

Funding Pool	Performance Indicator	Incentive Amount per Indicator
<p>Crisis</p> <p>Total of 2% of Emergency Services funding</p> <p>Note: Of the three indicators, only two apply to each center.</p> <p>For regions for which Crisis Measure #1 does not apply, #3 will carry 2% risk.</p>	<p>CRISIS1. Measure Name: Psychiatric Hospital Admissions for Adults Who Received Services in a CMHC Adult Crisis Stabilization Unit</p> <p>Measure #1 applies to CMHCs which operate an Adult Crisis Stabilization Unit (01, 03, 04, 05, 06, 10, 11, 13, 14, 15)</p> <p>The DBHDID shall assess the psychiatric hospital admission rate for clients receiving services in a CMHC Crisis Stabilization Unit (CSU) in accordance with 908 KAR 2:090. The goal is that the percentage of psychiatric hospital admission rate will be no more than 5% during the monitoring period. This measure applies to CMHC CSUs which have operated for the entire monitoring period.</p> <p>Goal: Increase Effectiveness of Residential Crisis Services in a CMHC Crisis Stabilization Unit</p> <p>Risk: 1% of crisis funding</p> <p>CRISIS2. Measure Name: Readmissions for Children Receiving Services in a CMHC Children’s Crisis Stabilization Unit</p> <p>Measure #2 applies to CMHCs which operate a Children’s Crisis Stabilization Unit (04, 05, 06, 08, 10, 11, 12, 13)</p> <p>There are no consequences attached to this measure during 2017 monitoring period. This performance indicator will be studied during the monitoring period to prepare for a finalized indicator for the next (2018) monitoring period.</p> <p>The DBHDID shall assess the crisis stabilization unit readmission rate for clients receiving services in a CMHC Crisis Stabilization Unit. The goal is that no more than 12% of CMHC child clients having a crisis stabilization unit stay lasting for four days or more were readmitted during the following 30 day period. This measure applies to CMHC CSUs which have operated for the entire monitoring period.</p> <p>Goal: No more than 12% of child clients having a crisis stabilization unit stay lasting for four days or more and who were readmitted during the following 30 day period.</p> <p>Risk: 0% of crisis funding</p> <p>CRISIS3. Measure Name: Crisis Service Utilization by Adults and Children</p> <p>Measure #3 applies to CMHCs which operate only a CSU Adult Unit or only a CSU Children’s Unit yet not both (01, 03, 06, 08, 12, 14, 15). Measure #3 applies to CMHCs which do not operate either a CSU Adult Unit or a CSU Children’s Unit (02, 07).</p> <p>The DBHDID shall assess the utilization of three specific crisis services for adults</p>	<p>1%</p> <p>0%</p> <p>1% or 2%</p>

	<p>(Clients/1,000 Census – Adult) and for children (Clients/1,000 Census – Children). The goal is to deliver the three designated services at a rate that is, at minimum, 75% of the Region’s average rate over the last three completed monitoring periods.</p> <p>Goal: Maintain access to specific crisis services</p> <p>Risk: This measure will carry 1% of crisis funding for CMHCs (01, 03, 06, 14, 15) which operate a CSU Adult Unit and not a CSU Children’s Unit. This measure will carry 2% risk for CMHCs (08, 12) which do not operate a CSU Adult Unit and do operate a CSU Children’s Unit. This measure will carry 2% risk for CMHCs (02, 07) which do not operate a CSU Adult Unit or a CSU Children’s Unit (02, 07).</p>	
<p>DIVERTS</p> <p>Total of 3% allocated DIVERTS funding</p>	<p>DIVERTS1. Measure Name: 14-Day Follow-up for Accessible Referrals Made to the ISA ASA Data Tracking Tool</p> <p>The DBHDID shall assess the percentage of accessible referrals made during the 2017 monitoring period which received an in-reach service. The CMHC must conduct an in-reach service within fourteen (14) days of the referral date for 90% of the accessible referrals made during the monitoring period.</p> <p>Goal: Follow-up on Accessible Referrals</p> <p>Risk: 3% of DIVERTS funding</p>	3%
<p>SMI</p> <p>Total of 1% allocated SMI funding</p>	<p>SMI1. Measure Name: Hospital Readmissions for CMHC Referrals – 30 Days</p> <p>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.</p> <p>Goal: Reduce state psychiatric hospital re-admissions</p> <p>Risk: 1% of SMI funding</p>	1%
<p>SED</p> <p>Total of 3% allocated SED funding</p>	<p>SED1. Measure Name: Clients Receiving Targeted Case Management and Having SED</p> <p>The 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 SFY2017 monitoring period.</p> <p>Goal: Increase the percentage of children who receive Targeted Case Management that also are marked SED.</p> <p>Risk: 2% of SED funding</p>	2%
		1%

	<p>SED2. Measure Name: Child Population with SED Who Receive Targeted Case Management</p> <p>The 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 8% for the SFY2017 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).</p> <p>Goal: Increase the percentage of child population served with SED who Receive Targeted Case</p> <p>Risk: 1% of SED funding</p>	
<p>KENTUCKY HIGH FIDELITY WRAPAROUND</p> <p>Total of 2% allocated IMPACT High- Fidelity funding</p>	<p>HIFI1. Measure Name: IMPACT Clients Entered into IMPACT Outcomes Management System</p> <p>The DBHDID shall assess the percentage of all children with an SED-High Fidelity Wraparound 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 SFY2017 monitoring period.</p> <p>Goal: Increase the percentage of children entered into the IMPACT Outcomes System</p> <p>Risk: 1% of IMPACT High-Fidelity funding</p> <p>HIFI2. Measure Name: IMPACT Surveys Completed</p> <p>The 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 SFY2017 monitoring period.</p> <p>Goal: Ensure that follow-up occurs for children in the IMPACT Program</p> <p>Risk: 1% of IMPACT High-Fidelity funding</p>	<p>1%</p> <p>1%</p>
<p>SA Prevention</p> <p>Total of 0% allocated SA Prevention funding</p>	<p>SAP1. Measure Name: Regional Prevention Centers Use of Community-Based Process Strategy</p> <p>Measure #1 applies to all CMHC regions operating a Regional Prevention Center</p> <p>The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy “Community-Based Process”. The BHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the “Community-Based Process” CSAP Strategy. The standard of performance for each respective center is an increase of 1% in the number of completed activities that are appropriately reported under “Community-Based Process” in the Prevention Data System during the current and</p>	<p>0%</p>

	<p>last monitoring periods.</p> <p>Goal: Increase Regional Prevention Center Usage of Community-Based Process CSAP Strategy</p> <p>Risk: 0% of Prevention funding</p>	
<p>SA Treatment</p> <p>Total of 4% allocated SA Treatment funding</p>	<p>SUD1. Percent of Census Population Served</p> <p>This measure calculates the percentage of the census population served who are estimated in need of treatment.</p> <p>Goal: Address penetration rate</p> <p>Risk: 1% of SUD funding</p>	1%
	<p>SUD2. Number of Services per Treatment Episode</p> <p>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.</p> <p>Goal: Address engagement rate</p> <p>Risk: 1% of SUD funding</p>	1%
	<p>SUD3. Percent of Treatment Episodes Lasting Thirty (30) Days or Longer</p> <p>This measure calculates the percent of outpatient TEDS Episodes which lasted thirty (30) days or longer.</p> <p>Goal: Address treatment retention</p> <p>Risk: 1% of SUD funding</p>	1%
	<p>SUD4. Number of Services in the First Thirty (30) Days</p> <p>This measure calculates the number of outpatient services provided during the first thirty (30) days post admission.</p> <p>Goal: Address treatment retention</p> <p>Risk: 1% of SUD funding</p>	1%
KIDS NOW PLUS (KN+)	No performance indicator identified.	NA
Driving Under the Influence (DUI) Services	No performance indicator identified.	NA
Alcohol	No performance indicator identified.	NA

Intoxication Services (AI)		
Developmental and/or Intellectual Disabilities (DDID) Total of 1% allocated I/DD general funds	<p>I/DD1. I/DD Clients with Multiple Hospital Admissions</p> <p>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.</p> <p>Goal: Reduce the number of individuals who experience psychiatric hospital re-admissions</p> <p>Risk: 1/2% of DDID funding</p>	1/2%
	<p>I/DD2. I/DD Department Periodic Report (DPR) Form 140 Submissions</p> <p>The DBHDID shall assess the timeliness of completed Form 140 as due through the Department Periodic Report processes. The completed form is due by the end of the calendar month following the end of each quarter.</p> <p>Goal: Completeness & Timeliness of DPR Form 140 Submissions</p> <p>Risk: 1/2% of DDID funding</p>	1/2%
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 – First Episode	No performance indicator identified.	NA

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Psychosis		
Other Services – Kentucky Adolescent Treatment Education Grant (KAT-ED)	No performance indicator identified.	NA
Other Services – Practicewise Implementation Support Services	No performance indicator identified.	NA
Other Services – Transition Age Youth Launching Realized Dreams (TAYLRD)	No performance indicator identified.	NA
Other Services – Zero Suicide Initiative (ZSI) Prevention Enhancement Site (PES)	No performance indicator identified.	NA
Consumer Operated Services (COS)	No performance indicator identified.	NA
Toll Free & DBHDID Treatment Call Line (For Region 6 only)	No performance indicator identified.	NA
Homeless Prevention Project	No performance indicator identified.	NA
Administrative Services	No performance indicator identified.	NA

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

CRISIS1. Measure Name: Psychiatric Hospital Admissions for Adults Who Received Services in a CMHC Adult Crisis Stabilization Unit

Measure #1 applies to CMHCs which operate an Adult Crisis Stabilization Unit (01, 03, 04, 05, 06, 10, 11, 13, 14, 15)

The DBHDID shall assess the psychiatric hospital admission rate for clients receiving services in a CMHC Crisis Stabilization Unit (CSU) in accordance with 908 KAR 2:090. The performance indicator is defined as the percentage of adult clients who received a residential crisis stabilization services in a CMHC CSU during the monitoring period and 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 from the last day of an episode of residential crisis stabilization services. Hospital admissions that occur on the same day or within 1 day from the last day of an episode of care of residential crisis stabilization services do not apply. The goal is that the percentage of psychiatric hospital admission rate will be no more than 5% during the monitoring period. This measure applies to CMHC CSUs which have operated for the entire monitoring period.

Goal: Increase Effectiveness of Residential Crisis Services in a CMHC Crisis Stabilization Unit

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 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 day of an episode of residential crisis stabilization services. Hospital admissions that occur on the same day or within 1 day of the last day of an episode of care of residential crisis stabilization services do not apply. For the purposes of this performance indicator, an episode of care of adult residential crisis stabilization services is determined by at least two days of consecutive adult crisis residential service (138) followed by a gap in adult crisis residential stabilization service of 30 days.

Denominator: the unduplicated count of adult clients at each center who received at least two days of consecutive adult crisis residential service (Service Code 138 -MH Adult) in a CMHC CSU followed by a gap in adult crisis residential stabilization service of 30 days during the monitoring period.

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 this service 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 the monitoring period will be a no more than 5% during the monitoring period.

Monitoring Period:

2016 = April 1, 2015 through March 31, 2016; 2017 = April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: Client & Event Data; Facilities Data

Denominator Source: Client & Event Data

CRISIS2. Measure Name: Readmissions for Children Receiving Services in a CMHC Children’s Crisis Stabilization Unit

Measure #2 applies to CMHCs which operate a Children’s Crisis Stabilization Unit (04, 05, 06, 08, 10, 11, 12, 13)

There are no consequences attached to this measure during 2017 monitoring period. This performance indicator will be studied during the monitoring period to prepare for a finalized indicator for the next (2018) monitoring period.

The DBHDID shall assess the crisis stabilization unit readmission rate for clients receiving services in a CMHC Crisis Stabilization Unit. The performance indicator is defined as the percentage of child clients who are client-status-1 clients who received a CMHC service within 60 days prior to receiving four or more days of consecutive child crisis residential service (Service Code 139 -MH Children) in a CMHC CSU during the monitoring period who are readmitted to the same residential crisis stabilization unit in 30 days or less from the day of the last residential crisis stabilization service episode. Readmissions that occur on the same day or within 1 day of the last day of an episode of care of residential crisis stabilization services do not apply. The goal is that no more than 12% of CMHC child clients having a crisis stabilization unit stay lasting for four days or more were readmitted during the following 30 day period. This measure applies to CMHC CSUs which have operated for the entire monitoring period.

Goal: No more than 12% of child clients having a crisis stabilization unit stay lasting for four days or more and who were readmitted during the following 30 day period.

Risk: 0% of crisis funding

Numerator: Of the clients counted in the denominator, the unduplicated number of clients who had at least one admission to a crisis stabilization unit in 30 days or less of the last day of an episode of residential crisis stabilization services. Admissions that occur on the same day or within 1 day of the last day of an episode of care of residential crisis stabilization services do not apply. For the purposes of this performance indicator, an episode of care of children residential crisis stabilization services is determined by having at four or more days of consecutive children crisis residential service (139).

Denominator: the unduplicated count of child clients at each center who are client-status-1 clients who received a CMHC service within 60 days prior to receiving four or more days of consecutive child crisis residential service (Service Code 139 -MH Children) in a CMHC CSU.

Service Name	Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”
Residential Crisis Stabilization	139 (MH Children)

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

Benchmark: No more than 12% of CMHC child clients having a crisis stabilization unit stay for four days or more were readmitted during the following 30 day period.

Monitoring Period:

2017 = April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: Client & Event Data

Denominator Source: Client & Event Data

CRISIS3. Measure Name: Crisis Service Utilization by Adults and Children

Measure #3 applies to CMHCs which operate only a CSU Adult Unit or only a CSU Children’s Unit yet not both (01, 03, 06, 08, 12, 14, 15). Measure #3 applies to CMHCs which do not operate either a CSU Adult Unit or a CSU Children’s Unit (02, 07).

The DBHDID shall assess the utilization of three specific 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 any of the three specific crisis services (MH Non-Residential Crisis Response, Crisis Intervention, or I/DD Crisis Prevention) during the monitoring period. 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 persons in the region. The goal is to deliver the three designated services at a rate that is, at minimum, 75% of the Region’s average rate over the last three completed monitoring periods.

Goal: Maintain access to specific crisis services

Risk: This measure will carry 1% of crisis funding for CMHCs (01, 03, 06, 14, 15) which operate a CSU Adult Unit and not a CSU Children’s Unit. This measure will carry 2% risk for CMHCs (08, 12) which do not operate a CSU Adult Unit and do operate a CSU Children’s Unit. This measure will carry 2% risk for CMHCs (02, 07) which do not operate a CSU Adult Unit or a CSU Children’s Unit (02, 07).

Numerator: the unduplicated count of adult or child clients at each center who received any of the following services:

Service Name	SFY2014 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”	SFY2015, SFY2016 and SFY2017 Service Code as entered in event file field NTE02 (DMHMRS_Modifier_1) “BHDID Service Code”
MH Non-Residential Crisis Response	076	176
I/DD Crisis Prevention	091	191
Crisis Intervention	n/a	200

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.

Denominator: the CMHC regions’ total adult or child population (per 2010 U.S. Census)

Total Population Census 2010 Source: (<http://ksdc.louisville.edu/index.php/component/content/article/123-2010-census-quick-tables/220-state-and-counties>)

CMHC Region #	2010 Census	2010 Census age 18 and over	2010 Census under age 18
01	205,912	161,545	44,367
02	209,786	158,100	51,686
03	213,472	161,977	51,495
04	284,195	217,231	66,964
05	269,117	200,640	68,477
06	959,091	730,843	228,248
07	438,647	326,235	112,412
08	56,478	42,757	13,721
10	219,536	170,601	48,935
11	154,093	119,756	34,337
12	114,762	89,550	25,212

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13	236,618	181,110	55,508
14	207,256	160,202	47,054
15	770,404	595,449	174,955

The calculated number using the numerator and denominator is then multiplied by 1,000 to show clients per 1,000 persons in the region.

Benchmark: The percent calculated during the 2017 monitoring period will be, at minimum, 75% of the Region's average rate over the last three monitoring periods.

Monitoring Periods

Last three completed:

2014 = April 1, 2013 through March 31, 2014

2015 = April 1, 2014 through March 31, 2015

2016 = April 1, 2015 through March 31, 2016

Current:

2017 = April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: Client & Event Data; report "M-1D: CMHC Service Mix/Utilization" which is posted to the CMHC Secure login page for each CMHC.

Denominator Source: 2010 Census – adult and child population per county according to the Kentucky Data Center, University of Louisville, 2011. (<http://ksdc.louisville.edu/index.php/component/content/article/123-2010-census-quick-tables/220-state-and-counties>)

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

DIVERTS1. Measure Name: 14-Day Follow-up for Accessible Referrals Made to the ISA ASA Data Tracking Tool

The DBHDID shall assess the percentage of accessible referrals made during the 2017 monitoring period which received an in-reach service. The CMHC must conduct an in-reach service within fourteen (14) days of the referral date for 90% of the accessible referrals made during the monitoring period.

Goal: Follow-up on Accessible Referrals

Risk: 3% of DIVERTS funding

Numerator: the number of accessible referrals made to the ISA ASA Data Tracking Tool during the 2017 monitoring period for which a valid in-reach service occurred within fourteen (14) calendar days of the referral date and for which this valid in-reach service has a valid date recorded in the “In-Reach” field in the ISA ASA Data Tracking Tool.

Denominator: the number of accessible referrals made to the ISA ASA Data Tracking Tool during the 2017 monitoring period. Referrals will be grouped by CMHCs according to the county of the personal care home where the person resides or the hospital discharge 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 accessible referrals made the ISA ASA Data Tracking Tool during the monitoring period which are assigned to the CMHC according to the location specified on the referral form.

Monitoring Period: April 1, 2016 through March 31, 2017

Data Sources:

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

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

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)

SMI1. 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.

Goal: Reduce state psychiatric hospital re-admissions

Risk: 1% of SMI funding

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

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. Criteria include client-status-1 clients who received a CMHC services within one (1) year prior to the psychiatric hospital admission.

Benchmark: The following benchmark criteria must be met:

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

And

B. The 5-year trend of the CMHC's 75th quantile mark must trend toward being equal to or less than the 75th quantile mark of the statewide rate calculated over the past five monitoring periods.

Monitoring Period: April 1, 2016 through March 31, 2017

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

SED1. Measure Name: Clients Receiving Targeted Case Management and Having SED

The 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 SFY2017 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)” or 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

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

Risk: 2% of SED funding

Numerator: The count of SED children and youth as defined by answer options 1 “Yes (SED)” or 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file and have received Targeted Case Management as indicated by answer option “061” (Case Management Services Children or Youth with SED) in the field “NTE02 DMHMRS_Modifier_1 (DBHDID Service code)” in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide

Denominator: The 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 SFY2017 monitoring period.

Monitoring Period: April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: client data (field #41, answer option 1 “Yes (SED)” or 2 “SED – High Fidelity Wraparound”).

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”.

SED2. Measure Name: Child Population with SED Who Receive Targeted Case Management

The 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 8% for the SFY2017 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/High Fidelity Wraparound marker is defined as answer options 1 “Yes (SED)” or 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. The Targeted Case Management service is defined as answer option “061” (Case Management Services Children with SED) in the field “NTE02 DMHMRS_Modifier_1 (DBHDID Service code)” in the event file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide.

Goal: Increase the percentage of child population served with SED who Receive Targeted Case

Risk: 1% of SED funding

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

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

Benchmark: The standard of performance is 8% for the SFY2017 monitoring period.

Monitoring Period: April 1, 2016 through March 31, 2017

Data Sources:

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

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

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 2.05—KENTUCKY HIGH FIDELITY WRAPAROUND

HIFI1. Measure Name: IMPACT Clients Entered into IMPACT Outcomes Management System

The DBHDID shall assess the percentage of all children with an SED-High Fidelity Wraparound 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 SFY2017 monitoring period. The SED-High Fidelity Wraparound marker is defined as answer option 2 “SED - High Fidelity Wraparound” in field #41 “Severe Emotional Disability (SED)” in the client file as submitted monthly to the BHDID according to the BHDID Data Implementation Guide. This measure excludes any SED-High Fidelity Wraparound 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 SFY2017 monitoring period.

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

Risk: 1% of IMPACT High-Fidelity funding

Numerator: The count of children with an SED-High Fidelity Wraparound 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-High Fidelity Wraparound 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: April 1, 2016 through March 31, 2017

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/cmhcdataareports.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”.

HIFI2. Measure Name: IMPACT Surveys Completed

The 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 SFY2017 monitoring period.

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

Risk: 1% of IMPACT High-Fidelity funding

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 SFY2017 monitoring period.

Monitoring Period: April 1, 2016 through March 31, 2017

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”.

SECTION 2.07 –SUBSTANCE ABUSE PREVENTION

SAP1. Measure Name: Regional Prevention Centers Use of Community-Based Process Strategy

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

The DBHDID shall assess the usage of the Center for Substance Abuse Prevention (CSAP)-supported strategy “Community-Based Process”. The BHDID will use the Prevention Data System to calculate the percentage of completed activities that are appropriately reported by the center under the “Community-Based Process” CSAP Strategy. The standard of performance for each respective center is an increase of 1% in the number of completed activities that are appropriately reported under “Community-Based Process” in the Prevention Data System during the current and last monitoring periods.

Goal: Increase Regional Prevention Center Usage of Community-Based Process CSAP Strategy

Risk: 0% of Prevention funding

Numerator: the number of completed activities reported in the Prevention Data System for the respective center that are appropriately associated with the CSAP Strategy “Community-Based Process”

Denominator: the number of completed activities reported in the Prevention Data System for the respective center

Benchmark: The percent calculated during the current monitoring period will be at least 1% more than the percent calculated for the previous monitoring period.

Monitoring Period:

Previous = April 1, 2015 through March 31, 2016

Current = April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: Prevention Data System

Denominator Source: Prevention Data System

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

SECTION 2.08—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

SUD1. Percent of Census Population Served

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

Goal: Address 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: April 1, 2016 through March 31, 2017

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.

SUD2. Number of Services per Treatment Episode

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

Goal: Address 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 monitoring period

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

Monitoring Period: January 1, 2016 through December 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”.

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

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

Goal: Address 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 monitoring period

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

Monitoring Period: January 1, 2016 through December 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”.

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

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

Goal: Address 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 monitoring period

Benchmark: at minimum, an average of four (4) outpatient services will be provided during the first thirty (30) days of a Treatment Episode Data Set (TEDS) episode.

Monitoring Period: January 1, 2016 through December 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 2.12–DEVELOPMENTAL AND OTHER INTELLECTUAL DISABILITIES (DID)

Risk: I/DD1 – 1/2% of DDID funding

Risk: I/DD2 – 1/2% of DDID funding

I/DD1. I/DD 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.

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

Risk: 1/2% of DDID funding

Numerator: the count of those in the denominator who had 2 or more admissions to any state-owned or state-contracted psychiatric hospital (ARH-Hazard Psychiatric Unit, Central State Hospital, Eastern State Hospital, Western State Hospital) within any 180 day period during the monitoring period.

Denominator: Regardless of payer source, 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. Criteria include client-status-1 clients who received a CMHC services within one (1) year prior to the psychiatric hospital admission.

Benchmark: The following benchmark criteria must be met:

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

And

B. The 5-year trend of the CMHC's 75th quantile mark must trend toward being equal to or less than the 75th quantile mark of the statewide rate calculated over the past five years.

Monitoring Period: April 1, 2016 through March 31, 2017

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".

I/DD2. I/DD Department Periodic Report (DPR) Form 140 Submissions

The DBHDID shall assess the timeliness of completed Form 140 as due through the Department Periodic Report processes. The completed form is due by the end of the calendar month following the end of each quarter.

Goal: Completeness & Timeliness of DPR Form 140 Submissions

Risk: 1/2% of DDID funding

SFY2017 Performance Indicator Implementation Guide

Numerator: The total number of completed reports submitted during the monitoring period which are submitted by the end of the calendar month following the end of each quarter.

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

Benchmark: The standard of performance is that three (3) of the four (4) quarterly reports will be received as complete by BHDID by the end of the calendar month following the end of each quarter.

Monitoring Period: April 1, 2016 through March 31, 2017

Data Sources:

Numerator Source: DPR Form 140 submitted to the BHDID following DPR processes

Denominator Source: The number of required DPR Form 140s during the monitoring period

Reports Available: Quarterly communications on successful receipt of completed DPR Form 140 will be relayed from the Division of Developmental & Intellectual Disabilities CMHC liaison staff during scheduled meetings between the liaisons and CMHC I/DD staff.
