the consumer. A reassessment is also needed at the time of discharge.

Assessments and reassessments are performed using the Child and Adolescent Needs and Strengths (CANS) comprehensive assessment (either the Birth – 5 tool or the 5 – 17 tool) for youth and the Adult Needs and Strengths Assessment (ANSA) for persons aged 18 and over, except where otherwise noted. In addition to these assessment tools, DMHA requires reporting of the National Outcome Measures (NOMS) at admission, approximately every six months and at discharge.

All outcome measures are based on the CANS or ANSA. The gatekeeper measures are based on data maintained in the State Operated Facilities client database.

## Reassessment Frequency and Clinical Outcomes

Many of the measures contained in this document are clinical outcome measures. They try to answer the question: "Do consumers receiving services from this provider have less intense needs or greater strengths over time?" For the performance measures in this document, outcomes are measured from the two assessments. For persons receiving services for shorter periods of time, the two most recent assessments may be an initial assessment and a discharge assessment which would actually measure any improvement in outcomes during the episode of care. However, for consumers receiving services for longer periods of time with multiple assessments (every 180 days), the two most recent assessments are usually reassessments and do not capture the level of need the consumer presented at the beginning of treatment. For consumers at any level of need, reassessments completed too frequently will tend to reflect insignificant change.

## Discharge (Transitional) Reassessments, General Guidance

DMHA is frequently asked when a discharge reassessment is mandatory. There is no single answer to this question. The CANS and ANSA tools are intended to prompt and improve communication. As a communimetric tool, the most clinically accurate answer to the question is that a discharge reassessment is always recommended as it defines the individual's needs and strengths at the end of an episode of treatment.

The communication qualities of the CANS and ANSA tools are very useful in successful transition from one level of care to a different level of care or from one program to a different program, such as youth to adult services. The CANS or ANSA helps plan transitional services, at a lower or high level of care (e.g., transitioning from a state hospital or a psychiatric residential treatment facility to community based care, transitioning from intensive community based services for youth to supportive care) and are, therefore, recommended for all transitions in services.

Behavioral health data indicates that most individuals/families are "discharged" following a period in which they are not seen by the clinician or for unknown reasons (administrative discharge). Discharge due to mutual agreement or due to treatment being completed is less often seen in the data. The question of when to do a discharge reassessment becomes viable due to this fact about the data.

DMHA cannot address every situation which may be encountered in the process of discontinuing an episode of treatment. However, the following general guidelines may be useful in deciding whether or not to complete a discharge reassessment. The situations below are intended to be examples of things that may happen during the course of behavioral health treatment episodes.

*Situations where a discharge reassessment is likely not needed:*

1. Individual is seen no more than three times and decides not to continue treatment.
2. Individual is seen only sporadically over a period of one to four months due to no-shows and completely drops out of treatment.
3. Individual is admitted to a nursing home, a state operated facility, or other institution within three months of beginning treatment when the admission was being planned or considered at the beginning of treatment.
4. If a reassessment has been completed shortly prior to the decision to discharge, a discharge reassessment may not be any different than the immediately preceding assessment. In fact, the six-month reassessment may trigger discussions with the individual/family that result in a mutual decision to discontinue treatment as maximum benefit has been realized. The individual/family may be seen a few more times for treatment closure and have no impact on the assessment. In such a situation, completing a discharge reassessment would serve no real purpose.
5. If services or circumstances following the most recent assessment do not result in changes in needs and/or strengths or if the decision to discharge occurs in less than three months after that assessment, a discharge reassessment may not be needed.

*Discharge due to completion of treatment:*

1. Best practice would indicate that, whenever a discharge occurs due to completion of treatment, a discharge reassessment must be completed to capture the changes in needs and strengths that occurred during the course of treatment.
2. If services or circumstances following the most recent assessment result in changes in needs and/or strengths or if the decision to discharge occurs three or more months after that assessment, a discharge reassessment is needed.

*Other Considerations*

1. Data from the CANS and ANSA assessments are used for outcome monitoring. Routine reassessments in collaboration with the individual/family will enhance monitoring of progress, documentation of improvement (or lack thereof), and quality of services.
2. If additional information is known about the individual/family circumstances since the last assessment, the best practice will be to document those circumstances in the clinical record and by rating the CANS or ANSA tools.
3. If the only option for the clinician is to copy the previous assessment item responses in a discharge reassessment, the discharge reassessment will have no real value.

**Data Requirements for Performance Measures**

In order for a consumer to be counted in the performance measure calculations several business rules must be met within the data. These include:

- Agreement type
- An episode of care must be open at some time during the month
- DMHA Supported Consumer (DSC) Eligibility – consumer must be DSC Eligible or DSC Eligible – Medication Only status as of the most recent DSC status. (Note: this status was previously known as HAP status.)
- At least one encounter reported during the month
- Two assessments using the same tool. A CANS 0-5 at time 1 and a CANS 5-17 at time 2 or a CANS 5-17 at time 1 and an ANSA at time two cannot be used to measure outcomes.
- To be counted as reassessed on time, there must be two assessments within 240 days of each other.

**Routine and Performance Payments for DMHA Contracted Providers**

DMHA uses two basic funding strategies for the providers who are contracted to provide services for persons who are Seriously Mentally Ill (SMI), Chronically Addicted (CA), and Seriously Emotionally Disturbed Children (SED). Using a formula, DMHA allocates state and federal funds to providers at the beginning of each fiscal year. DMHA finance staff estimates the amount of Medicaid Rehabilitation Option (MR0) claims that each provider will generate over the fiscal year. The state match portion for MRO is paid by DMHA to the Office of Medicaid Policy and Planning from state funds. These state funds are retained by DMHA from each CMHC's state funds allocation. The remaining funds are paid to providers during the fiscal year by two methods as described below.

*Non-–Performance Criteria Funding:* Funding in excess of Medicaid set asides and pay for performance funding for Seriously Mentally Ill (SMI), Chronically Addicted (CA), and Seriously Emotionally Disturbed Children (SED), if available, will be distributed on a quarterly basis. In order to receive these quarterly payments contractors must submit required data to DMHA through the DARMHA data system. Payments will be a per-quarter lump-sum payment, usually payable in July, October, January, and April.

*Pay for Performance Funding:* For budgetary purposes, the funds that are set aside for performance payments are classified as Performance Measure funding. Performance Measures are grouped into three funding pools: Seriously Mentally Ill (SMI) Performance Measures, Chronically Addicted (CA) Performance Measures, and Seriously Emotionally Disturbed Children (SED) Performance Measures. Each month providers can download Performance Scorecards from the DMHA community services database (DARMHA). Performance Scorecards are produced on the first day of September, October, November, December, January, February, March, April, May, June, July, and August. This allows providers to ensure that monthly data is submitted to DARMHA by the end of the month following the month of service. The scorecards let the providers know the percents of targets met for each performance measure and the overall percent of targets met for each funding pool.

In the second month following the end of each fiscal quarter, finance staff-determine the amount of performance funds each provider has "earned" on a year-to-date basis. One-fourth of the performance funds plus any funds not earned in previous quarters are available each quarter. The amount of payment each quarter is based on the overall percentage of targets met for SMI, for CA, and for SED funding pools. Providers are paid up to 100% of dollars available for the fiscal quarter. If the provider meets the established target, they will receive 100% of the dollars allocated toward that funding pool. If the performance is less than the established target, providers receive a reduced percentage of funds related to the level of performance.

*Bonus Pool:* If any allocated dollars are not paid out due to under performance, those dollars will be shifted to a bonus pool. When a provider exceeds 100% of a designated performance target, they will be eligible for participation in receiving funds as available from a bonus pool. The bonus pool created from the performance measures will be paid out during the last quarter of the year.

*Timing of Performance Payments:* Performance payments during a fiscal year have overlapping fiscal year performance measures. The first quarterly payment each fiscal year is processed in September and covers performance for July through June of the previous fiscal year. This is due to the one month delay in receiving data from the providers. The next three quarterly payments each fiscal year are based on performance during the first nine months of the fiscal year.

## SFY 2016 Summary of Changes

| SFY 2016 Measure | Difference from SFY 2015 Measures |
|---|---|
| Improvement in One Domain – SMI | More sensitive calculation method, new RCIs, new target, New population, Change back to six month timeframe |
| Improvement in One Domain – CA | More sensitive calculation method, new RCIs, new target |
| Improvement in One Domain – Youth 5-17 | More sensitive calculation method, new RCIs, new target |
| Improvement in One Domain – Youth Birth-5 | More sensitive calculation method, new RCIs, new target |
| Improvement in One Domain for Closed Episodes - SMI | New Measure |
| Improvement in One Domain for Closed Episodes - CA | New Measure |
| Improvement in One Domain for Closed Episodes – Youth 5-17 | New Measure |
| Improvement in One Domain for Closed Episodes – Youth Birth-5 | New Measure |
| Community Integration – SMI | New Way to Measure |
| Community Integration – CA | New Way to Measure |
| Strength Development – SMI | New Measure |
| Strength Development – CA | New Measure |
| Strength Development – Youth 5 - 17 | New Measure |
| Strength Development – Youth Birth-5 | New Measure |
| Adults Served – SMI | No changes |
| Adults Served – CA | No changes |
| Youth Served SED & CA | No changes |
| Reassessment -- NOMS | Increase reassessment window |
| Reassessment – CANS/ANSA | Increase reassessment window |
| Administrative Code Gatekeeping Compliance | Change in Annual Average Compliance Rate |
| Timely Discharge from State Operated Facilities (SOF) of All Populations | No changes |
| Reducing the Use of Allocated Beds in State Operated Facilities (SOF) | Now included in funding |

## Definitions and Acronyms

***Adult*** — person aged 18 and over An exception to this age grouping applies to persons who started receiving child and adolescent services prior to age 18 and whose child and adolescent services will continue post age 18 and end prior to age 22

***Youth*** — any person up to age 22 with an SED agreement type and youth with a CA agreement type who are aged 0 – 17 See above for special consideration for some persons aged 18 – 21.

***SMI*** — adult person with serious mental illness

***CA*** — person with addiction/substance abuse conditions

***SED*** — youth with serious emotional disturbance

***Consumers with both SMI and CA Identifiers*** — Providers may at times have a consumer with a SMI and a CA agreement identifier at different times. When this happens, the consumer could be counted twice in performance measures as they are based on the agreement identifier in DARMHA. In order to avoid duplication, the most recent agreement identifier in the reporting period will be used as the default identifier.

***DARMHA*** — Data Assessment Registry for Mental Health and Addiction

***Medication Only*** — DARMHA allows consumers to be identified as receiving Medication Only services. Since these services are provided only a few times per year, the consumers identified as Medication Only will **not** be included in Outcome Measures. However, they will be counted for Average Monthly Number Served during the months in which services are provided.

***DSC Status (DMHA Supported) Consumer)*** — DARMHA allows a continuous episode of care for persons whose DSC eligibility status may change due to changes in income which are not anticipated to be permanent. For example, a consumer may have a history of employment instability where he/she obtains employment for short periods and again becomes unemployed. In these situations, the provider may determine that an actual discharge in DARMHA is unwarranted since the consumer will continue receiving services. If the provider chooses to use the DSC status field to change from DSC Eligible to No Longer DSC Eligible, the consumers with this status at the end of a reporting month will not be included in performance measure calculations for that month.

If consumers become DSC Eligible again, they will be counted in people served beginning in the month they are recoded as DSC Eligible and they have at least encounter in the month. They will be counted in the reassessment numbers after becoming DSC Eligible.

## Overview of Performance Measures and Targets

Effective October 1, 2015

| SFY 2016 Measures from DARMHA Data | Pay for Performance | Target |
|---|---|---|
| Improvement in One Domain (New Calculation)– SMI | Included in dollars | 40% |
| Improvement in One Domain (New Calculation) – CA | Included in dollars | 50% |
| Improvement in One Domain (New Calculation) – Youth 5 – 17 | Included in dollars | 50% |
| Improvement in One Domain – Youth 0 - 5 | Not included in dollars | NA |
| Improvement in One Domain for closed episodes – SMI | Included in dollars | 50% |
| Improvement in One Domain for closed episodes – CA | Included in dollars | 50% |
| Improvement in One Domain for closed episodes – Youth 5 – 17 | Included in dollars | 60% |
| Strength Development – SMI | Included in dollars | 20% |
| Strength Development – CA | Included in dollars | 30% |
| Strength Development – Youth 5 - 17 | Included in dollars | 20% |
| Community Integration – SMI | Included in dollars | 25% |
| Community Integration – CA | Included in dollars | 35% |
| Adults Served – SMI | Included in dollars | Per Provider |
| Adults Served – CA | Included in dollars | Per Provider |
| Youth Served SED & CA | Included in dollars | Per Provider |
| Reassessment -- NOMS | Included in dollars | 80% |
| Reassessment – CANS/ANSA | Included in dollars | 80% |
| **Gatekeeper Measures** | | |
| Administrative Code Gatekeeping Compliance | Included in dollars | 90% |
| Timely Discharge from State Operated Facilities (SOF) of All Populations | Included in dollars | 80% |
| Reducing the Use of Allocated Beds in State Operated Facilities (SOF) | Included in dollars | ≤75% |

## Performance Outcome Measures for SFY 2016

**Improvement in One Domain (New Calculation)**

Improvement in at least one of the domains constitutes improvement for this measure. Measure is reported monthly based on the reassessments completed during the month. At the end of each quarter, measure is cumulative year-to-date, that is, all reassessments completed during the fiscal year from beginning of fiscal year through the end of the specific quarter.

**Populations**: SMI, CA, SED (Birth-5 years) and (5-17 years)

**ANSA Domains Included:** Life Functioning, Behavioral Health Needs, Strengths, and Risk Behaviors.

**CANS Domains Included:** Life Functioning, Child Strengths, Caregiver Strengths and Needs, Child Behavioral/Emotional Needs, and Child Risk Behaviors.

**Time 2:** Time 2 is the most recent assessment in the reporting period.

**Time 1:** Time 1 is the assessment immediately prior to the Time 2 assessment, unless the date for that assessment is less than 120 days before Time 2, then look for an assessment more than 120 days before Time 2, generally the next prior assessment. If there is not an assessment greater than 120 days before, the oldest assessment is used.

### Calculation

**Step 1:** Average the scores in a domain. Multiply domain averages by 10 for both the Time 1 and Time 2 assessment. Note: If the Time 1 domain average score is less than the Reliable Change Index (RCI), the domain is not counted in the calculation since there is no possibility for improvement at Time 2.

**Step 2:** Subtract the Time 2 domain average from the Time 1 domain average.

**Step 3:** If the result is a positive number, then compare the number to the RCI, if equal to or greater than the RCI, then count record as improvement. If not, move on to Step 4.

**Step 4:** **Within the improved domain,** look for resolved Actionable Needs, scores of “2” or “3” in Time 1 and scores of “0” and “1” at Time 2. If there are resolved actionable needs within the domain, then record would count as improvement.

The total number of individuals with an improvement in at least one domain is the numerator. The total number of individuals with at least two assessments and a Time 1 average score equal to or more than the RCI is the denominator. Calculation is numerator divided by denominator multiplied by 100.

**Improvement in One Domain (New Calculation) for Closed Episodes**

Improvement in at least one of the domains constitutes improvement for this measure. Measure is reported monthly based on the reassessments completed during the month. At the end of each quarter, measure is cumulative year-to-date, that is, all reassessments completed during the fiscal year from beginning of fiscal year through the end of the specific quarter.

**Populations**: SMI, CA, SED (Birth-5 years) and (5-17 years)

**ANSA Domains Included:** Life Functioning, Behavioral Health Needs, Strengths, and Risk Behaviors.

**CANS Domains Included:** Life Functioning, Child Strengths, Caregiver Strengths and Needs, Child Behavioral/Emotional Needs, and Child Risk Behaviors.

**Time 2:** Time 2 is the most recent assessment for an episode that closed within the reporting period.

**Time 1:** If there are only two assessments within the episode, then Time 1 would be the initial assessment. Otherwise, the Baseline Assessment is determined. The Baseline Assessment is the highest level of need at the beginning of an episode of treatment. The calculation for the Baseline Assessment takes the initial and next assessment and determines which one had highest mean based on the following domains: for ANSA - Behavioral Health, Life Functioning, & Risk Behaviors and for CANS - Life Functioning, Caregiver Strengths and Needs, Child Behavioral/Emotional Needs, and Child Risk Behaviors. The assessment with the highest mean should be used as the Baseline Assessment for Time 1.

## Calculation

**Step 1:** Average the scores in a domain. Multiply domain averages by 10 for both the Time 1 and Time 2 assessment. Note: If the Time 1 domain average score is less than the Reliable Change Index (RCI), the domain is not counted in the calculation since there is no possibility for improvement at Time 2.

**Step 2:** Subtract the Time 2 domain average from the Time 1 domain average.

**Step 3:** If the result is a positive number, then compare the number to the RCI, if equal to or greater than the RCI, then count record as improvement. If not, move on to Step 4.

**Step 4:** Within the improved domain, look for resolved Actionable Needs, scores of "2" or "3" in Time 1 and scores of "0" and "1" at Time 2. If there are resolved actionable needs within the domain, then record would count as improvement.

The total number of individuals with an improvement in at least one domain is the numerator. The total number of individuals with at least two assessments and a Time 1 average score equal to or more than the RCI is the denominator. Calculation is numerator divided by denominator multiplied by 100.

**Community Integration**

The ANSA contains fourteen (14) items that are indications of an individual's recovery through integration in the community in which the individual lives. These items are Social Connectedness, Community Connection, Natural Supports, Resourcefulness, Social Functioning, Job History, Recreation, Family Functioning, Volunteering, Educational, Employment, Family Strengths, Spiritual/Religious, and Involvement in Recovery. These 14 items will be used to measure Community Integration. Measure is reported monthly based on the reassessments completed during the month. At the end of each quarter, measure is cumulative year-to-date, that is, all reassessments completed during the fiscal year from beginning of fiscal year through the end of the specific quarter.

**Population:** SMI and CA

**Time 2:** Time 2 is the most recent assessment in the reporting period.

**Time 1:** Time 1 is the assessment immediately prior to the Time 2 assessment, unless the date for that assessment is less than 120 days before Time 2, then look for an assessment more than 120 days before Time 2, generally the next prior assessment. If there is not an assessment greater than 120 days before, the oldest assessment is used.

**Strengths:** Social Connectedness, Community Connection, Natural Supports, Resourcefulness, Job History, Volunteering, Educational, Family Strengths, and Spiritual/Religious [Usable Strengths (0/1) = 1.]

**Life Functioning Needs:** Social Functioning, Recreation, Family Functioning, Employment, and Involvement in Recovery [Actionable Needs (2/3) = 1.]

## Calculation

**Step 1:** In Time 1 and Time 2, items are recoded. For Strengths, scores of "0" and "1" are recoded to "1." For Needs, scores of "2" and "3" are recoded to "1."

**Step 2:** For Strengths, Time 1 count is subtracted from the Time 2 count. For Needs, Time 2 count is subtracted from the Time 1 count. Add both results together, an answer greater than zero would be counted as improvement.

The total number of individuals with an improvement is the numerator. The total number of individuals with at least two assessments is the denominator. Calculation is numerator divided by denominator multiplied by 100.

**Strength Development**

Improvement is defined as developing useable ("1") and centerpiece strengths ("0"). Measure is reported monthly based on the reassessments completed during the month. At the end of each quarter, measure is cumulative year-to-date, that is, all reassessments completed during the fiscal year from beginning of fiscal year through the end of the specific quarter.

**Population:** SMI, CA, SED (Birth-5 years) and (5-17 years)

**Time 2:** Time 2 is the most recent assessment in the reporting period.

**Time 1:** Time 1 is the assessment immediately prior to the Time 2 assessment, unless the date for that assessment is less than 120 days before Time 2, then look for an assessment more than 120 days before Time 2, generally the next prior assessment. If there is not an assessment greater than 120 days before, the oldest assessment is used.

## Calculation

Step 1: For Time 1 and Time 2, items in the Strength Domain are recoded. Scores of "0" and "1" are recoded to "1."

Step 2: Time 1 count is subtracted from the Time 2 count. An answer greater than zero would be counted as improvement.

The total number of individuals with an improvement is the numerator. The total number of individuals with at least two assessments is the denominator. Calculation is numerator divided by denominator multiplied by 100.

## Performance Process Measures for SFY 2016

**Individuals Served**

**Population**: SMI, CA, Youth (SED and CA)

**SMI Definition:** Adult consumers with mental health diagnoses include all persons age 18 years and older who have an open episode of care and a SMI agreement identifier in the DARMHA data system.

**CA Definition:** Adult consumers with substance-related or addictive disorder diagnoses include all persons age 18 years and older who have an open episode of care and a CA agreement identifier in the DARMHA data system.

**Youth Definition:** Child and adolescent consumers include any youth with an SED agreement type and youth with a CA agreement type who are aged 0 - 17 with an open episode of care in the DARMHA data system during the reporting month.

A service during the month is defined as one or more encounter records during the month. All consumers with open episodes will be included in the calculation.

To be counted, consumers need to be identified as DMHA Supported Consumers during the reported period.

**Calculation**

On a monthly basis, this is a simple count of the unduplicated number of consumers with a SMI agreement identifier who have one or more encounters reported during the month. The calculation of average monthly takes the specific number served each month and averages the months in the reporting period. The measure is cumulative during the reporting year in that for the first reporting period, three months are averaged; in the second reporting period, six months are averaged; in the third reporting period, nine months are averaged; and in the fourth reporting period, twelve months are averaged.

**Reassessment – NOMs**

Percentage of DARMHA National Outcome Measures (NOMs) reassessments completed on time

**Population:** All DMHA supported consumers, excludes Medication Only consumers,

DMHA recommends assessing consumers approximately every six months. However, recognizing the barriers to accomplishing this standard (missed appointments, end dates of MRO, etc.) the window to complete a reassessment is now 240 days.

**Calculation**

Step 1: Identify all consumers active at any time during the reporting period who should have been assessed and have not been reassessed (greater than 210 days). Also, identify new consumers who have not had an assessment within 30 days of admission. These are eligible for reassessment. (Denominator)

Step 2: Of the consumers who were assessed in the reporting month, who were assessed within the 240 days. These are the on time reassessments. (Numerator

**Reassessment – CANS and ANSA**

Percentage of DARMHA CANS and ANSA reassessments completed on time

**Population:** All DMHA supported consumers, excludes Medication Only consumers

DMHA recommends assessing consumers approximately every six months. However, recognizing the barriers to accomplishing this standard (missed appointments, end dates of MRO, etc.) the window to complete a reassessment is now 240 days.

**Calculation**

Step 1: Identify all consumers active at any time during the reporting period who should have been assessed and have not been reassessed (greater than 210 days). Also, identify new consumers who have not had an assessment within 30 days of admission. These are eligible for reassessment. (Denominator)

Step 2: Of the consumers who were assessed in the reporting month, who were assessed within the 240 days. These are the on time reassessments. (Numerator)

## Gatekeeper Measures for SFY 2016

**Administrative Code Gatekeeping Compliance**

**Program**: Applies to all CMHC gatekeepers with enrolled clients in State Operated Facilities (SOF)

**Long Title:** Percentage of Face-to-Face Visits Completed within the Required Timeframe during a Reported Quarter

**Definition:** The Gatekeeper's role is defined in 440 IAC 5-1-3.5. Discharge planning for an individual client begins at admission to an SOF. After a client is admitted to a State Operated Facility the assigned gatekeeper shall conduct a face-to- face meeting with the client within 30 calendar days of admission and at least every 90 calendar days thereafter to evaluate treatment progress and discuss discharge planning.

**Purpose/Importance:** It is imperative that each client in the Mental Health Delivery system receive the least restrictive and most appropriate level of care based on their individual needs. Therefore, routine assessment of progress and discharge readiness by a gatekeeper for community placement is critical for the continuing recovery of each client while in an SOF.

**Measure Specific Source of Data:** During the state fiscal year the gatekeeper will complete a standard form of documentation entitled "Gatekeeper State Operated Facility Community Readiness Assessment and Recovery Summary" when conducting a face-to-face visit with the client. This documentation, which includes a measurable assessment, will be provided directly by the gatekeeper to the designated State Operated Facility within 2 business days following the face-to-face visit. Information from this document will be entered into the client's SOF electronic clinical record. Routine data will be generated from clinical record in a monthly report entitled "All SOF Gatekeeper Visit Detail Compliance Report" to monitor the frequency of face-to-face contact the gatekeeper has with the client.

The completion of a 30 day face-to-face visit and concurrent 90 day face-to-face visits (or authorized alternative) will be monitored in accordance to 440 IAC 5-1-3.5. Criteria identified to generate data verifying this measure will include admission date, date of last visit, number of days between visits, assessment type, participants in visit, and verification of patient participation by client signature (or SOF witness signature). Assessments must be complete to demonstrate compliance.

The calculation of a 30 day face-to-face visit after admission is measured within 30 calendar days of the client's admission date to an SOF. This visit is required to be a face-to-face "in person" visit between gatekeeper and patient. Alternative methods to conduct a face-to-face visit are not allowed for this initial visit.

The minimum 90 day face-to- face visit is measured within 90 calendar days from the initial 30 day visit and every 90 days thereafter until discharge. It is preferred, the 90 day face-to-face visit be an "in person" visit between assigned gatekeeper and client. However, the SOF may clinically authorize the use of videoconferencing as an alternative to a direct face-to-

face 90 day visit. This authorization must be clearly documented in the client's SOF clinical record. Videoconferencing must be acceptable to the client. If the client requests an in person face-to-face with the gatekeeper a visit is required. Only one videoconference may be conducted in a 6 month period of time. They may not be authorized for back-to-back visits. The "Gatekeeper State Operated Facility Community Readiness Assessment and Recovery Summary" is still required for videoconference meetings and must be sent to the SOF for signatures and entry in the clinical record.

**Method of Calculation:** Data for the calculation of compliance with face-to-face visits will be generated and compiled in a report entitled "All SOF Gatekeeper Visit Detail Compliance Report". This report will be generated on a quarterly basis and provides a list of SOF enrolled client's by gatekeeper. The report will identify the SOF and the specific unit the client currently resides. The report will count the calendar days between visits and specify with a "Yes or No" if the gatekeeper conducted a face-to-face or authorized alternative visit within 30 days of the admitting date and within every 90 calendar days thereafter.

The measure of the gatekeeper's average quarterly compliance with administrative code will be reflected on the "All SOF Gatekeeper Visit Detail Compliance Report". The total number of client's showing a "Yes" for gatekeeper compliance will be divided by the total number of client's the gatekeeper has enrolled in the SOF.

The CMHC gatekeeper shall demonstrate a quarterly compliance rate of 90% for face-to-face visits with all enrolled client's in State Operated Facilities.

- Compliance rates of 90% or above associated with this measure will be paid at $25,000 per quarter.
- Compliance rates of 75-89% with this measure will be paid a reduced rate of $15,000 per quarter.
- Compliance rates of 0-74% will receive $0 for the quarter.
- If the provider achieves an annual average compliance rate of 90%, 50% of their lost funds during the year will be restored.
- To qualify, the provider cannot show a noncompliant visit for the same individual in consecutive quarters.

**Data Limitations:** The DMHA has established standard timeframes for gatekeepers to submit documentation to SOFs and for SOF staff to conduct data entry of this information. It is imperative that gatekeepers set reminders to submit timely documentation. If there are concerns about documentation not being entered or filed in a timely manner, the gatekeeper must document their concerns in writing to the SOF clinical director and the DMHA Assistant Deputy Director of Provider and Community Relations. A monthly test report will be sent to the gatekeeper to help identify missing or incomplete documentation.

**Timely Discharge from State Operated Facilities (SOF) of All Populations**

**Program**: All Units in State Operated Facilities, except forensic units

**Long Title:** Quarterly percentage of individuals identified as ready for discharge from a SOF that are discharged within 90 calendar days of identification.

**Definition:** Timely discharge is defined as the Gatekeepers community placement of a client from the SOF within 90 calendar days from the date the client is placed on the DMHA Pending Discharge List (PDL) by the SOF(s) and determined ready for discharge.

Ready for Discharge is defined as the determination by an SOF treatment team that stabilization of psychiatric and/or behavioral symptoms, minimal risk towards self or others, and maximum benefit from hospitalization has been reached.

**Purpose/Importance:** It is imperative that clients in the Mental Health Delivery system receive the least restrictive and most appropriate care based on their individual needs. Therefore, timely discharge is critical for the continuing recovery of each individual ready for community placement.

**Measure Specific Source of Data:** Individual client data will be provided directly by the SOFs to DMHA through the use of an electronic Pending Discharge List (PDL).

During the state fiscal year, the Pending Discharge List will be generated each month and mailed to providers for review. The report will include the consumers name, population type, admission date, date placed on list, length of time on list measured in calendar days for each consumer, and the average length of wait by population for the identified gatekeeper. From the post-marked date, providers will have 10 business days to review the list for accuracy and notify the SOF in writing that they wish to invoke the Community Care Rule to discuss concerns about the individual's community readiness.

In addition, the SOF can report the following on the pending discharge list: status of the transition, target placement, barriers to transition, if the community care rule has been invoked, and when the person is discharged.

**Method of Calculation:** This measure will be calculated quarterly by comparing the "Gatekeeper Discharge Ready Status Report" and the "Monthly SOF Discharge Report". The measure will be reported by gatekeeper for each client discharge ready in a state operated facility and a percentage of those ready in all state operated facilities combined.

CMHC's must submit monthly discharge plans for all individuals exceeding ninety days on the pending discharge list to DMHA. Plans must include clinical progress, community barriers, and transitional action steps for each consumer.

For providers with four or less individuals on the quarterly pending discharge list, DMHA will allow one individual over 90 days to count towards the measure target if the discharge plan submitted to DMHA demonstrates sufficient efforts by the gatekeeper to address all barriers to transition. The one individual counted cannot be the same individual in consecutive quarters.

The target performance for each provider is 80% of all individuals listed on the monthly pending discharge list will be discharged to the community within 90 calendar days.

**Data Limitations:** It has been reported that occasionally a gap in communication between SOFs and gatekeepers occur when determining the readiness of an individual for discharge. It will be critical that gatekeepers maintain ongoing contact and consistent communication with SOF treatment teams in order to actively participate in the discharge readiness process. If there are differing opinions regarding readiness for discharge between the SOF and Gatekeeper, it is important all involved work together to exam the concerns and resolve differences. If efforts fail, the Community Care Rule (440 IAC 5-1-4) may be invoked and an appeal made to the State Operated Facility.

When an appeal is made, the practice implemented by the DMHA consists of the following steps to facilitate discussion between gatekeeper and SOF prior to DMHA review:

- Documented discussion between gatekeeping liaison and treatment team
- Documented discussion between gatekeeping medical director and SOF medical director
- Documented discussion between gatekeeping CEO and SOF Superintendent

If a resolution cannot be reached, written documentation of discussions from each level and the remaining discrepancies may be submitted to the Division of Mental Health and Addiction for review and a final decision on readiness for discharge. Individuals actively being reviewed under the Community Care Rule will not be included in this measure for 15 business days after the date invoked to allow discussion of the individual's readiness between SOF and Gatekeeper.

**Reducing the Use of Allocated Beds in State Operated Facilities (SOF)**

**Program**: All Adult Units in State Operated Facilities (excludes SED, forensic, and research population types)

**Long Title:** Monitoring the average number of allocated State Operated Facility (SOF) beds utilized by each provider for a reduced or maintained reduction in annual use.

**Definition:** Utilization refers to the total number of clients enrolled in the provider's allocated beds in State Operated Facilities (SOF). Allocated beds are the maximum number of SOF beds assigned by DMHA to each provider annually. Quarterly average references a three consecutive month average of beds utilized. Annual average references the average utilization of four consecutive quarters. Reduction references fewer allocated beds used at the end of an annual cycle than those used at the beginning.

**Purpose/Importance:** It is imperative that individuals in the Mental Health Delivery system receive the least restrictive and most appropriate care based on their individual needs. Therefore, it is imperative providers strive to develop community infrastructures, with emphasis on natural supports, to help meet those recovery needs in a community setting and demonstrate less reliance on State Operated Facilities.

**Measure Specific Source of Data:** A report entitled "SOF Client Enrollment Report by Gatekeeper" will be utilized and contains specific information as client name, SOF location, admission date, population type, and how many individuals of each population type are in SOFs per gatekeeper. This report is specific to each gatekeeper and is generated from the SOF electronic clinical record that maintains client admission and discharge information. In order to ensure accuracy, the report will be mailed to each provider serving as gatekeeper on a monthly basis. From the post-marked date, providers will have 10 business days to review the list for accuracy and notify DMHA in writing of any discrepancies per instruction on the cover letter included with the mailing.

**Method of Calculation:** Individual provider data will be generated on the first business day of each month in individualized gatekeeper reports entitled "SOF Client Enrollment Report by Gatekeeper" and "All SOF Gatekeeper Detailed Allocation". Both reports are mailed to the provider reflecting the number of individuals at each SOF, population type, and how many of these individuals count towards an individual provider's allocation. For monitoring purposes, DMHA will use these reports to calculate the utilization averages of each provider.

Monthly:

- The total number of allocated beds utilized by the provider on the first business day of the month divided by the total number of allocated beds assigned annually by DMHA

Quarterly:

- Adding the total number of allocated beds utilized by the provider on the first business day of the three consecutive months for a combined total of the current quarter
- Dividing the combined total of the quarter by three for a quarterly average

Annual:

- Adding four consecutive quarterly averages for a combined annual total
- Dividing the combined annual total by four for an annual average of allocated beds utilized

Averages will be reflected as a specific number of beds utilized, as well as, the percent of a provider's total allocation being utilized. Providers will be notified of their biannual and annual utilization averages.

Although providers are allowed to "borrow" unused allocated beds from another provider, borrowed bed(s) will not be reflected when calculating this measure.

Reduced average (or maintained reduction) of allocated beds will be calculated by comparing a provider's starting average to their final annual average.

The target performance for each provider is an average annual percentage of 75% or less utilization of allocated beds.

**Data Limitations:**
It has been reported that occasionally a client unknown to the provider is noted on the All SOF Client Enrollment Report by Gatekeeper. It will be critical that gatekeepers review this report on a monthly basis and immediately notify DMHA Assistant Deputy Director of Provider Quality and Performance in writing of the possible error so research and adjustment can be made to the monthly utilization calculations.

It is also critical for providers to check the population type of each client on the All SOF Client Enrollment Report by Gatekeeper. Population type is used to calculate how many clients are counted towards the providers allocated beds.

## Reliable Change Indices

Betty Walton, PhD

To measure change over time using the CANS and ANSA tools, changes between one rating score and another are clinically meaningful for an individual child. However, when rating scores are aggregated for a group of youth, statistically methods are used to help determine how much change is enough to be considered sufficient, not related to chance. The Reliable Change Index (RCI) is one method that can be used to determine when the change is large enough to be categorized as real change. The RCI is the size of a change that would be difficult to explain due to measurement error. Given the reliability of the measure, how large of a change would need to be observed on a scale to be replicable? The size of the RCI depends on the variability of the measure (standard deviation) and the reliability of the measure. A standard error of measurement of 1.28 is used as the standard of sufficient change.

RCI = 1.28 * (standard deviation) * Square Root (1- reliability)

Domain scores were calculated by averaging items within the domain; each domain is then multiplied times "10" to create a 30 point scale. In the 30 point scale, '0' indicates all '0' ratings and '30' indicates all '3' ratings. Note that only items which can change over time are included. For example, for young children, risk factors are not included.

Given an RCI for Life Domain Functioning of 2.68, this would mean that an individual would have to evince a change in the domain score of more than this value to achieve an improvement that could be seen as sufficient to be larger than to have occurred by chance.

**RCI Information** – Based on data run in previous years or 2015 data (The lowest RCI was chosen to be this year's RCI. If the RCI is new this year and based on 2015 data, then the RCI is bolded.)

| **ANSA Domains – SMI Population** | **n** | **mean** | **sd** | **RCI** | **SFY 2016 RCI** |
|---|---|---|---|---|---|
| Life Domain Functioning | 106,947 | 11.71 | 4.43 | 2.52 | 2.52 |
| Risk Behaviors | 83,860 | 2.47 | 2.56 | 1.50 | **1.50** |
| Behavioral Health | 83,860 | 9.70 | 4.01 | 2.36 | **2.36** |
| Strengths | 106,242 | 17.12 | 5.60 | 3.29 | 3.29 |

| **ANSA Domains – CA Population** | **n** | **mean** | **sd** | **RCI** | **SFY 2016 RCI** |
|---|---|---|---|---|---|
| Life Domain Functioning | 14,588 | 9.32 | 4.57 | 2.68 | **2.68** |
| Risk Behaviors | 14,588 | 2.17 | 2.35 | 1.38 | **1.38** |
| Behavioral Health | 14,588 | 7.88 | 4.38 | 2.57 | **2.57** |
| Strengths | 14,588 | 14.81 | 5.99 | 3.51 | **3.51** |

| **CANS Domains – 5 – 17 years** | **n** | **mean** | **SD** | **RCI** | **SFY 2016 RCI** |
|---|---|---|---|---|---|
| Life Domain Functioning | 56,532 | 9.77 | 3.71 | 2.18 | **2.18** |
| Child Strengths | 56,532 | 16.80 | 5.11 | 3.00 | **3.00** |
| Caregiver Needs & Strengths | 56,532 | 7.76 | 4.73 | 2.78 | 2.78 |
| Emotional/Behavioral | 31,493 | 6.92 | 3.75 | 2.20 | 2.20 |
| Risk Behaviors | 31,493 | 2.20 | 2.70 | 1.58 | 1.58 |

| **CANS Domains – Birth – 5 years** | **n** | **mean** | **SD** | **RCI** | **SFY 2016 RCI** |
|---|---|---|---|---|---|
| Life Domain Functioning | 3412 | 9.80 | 4.23 | 2.40 | 2.40 |
| Child Strengths | 3388 | 13.40 | 5.63 | 3.29 | 3.29 |
| Caregiver Needs & Strengths | 1647 | 5.94 | 5.09 | 2.98 | 2.98 |
| Emotional/Behavioral | 1647 | 4.70 | 4.07 | 2.39 | 2.39 |
| Risk Behaviors | 2640 | 6.20 | 4.53 | 2.65 | **2.65** |

## Replicating Performance Measure Calculations

Providers may replicate performance measure calculations from their local databases if the CANS and ANSA assessments are stored locally. Some providers have established internal performance monitoring based on location of services or based on specific programs. For consistency between the state-level calculations and local calculations, several business rules need to be applied.

a. For each measure, only items that are included in the definition and have a rating that is 0, 1, 2, or 3 are included. (Any item with a not applicable response is excluded from the calculation.)
b. Only the comprehensive CANS tools are to be used in calculations. If either the Time 1 or Time 2 CANS assessment is based on the older reassessment tool, those consumers should be excluded from the calculations due to absence of the extension modules and some differences in the domain items.
c. Calculations for any measure based on one or more domains or on an extension module utilize the mean (average) statistic. Mean (average) is recommended for the calculation formula since the 'n' sometimes changes. For example, on the ANSA, if Parental/Caregiver Role functioning is not rated (N/A) it should be omitted. Several items on the CANS 0 to 5 are similar due to developmental considerations. Many Caregiver items may be missing for specific youth on both CANS tools. The Mean function is more precise and would accommodate whatever data is there. Be sure to omit N/A by not using the -1 coding which is in DARMHA.

Providers can also download scorecard raw data from DARMHA to identify data issues and see the client level data that represents the performance measure numbers.